

The Afghan Symptom Checklist: A Culturally Grounded Approach to Mental Health Assessment in a Conflict Zone

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This article describes a methodology for developing culturally grounded assessment measures in conflict and postconflict situations. A mixed-method design was used in Kabul, Afghanistan, to identify local indicators of distress and develop the 22-item Afghan Symptom Checklist (ASCL). The ASCL contains several indigenous items and items familiar to Western mental health professionals. The ASCL was pilot tested and subsequently administered to 324 adults in 8 districts of Kabul. It demonstrated excellent reliability ($\alpha = .93$) and good construct validity, correlating strongly with a measure of exposure to war-related violence and loss ($r = .70$). Results of the survey indicate moderate levels of distress among Afghan men and markedly higher levels of distress and impaired functioning among women (and widows in particular).

Keywords: PTSD, assessment, Afghanistan, war, culture

There is a growing recognition of the value of incorporating culturally specific idioms of distress into assessments of mental health when working in conflict and postconflict situations (de Jong, 2002; van de Put & Eisenbruch, 2004; Wessells & Monteiro, 2004). The great majority of the world's violent political conflicts during the past 50 years have taken place in non-Western societies, with cosmologies quite distinct from those found in Western industrialized nations (Englund, 1998; Miller, Kulkarni, & Kushner, 2006). A strict reliance on the language and constructs of Western psychiatry risks inappropriately prioritizing psychiatric syndromes that are familiar to Western practitioners, such as posttraumatic stress disorder (PTSD), but that may be of secondary concern or simply lack meaning to non-Western populations for whom local idioms of distress are more salient.

Kleinman (1987) has cautioned against what he termed the *category fallacy*, which entails the erroneous assumption that a diagnostic construct developed in one cultural context is meaningful in a different cultural context simply because the symptoms that constitute it can be identified in both settings. A consideration of the category fallacy suggests two essential and overlapping lines of research: The first entails studying the cross-cultural validity of Western diagnostic constructs, and the second involves the identification of culturally specific ways in which psychological dis-

tress is expressed and understood. From a clinical perspective, the latter focus is especially important: the development of effective psychological interventions requires an understanding of the ways in which people in particular cultures experience and articulate the ways they have been affected by adverse life events (de Jong, 2002; Summerfield, 1999).

Researchers interested in developing culturally grounded assessment measures will find little by way of guidance in the existing literature on the mental health effects of organized violence. In a recent methodological review of the refugee mental health literature, Hollifield et al. (2002) found that, of 183 studies examining refugee mental health, 141 (78%) relied exclusively on measures of psychopathology developed in research with Western populations; moreover, half of the studies reviewed provided no information regarding the psychometric properties of their measures in the specific population studied (i.e., any psychometrics reported were based on the instruments' use in previous research either with Western nonrefugee populations, or with refugees of different ethnic and national backgrounds than those of the target population). This reliance on Western psychiatric instruments and the failure to appropriately standardize or adapt existing measures for use with specific refugee populations reflect an essentialist belief within the Western mental health professions that core symptoms of psychopathology and their underlying causal mechanisms are essentially culturally invariant (Bracken, Giller, & Summerfield, 1995; Miller et al., 2006). Once we presume the cross-cultural salience of Western diagnostic constructs, there is little apparent need to examine cultural variations in the nature of psychological distress and the diverse ways in which it may be expressed and understood.

A Constructivist Alternative to Psychiatric Essentialism

In contrast to the essentialism of contemporary Western psychiatry and clinical psychology, a social constructivist perspective draws our attention to research documenting the profound influ-

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ence that cultural contexts have on the experience and expression of emotional distress (Kleinman, 1987). A constructivist framework does not negate the possibility of common responses to stressful life events; however, it does caution against assuming that psychiatric constructs identified in one culture are similarly meaningful in other cultural contexts. For example, symptoms of PTSD have been identified in numerous studies of non-Western, war-affected populations; however, anthropological research with many of these same populations suggests that idioms of distress other than PTSD are more salient in people's experience of war-related distress. Such idioms include *susto*, *nervios*, and *calor* among survivors of political repression and civil war in Central America (Farias, 1991; Jenkins, 1996), "thinking too much" and "Cambodian sickness" among survivors the Cambodian genocide (van de Put & Eisenbruch, 2004), and spirit possession among displaced Mozambicans (Englund, 1998).

Familiarity with culturally specific idioms of distress allows practitioners to communicate effectively with distressed community members and to develop mental health interventions that are likely to be perceived as responsive to local beliefs and values. In contrast, mental health programs that exclusively target culturally unfamiliar syndromes are more likely to be seen as alienating and imposed (Summerfield, 1999).

This article describes an easily implemented methodology for learning about the ways that psychological well-being and distress are understood and expressed in specific cultural settings. Adapted from similar methodologies that have been utilized in Rwanda and Uganda (Bolton & Tang, 2002), as well as Guinea (Hubbard & Pearson, 2004), it offers an accessible and efficient approach to creating culturally meaningful mental health assessment measures for use in conflict and postconflict situations, where information must be gathered quickly and with relative ease by program staff, many of whom may not have mental health backgrounds. Working in Afghanistan's capital city of Kabul, we used a multimethod approach that integrated qualitative and quantitative research methods to identify key dimensions of mental health and salient indicators of psychological well-being and distress. These indicators were used to develop a 22-item instrument, the Afghan Symptom Checklist (ASCL), a brief assessment tool designed for efficient and culturally grounded needs assessment and program evaluation. The development of the ASCL is described, and its psychometric properties are reported. We also describe briefly the results of the mental health survey that we conducted in Kabul using the ASCL.

Political Violence and Displacement in Afghanistan

Afghans have endured more than 20 of war and political repression: 10 years of *jihad*, or "holy war," against the Soviets, in which nearly 1 million Afghans were killed and a far greater number displaced from their homes and communities; 4 years of civil war among warlords competing for control of the country; and the ensuing rule of the Taliban, an Islamic fundamentalist group that brought some degree of order to the country but also imposed severe restrictions on all aspects of daily life (Goodson, 2001; Kakar, 1995; Rashid, 2000).

It was during the civil war, between 1992 and 1996, that Kabul experienced an extraordinary degree of destruction and loss of life. Before the civil war, Kabul had been spared the devastating violence that enveloped the countryside during the *jihad*. After the

Soviet withdrawal, however, competing warlords, former commanders in the *jihad* against the Soviets, turned their sights on gaining control of the country and, in particular, the capital city of Kabul. From bases atop the mountains that surround the city, they rained down thousands of rockets on the civilian population below. Entire neighborhoods were reduced to rubble, tens of thousands of people were killed or severely injured, and many fled for the relative safety of refugee camps in Pakistan or areas of lesser conflict within Afghanistan.

The conquest of Afghanistan by the Taliban, who took control of Kabul in 1996, was initially welcomed by most Afghans. A fundamentalist Islamic group with roots in the largely Pashtun province of Qandahar, the Taliban promised an end to the destructive violence and widespread lawlessness brought on by the *jihad* and the civil war. Widespread relief over the end of the fighting was short-lived, however, and was quickly replaced by horror at the repressive interpretation of Islamic law imposed by the Taliban. For women and girls, Taliban laws were particularly oppressive: Access to health care and education for females was dramatically curtailed, and women were not allowed to be outside the home without male accompaniment—a particularly devastating law for widows who had no source of income and no male relative to accompany them in search of work or material assistance. For both men and women, violations of Taliban laws were met with imprisonment, torture, and in many instances, execution (Physicians for Human Rights, 1998; Rashid, 2000).

The overthrow of the Taliban in November 2001 created a window of opportunity to address the mental health needs of Afghans affected by more than 2 decades of war and oppression. The country remains a conflict zone, however. Much of Afghanistan is still controlled by warlords, the Taliban and Al Qaeda remain active in the country's southern and eastern provinces, and terrorist attacks continue both within and outside of the capital.

Despite these conditions, however, numerous nongovernmental organizations (NGOs) are developing mental health projects in Afghanistan, and researchers have begun to document the mental health of war-related violence and other stressors on Afghans (Lopes Cardozo et al., 2004; Scholte et al., 2004). To date, however, research and intervention efforts have been guided primarily by a Western conceptualization of mental health. There are no assessment measures that include indigenous Afghan idioms of distress and no empirically based framework for understanding how Afghans understand and articulate psychological well-being and suffering. The present study was designed both to address this empirical gap and to field test a methodology for developing culturally grounded assessment measures for use in conflict and postconflict situations.

Method

The Research Team

The research was designed and carried out through a collaborative effort between Kenneth E. Miller—a psychology professor based in the United States, the staff of the AFSC Quaker Service in Kabul, and a team of local community members who have worked with the director of AFSC on several previous research projects. AFSC has been active in Afghanistan since shortly after the fall of the Taliban and is focused on educational and mental health activities developed in collaboration with local communities in various parts of the country. The director of AFSC (Patricia Omidian) is an American medical anthropologist who has worked extensively with

Afghans both within Afghanistan and in living as refugees in Pakistan and the United States. All other AFSC staff are Afghans, as are the other members of the research team, with educational backgrounds ranging from high school to advanced graduate education. Research team members live in several of the neighborhoods in which data were gathered, and most were in Kabul throughout the civil war. Both of the female surveyors lost their husbands during the war, and one of the men was imprisoned by the Taliban when he was caught with a beard shorter than the proscribed length.

Step 1: Eliciting Narratives and Identifying Indicators of Well-Being and Distress

The first task in the development of a culturally grounded measure of mental health is to identify locally meaningful indicators of well-being and distress. To accomplish this, we used a convenience sample of 20 community members, 10 women and 10 men, in two districts of Kabul. Women were approached in their homes by the 2 Afghan female interviewers, and men, who are rarely at home during the day, were approached in mosques, in shops, and on the street by the 2 male interviewers. Each person interviewed was asked to think of two people they knew, both of whom had suffered emotionally because of difficult life experiences. One person should be someone who had recovered and was now functioning well despite the hardships he or she had endured; the other person should be someone who continued to suffer despite the passing of time. Participants were then asked to tell each person's story in detail (i.e., what difficult life events they had experienced, how they had been affected). They were also asked to describe specific indicators that reflected each person's suffering or, conversely, their recovery and well-being. Finally, participants were asked why they believed the healthier person had recovered (i.e., was no longer suffering) and why the distressed person was still experiencing difficulties.¹

An equal number of women and men were interviewed over the course of 5 days, and a total of 40 narratives were collected: 10 women and 10 men who were doing well, and 10 women and 10 men who were still suffering. The narratives focused equally on participants' relatives and neighbors. Because Afghans are generally wary of being tape recorded, the interviewers took handwritten notes during the interviews. The process of content analysis was conducted in a fairly informal manner, given our time constraints and the sudden illness of our transcriptionist. Categories of distress, as well as common indicators of distress, were identified by reading through handwritten notes, noting the frequency with which different indicators of distress were mentioned, sharing our impressions in group discussions, and eventually reaching group consensus. Although this approach lacks the rigor of formal coding, assessment of interrater reliability, and formal thematic analysis (e.g., Denzin & Lincoln, 2000), we believe it closely approximates the approach to qualitative data analysis that is likely to take place in community-based organizations working under the challenging conditions of conflict and postconflict settings.

The painful life experiences mentioned in the narratives were primarily related to the *jihad* and the civil war but also included other stressors such as family violence, poverty, and illness. A content analysis revealed three dimensions of mental health: (a) behavior within the community (e.g., the degree of respect shown toward one's neighbors and the quality of one's participation in community life), (b) behavior within the family (e.g., the degree to which one maintained harmonious family relations), and (c) a person's internal state (e.g., quality of mood, relative state of calm or agitation, faith in God, and maintenance of hope and patience in the face of hardships). Within each of these three domains, several indicators of poor mental health were identified that would eventually form the items on the questionnaire. A sample narrative is given later (the Dari terms in the narrative are explained below).

Step 2—Selecting Indicators of Distress

In the next step, the team identified the most commonly mentioned indicators of distress in the narratives and created a measure that assessed

the frequency with which an individual had experienced each item during the previous 2 weeks. Three categories of indicators were selected, corresponding to the three dimensions of mental health mentioned earlier: functioning in the community, functioning within one's family, and one's internal state.

Sample Narrative

The daughter of the woman who is the focus of this story told us the following story.²

We were four sisters and four brothers. Only two of our sisters were older, and the rest of our brothers and sisters were younger when our father died of natural causes. Our mother raised the children under very poor circumstances. During that time the fighting was very bad. One of our brothers left home to go get groceries; he was only 21 years old. The fighters asked him where he was from, then they killed him. This affected our mother very much. Then our 18-year-old brother left to go get groceries, too, and a bomb hit that area and he died. Our family was at home, but they brought the bodies to our mother. Our second brother died 2 months after the first brother. Our mother continued to live her life, but she is very weak. She works at a hospital. Her pay, which is 1700 to 1800 Afghanis [about US\$36] a month helps her live her life. And her two sons live with her. She always has a severe headache. Her *fishar* is always high and she has diabetes. She doesn't have much of an appetite. She often becomes *jigar khun* and cries a lot and tries to stay away from people when she is at home. She tries to stay away from gatherings, and if she does go she becomes very impatient while she is there. Every time she thinks about one of her sons and how one was shot with holes in his body and how the other one was shattered into pieces because of the bomb, she becomes very impatient. When she is very impatient she becomes angry and starts fighting. She is always talking about her sons. There are tears in her eyes all the time, and when she cries too much her eyes turn red. When she is at home, she puts a curse on the people who took her sons away from her. She prays, and she does not have a good relationship with her family.

Our original plan was to select the eight most commonly mentioned items in each category; however, a small number of highly salient indicators were identified in the social domains (family and community), whereas considerably more items reflecting internal psychological states were mentioned. Thus, the measure includes fewer items from each of the social domains than it does from the category of internal states. Two of the 24 items were subsequently found to be overly redundant with other items on the measure and were therefore dropped, leaving a total of 22 items. The 22-item ASCL (English version) can be seen in the Appendix. (The Dari version is available upon request.)

The ASCL includes numerous indicators of distress familiar to Western psychiatry. It also includes several indigenous items, as can be seen in the sample narrative above. One such item is "thinking too much," a commonly recognized symptom of distress found throughout Asia (de Jong, 2002; van de Put & Eisenbruch, 2004). Another item is *jigar khun*, a form of sadness that includes grief following interpersonal loss but that may also be a reaction to any deeply disappointing or painful experience. *Jigar khun*, rather than *gham-geen* (sadness), was the term normally used to describe the emotional reaction of people who had lost family members during the war. Another indigenous term is *asabi*, which refers to feeling nervous or highly stressed; people with high levels of *asabi* were described as overwhelmed by major life stressors such as poverty, domestic violence, and single parenting and were more likely

¹ Readers interested in this sort of highly focused ethnographic approach are referred to the highly informative work of Handwerker (2001) on "quick ethnography."

² Indigenous terms in the sample narrative are described later.

to quarrel with family members and beat their children. Two other indigenous constructs are closely related; these are *fishar-e-bala* and *fishar-e-payin*.³ These terms are commonly misinterpreted by Afghans as high and low blood pressure, respectively; 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*). Although they reflect different internal states, Afghans often refer to *fishar-e-bala* and *fishar-e-payin* simply as *fishar*; furthermore, *fishar* was among the most common reasons for seeking medical treatment or self-medicating, typically with benzodiazepines or herbal remedies. There is also an item on the ASCL that was endorsed only by women, "beating oneself," which entails hitting oneself in the head or elsewhere on the body as an expression of intense distress.

Step 3: Translation and Back-Translation of the ASCL

The ASCL was initially constructed in English. The English version was then translated into Dari by a bilingual Afghan consultant. The Dari version was then back-translated into English by a second bilingual Afghan consultant unfamiliar with the original English items. Discrepancies between the original and back-translated versions of the ASCL were noted and resolved through discussion with the two consultants. Numerous changes were made to the original Dari version to better capture the intended meaning of specific questionnaire items. The decision to conduct the survey in Dari rather than Pashto (the other primary language in Afghanistan) was based on the fact the Dari is the common language in the capital city of Kabul.

Step 4: Group Review of Appropriateness and Ease of Comprehension of ASCL Items

The next step entailed a careful review of all items on the Dari version of the ASCL by the two consultants, the data collection team, and the two expatriate members of the research team. The wording of several items was modified to enhance ease of understanding.

Step 5: Pilot Testing the ASCL

Because the majority of Kabul residents have very limited literacy skills, we created a visual graphic that depicts five glasses ranging from empty ("never") to some liquid ("1 day per week") to half full ("2–3 days per week") to mostly full ("4–5 days per week") to full ("every day"). The surveyors read all of the items aloud to each participant and asked the participant to point to the glass that best corresponded to the frequency with which he or she had experienced each item on the questionnaire (see Appendix).

The ASCL was pilot tested on a sample of 30 women and 30 men in two districts of Kabul. The measure demonstrated a high level of internal consistency (Cronbach's $\alpha = .93$). Item analysis revealed that all 22 items contributed to the reliability of the scale; therefore, all items were retained. Because no modifications were made to the ASCL as a result of the pilot administration, all 60 pilot questionnaires were subsequently included as part of the full sample.

Step 6: The Eight-District Survey

The ASCL was administered to 324 adults (162 women and 162 men) in 8 of Kabul's 16 districts over the course of 5 days. The mean age of participants was 41.23 years ($SD = 4.83$). We attempted to select districts that had experienced varying levels of war-related violence although, in fact, most of Kabul had been subjected to severe shelling during the war. As before, the 2 female surveyors went from house to house inviting women to participate in the study; similarly, the male surveyors again approached men in mosques, in their shops, and on the street.

The survey team explained the purpose and voluntary nature of the study, and attained informed consent from all participants. Individuals with

limited literacy skills gave their consent orally.⁴ Participants were curious about the rationale for the survey and many asked what concrete benefit they would receive for their participation. The surveyors explained that the data would be used to help local organizations develop more effective mental health resources for Afghans, but that there was no immediate or concrete benefit for participating. Although we were concerned that this might dissuade people from completing the survey, this explanation turned out to be sufficient: there was a 100% participation rate among the women, and a 90% participation rate among the men. All of the men in the sample were married, and a nearly equal proportion of the women were married ($n = 83, 51%$) or widowed ($n = 79, 49%$). This high proportion of widows reflects the extent of destruction caused by the war, in which an extraordinary number of men died either as civilians during the civil war or as combatants during the *jihad* against the Soviets. The disruptive nature of the war is also evident in the number of participants who reported having left the city at some point as a result of the violence ($n = 188, 58%$).

The ASCL again proved to be highly internally consistent, with a Cronbach's alpha of .93 (identical to that found in the pilot administration). Item analysis again indicated that all 22 items contributed to the internal consistency of the instrument; therefore, all of the original 22 items were retained.

Step 7: Assessing the Validity of the ASCL

To assess the construct validity of the ASCL, we sought to assess whether it would correlate as expected with a measure of exposure to war-related experiences of violence and loss. Previous research with other war-affected populations has documented a strong positive correlation between level of exposure to war-related violence and loss and level of psychiatric symptomatology (Miller et al., 2002; Mollica et al., 1998). In the present study, we assessed exposure to war-related violence and loss with the Afghan War Experiences Scale (AWES), which asks participants to indicate whether they have experienced each of 17 war-related experiences of violence or loss, with the answer choices *Never* (0), *Once* (1), or *More Than Once* (2). Scores on the 17 items are totaled, yielding a possible range of 0–34, with higher total scores reflecting greater exposure to war-related experiences. The AWES was adapted from the War Experiences Scale (WES) developed by Weine et al. (2000) and Miller et al. (2002) in their research with Bosnian refugees. Additional items were added to the WES to assess land mine-related injuries and rockets destroying one's home; the measure was subsequently translated into Dari by a bilingual consultant and the accuracy of translation was then checked by a second bilingual consultant. The internal consistency (reliability) of the AWES in the present study was excellent, with a Cronbach's alpha of .93.

Because of logistical difficulties, we were unable to administer the AWES together with the ASCL during the initial eight-district survey. Therefore, we administered both measures to an additional sample of 100 adults (50 women, 50 men) in five districts of Kabul, using the same recruitment process described earlier. The ASCL demonstrated excellent construct validity. Scores on the ASCL were highly and positively associated with scores on the AWES ($r = .70, p < .001$), indicating that higher levels of exposure to war-related stressors were associated with higher levels of self-reported distress. Women scored significantly higher than men on the AWES, indicating greater exposure to war-related violence and loss, $t(99) = 12.17, p < .001$. A more detailed analysis of the relationship between exposure to war-related stressors as measured by the AWES and mental health status on the ASCL is currently being prepared.

³ Because Afghans often refer to *fishar* without specifying *bala* or *payin*, we originally included *fishar bala* and *fishar payin* as a single item on the ASCL. However, we recommend assessing each form of *fishar* as a separate item, because each reflects a different psychological state. We have revised the ASCL accordingly.

⁴ The research protocol and informed consent procedures (including the use of oral consent) for this project were approved by the Committee for the Protection of Human and Animal Subjects at San Francisco State University.

Step 8: Examining the Factor Structure of the ASCL

To determine the factor structure of the ASCL, we conducted an exploratory principal components factor analysis with varimax rotation. The results of this analysis can be seen in Table 1. Four factors with eigenvalues >1 were identified, accounting for 62% of the total variance in the ASCL. To minimize the number of complex items (those loading highly on more than one factor), we set a cutoff point of .40 for a variable to be included on a factor. Even with this criterion, however, several items still loaded highly on more than one factor. To further reduce the number of complex items, we followed Fiola, Bjorck, and Gorsuch (2002) and considered an item to load exclusively on a single factor if its loading on that factor was greater than its loading on any other factor by at least .15. Using these guidelines, four items still loaded on multiple factors: feeling sad, becoming *jigar khun, asabi*, and difficulty concentrating. This multiple loading is not surprising, considering that different clinical syndromes often contain overlapping symptoms (e.g., impaired concentration and insomnia in both depression and trauma). Therefore, we allowed each of these items to load on more than one factor. Given the multiple loadings of these factors, the high internal consistency of the measure, and the strong correlations among items, we also conducted an oblique factor analysis to account for possible nonorthogonality among factors. Although the resultant factors were moderately correlated (.33), the factor structure and item loadings were nearly identical to those found in the orthogonal analysis; consequently, only the results of the orthogonal analysis are presented here.

The task of labeling factors is inherently subjective, particularly when analyzing cross-cultural data that may not comprise diagnostic clusters familiar to the researchers. To avoid using psychiatric labels with unknown relevance to the Afghan cultural context, we have selected factor labels that reflect concretely the items constituting each factor. We have labeled the first factor "Sadness With Social Withdrawal and Somatic Distress," the

second factor "Ruminative Sadness Without Social Withdrawal and Somatic Distress," and the remaining factor "Stress-Induced Reactivity." The fourth factor is not considered here, as it includes only two items and is therefore unreliable (Russell, 2002).

Factor 1, Sadness With Social Withdrawal and Somatic Distress, accounted for 25% of the variance after rotation and includes primarily symptoms associated with dysphoria, as well as symptoms of social withdrawal and somatic distress. It is the only factor on which the item indicating a perception of impaired psychosocial functioning loaded strongly (i.e., "During the last 2 weeks, have many times have you had difficult meeting your responsibilities at home or at work because of *jigar khun, asabi, or fishar?*"). Factor 1 includes several of the indigenous items, including *jigar khun, asabi, fishar*, and beating oneself. As a subscale of the ASCL, Factor 1 demonstrated a high level of internal consistency ($\alpha = .93$).

Factor 2, Ruminative Sadness without Social Withdrawal or Somatic Distress, accounted for 15% of the total variance following rotation. As suggested by its label, Factor 2 includes a combination of depressive symptoms and unwanted thoughts in the form of intrusive, distressing memories and "thinking too much" (rumination) about one's problems. Unlike Factor 1, however, Factor 2 does not entail symptoms of social withdrawal or somatic distress. As a subscale of the ASCL, Factor 2 showed a high level of internal consistency ($\alpha = .88$).

The remaining factor, Stress-Induced Reactivity, accounted for 11% of the variance and includes *asabi* (nervous agitation), quarrelling with family members as well as with friends or neighbors, and beating one's children.⁵ The Stress-Induced Reactivity subscale has an acceptable level of internal consistency ($\alpha = .74$).

Results

Table 2 presents mean scores on all 22 items of the ASCL, separated by gender. In the first analysis, we conducted independent sample *t* tests comparing the mean total score for the ASCL, and for all 22 individual items, between women and men. Given the large number of between group comparisons that this entailed, and the corresponding risk of Type I (false-positive) errors, we set alpha at .01 rather than the more conventional .05; that is, we considered only those between-groups differences where $\alpha < .01$ to be statistically significant.

As can be seen in Table 2, on nearly every item, women scored significantly higher than men.

Women's mean total score on the ASCL (68.21, $SD = 16.70$; range 22–110) was significantly higher than men's (50.54, $SD = 12.10$), $t(322) = 10.91$, $p < .001$, indicating a markedly higher level of self-reported distress and impaired psychosocial functioning. When we used factor scores as variables, between-group differences were all significant, with women reporting much higher levels of sadness with social withdrawal and somatic distress, $t(279) = 14.32$, $p < .001$; and ruminative sadness without social withdrawal or somatic distress, $t(316) = 4.92$, $p < .001$; and moderately greater stress-induced reactivity, $t(316) = 3.3$, $p < .01$.

⁵ Although Afghans condone the use of violence against children under certain conditions (e.g., when a child's behavior brings dishonor to the family), it was evident from our narrative data that a clear distinction is made between such culturally "appropriate" violence and the kind of inappropriate beatings that occur when parents are highly stressed by the numerous stressors of everyday life in Kabul (poverty, unemployment, crime, poor medical care, substandard housing conditions, acts of terrorism, etc.). Parents often express regret after acts of stress-induced reactive violence toward their children and recognize the inappropriateness of their behavior.

Table 1
Rotated Component Matrix for the Afghan Symptom Checklist
($N = 324$)

Variable	Factor 1 ^a	Factor 2 ^b	Factor 3 ^c	Factor 4 ^d
Crying	.73	.27	-.04	.39
Loss of appetite	.83	-.01	.11	.08
Insomnia	.70	.01	.27	-.26
Quarreling with family	.24	.21	.70	.31
Quarreling with friends or neighbors	-.06	.21	.65	-.07
Feeling hopeless	.31	.70	.07	.19
Beating one's children	.26	-.03	.67	.27
Feeling socially withdrawn or isolated	.77	.27	.07	.21
Feeling sad	.53	.56	.23	.19
Becoming <i>jigar khun</i>	.40	.45	.37	.34
Headaches	.72	.17	.24	.25
Nightmares	.46	.16	.23	.20
Feeling irritable	.41	.61	.18	.39
Easily startled	.12	.21	.15	.82
Intrusive, unwanted memories	.04	.77	.15	.15
Thinking too much	.10	.73	.13	-.10
<i>Asabi</i>	.46	.24	.58	.11
Trouble remembering things	.28	.05	.15	.73
Beating oneself	.76	.20	.02	.25
<i>Fishar bala</i> or <i>fishar payin</i>	.42	.18	.19	.31
Difficulty concentrating	.53	.42	.23	.32
Difficulty functioning at home or work	.58	.35	.15	.31

Note. Numbers in bold indicate items included on each factor.

^a Sadness With Social Withdrawal and Somatic Distress. ^b Ruminative Sadness Without Social Withdrawal and Somatic Distress. ^c Stress-Induced Reactivity. ^d Only two items from the Afghan Symptom Checklist load on Factor 4, making it unreliable as a factor or subscale. Therefore, we did not label it nor do we consider it in this article.

We then compared the scores of married women and widows, most of whom had lost their husbands during the *jihad* and civil war. As can be seen in Table 3, widows scored significantly higher than married women on the majority of ASCL items, and on the total ASCL score, $t(159) = -3.85, p < .001$. On the variables created from the factor analysis, widows reported significantly higher levels of sadness with social withdrawal and somatic distress, $t(125) = 4.50, p < .001$; and ruminative sadness without social withdrawal or somatic distress, $t(151) = 3.19, p < .01$; but not stress-induced reactivity, $t(157) = 1.72, p = .09$.

Salience of the Indigenous Items

The indigenous items were among the most frequently endorsed symptoms of distress on the ASCL. In fact, "thinking too much" was the most frequently item on the scale and one of the few items on which men and women did not differ. *Jigar khun* and *fishar* were also very common, whereas *asabi* was somewhat less frequently reported. The symptom "beating oneself" was endorsed only by women, who reported engaging in this self-destructive behavior roughly once a week (see Tables 2 and 3).

Discussion

The primary aim of the project described in this article was to field a test a methodology for identifying local beliefs regarding psychological well-being and distress and for rapidly developing culturally grounded mental health assessment measures for needs assessment and program evaluation with war-affected populations. Organizations doing mental health work in conflict

Table 2
Descriptive Statistics and Between-Group Differences by Gender for the Afghan Symptom Checklist

Item	M (SD) for:	
	Men (n = 162)	Women (n = 162)
Crying	1.06 (0.27)	2.73 (1.10)****
Loss of appetite	2.14 (1.19)	3.90 (1.39)****
Insomnia	2.45 (1.28)	3.39 (1.51)****
Quarreling with family	2.25 (1.06)	2.56 (1.20)**
Quarreling with friends or neighbors	1.59 (0.70)	1.41 (0.73)*
Feeling hopeless	2.43 (1.16)	2.93 (1.42)***
Beating one's children	1.94 (0.84)	2.50 (1.18)****
Feeling socially withdrawn or isolated	1.72 (0.89)	3.49 (1.44)****
Feeling sad	2.58 (1.06)	3.41 (1.32)****
Becoming <i>jigar khun</i>	2.69 (0.96)	3.36 (1.16)****
Headaches	2.67 (1.35)	4.08 (1.25)****
Nightmares	1.55 (0.71)	2.09 (1.05)****
Feeling irritable	2.41 (0.93)	3.06 (1.22)****
Easily startled	1.89 (0.77)	2.79 (1.41)****
Intrusive, unwanted memories	3.38 (0.98)	3.27 (1.26)
Thinking too much	4.49 (0.91)	4.36 (1.20)
<i>Asabi</i>	2.45 (0.98)	2.83 (1.19)***
Trouble remembering things	2.42 (1.06)	3.56 (1.20)****
Beating oneself	1.00 (0.00)	2.16 (0.95)****
<i>Fishar bala</i> or <i>fishar payin</i>	2.47 (1.68)	3.54 (1.20)****
Difficulty concentrating	2.22 (0.76)	2.96 (1.10)****
Difficulty functioning at home or work	2.89 (1.01)	4.21 (1.19)****

* $p = .03$. ** $p = .02$. *** $p < .01$. **** $p < .001$.

Table 3
Descriptive Statistics and Between-Group Differences: Married Women vs. Widows

Item	M (SD) for:	
	Married women (n = 83)	Widows (n = 79)
Crying	2.39 (1.06)	3.08 (1.03)***
Loss of appetite	3.32 (1.54)	4.49 (0.90)***
Insomnia	3.04 (1.53)	3.76 (1.40)**
Quarreling with family	2.46 (1.34)	2.66 (1.04)
Quarreling with friends or neighbors	1.41 (0.78)	1.42 (0.68)
Feeling hopeless	2.65 (1.46)	3.23 (1.33)**
Beating one's children	2.52 (1.21)	2.48 (1.15)
Feeling socially withdrawn or isolated	3.13 (1.50)	3.86 (1.29)**
Feeling sad	3.07 (1.38)	3.76 (1.17)**
Becoming <i>jigar khun</i>	3.24 (1.20)	3.48 (1.11)
Headaches	3.77 (1.41)	4.40 (0.94)**
Nightmares	2.04 (1.16)	2.14 (0.92)
Feeling irritable	2.77 (1.28)	3.37 (1.08)**
Easily startled	2.89 (1.53)	2.68 (1.27)
Intrusive, unwanted memories	2.98 (1.39)	3.59 (1.03)**
Thinking too much	4.13 (1.37)	4.59 (0.95)*
<i>Asabi</i>	2.47 (1.12)	3.21 (1.14)***
Trouble remembering things	3.45 (1.29)	3.67 (1.11)
Beating oneself	1.91 (1.04)	2.42 (0.78)**
<i>Fishar bala</i> or <i>fishar payin</i>	3.40 (1.39)	3.70 (0.95)
Difficulty concentrating	2.76 (1.22)	3.16 (0.93)*
Difficulty functioning at home or work	3.96 (1.30)	4.47 (1.00)**

* $p = .02$. ** $p < .01$. *** $p < .001$.

and postconflict situations are confronted with the need to rapidly develop an understanding of the local cosmology and to assess the needs of the target population so that appropriate program planning and implementation can begin. The methodology described here is well suited to work in such contexts. The full project, including training, instrument development, and data collection, took 15 days, including 4 days of training and 11 days of data collection. Although the citywide survey was carried out in just 5 days, the qualitative phase was more time-consuming for several reasons. First, the stories that the research team gathered each day were highly distressing, and we found it necessary to spend part of each afternoon debriefing the team, helping team members manage their emotional reactions to stories of wartime trauma and loss. The stories affected everyone on the team; for the Afghan team members, however, the stress generated by the narratives was particularly acute, as the stories they gathered resonated with their own experiences of war-related violence and loss.⁶

It might be possible in other contexts to expedite the "free-listing" process by which participants generate indicators of well-being and distress. In our experience, however, we spent 2 days just developing a shared understanding of what was meant by "doing well" and "doing poorly" psychologically. Afghans have three categories of psychological distress: disorders caused by biology, such as schizophrenia; distress caused by *jinn*s, spirits that can take over a person's mind and body and cause them to

⁶ See Omidian (2000) for a discussion of the potentially stressful nature of doing qualitative interviews in war-affected communities and of helpful ways of coping with such stress.

experience acute emotional and physical discomfort; and distress caused by stressful life experiences, such as war, poverty, and family violence. It was only after exploring each of these categories and delineating the distinctions between them that we could proceed to the next step: identifying the various ways in which life stress (the focus of the present study) affects people.⁷

The labels that we applied to the three factors identified in the factor analysis should be viewed with caution. Afghans are more likely to refer specifically to indigenous indicators of distress such as “thinking too much,” “beating oneself,” *jigar khun*, *fishar*, and *asabi*, than to clusters of symptoms such as those found in our factor analysis. For example, references to someone becoming *jigar khun* are frequent in Kabul, as they were in our narrative data, reflecting the painful reality of the *jihād* and civil war, the widespread experience of displacement, and the chronic poverty of everyday life in this war-torn city. Even more common is *fishar*, for which people take a variety of homeopathic and allopathic medications, including benzodiazepines, which are easily attained throughout Kabul without a medical prescription.

The factor analysis provides an empirical look at the ways in which commonly experienced symptoms tend to cluster in our sample, whereas the narrative data reveal the ways in which people actually talk about distress. From an intervention perspective, both types of information are useful. The identification of empirically derived syndromes of distress and their distribution among different sectors of a population can inform the development of mental health programs that target vulnerable groups (e.g., widows) on the basis of an understanding of the particular psychological difficulties they are experiencing. At the same time, familiarity with the ways in which people describe their distress allows for greater communication between mental health workers and community members in need of assistance.

An important finding from this study was the lack of a clearly defined trauma syndrome in either the narrative or survey data. Several symptoms of PTSD were mentioned in the narratives and included on the ASCL; however, the trauma symptoms were not particularly salient within the narratives, and the factor analysis did not yield a factor that primarily comprised trauma symptoms. This does not mean that Afghans do not experience symptoms of psychological trauma; on the contrary, our data and those of two recent studies that assessed PTSD symptoms indicate that trauma symptoms are present in the population (Lopes Cardozo et al., 2004; Scholte et al., 2004). It does suggest, however, that other idioms of distress are more salient among Afghans and that Afghans may react to traumatic stress in ways that differ from the model of PTSD derived from research with other populations. This has important implications for mental health interventions with Afghans. The dominant approach to understanding and treating war-related distress is focused primarily on assessing and ameliorating symptoms of PTSD (Miller et al., 2004; Summerfield, 1999). For Afghans, however, a broader approach that addresses locally salient idioms of distress and empirically derived syndromes such as those identified in this study, may be better received than a strictly trauma-focused intervention. From a policy perspective, it would seem most useful to direct limited mental health resources toward the amelioration of those symptoms of distress that Afghans themselves have identified as most pressing; in contrast, there is little utility in targeting psychiatric symptoms and syndromes that have been inappropriately prioritized because of a lack of familiarity with the cultural context.

Validity of the ASCL

Assessing the construct validity of a new assessment measure is challenging when there are no previously validated measures with which to correlate it. Our use of the AWES, an adaptation of a psychometrically sound measure of war exposure designed for use with Bosnian refugees, is an imperfect solution, as it meant assessing the validity of the ASCL using a second measure for which construct validity had not been established with Afghans. However, we believe this approach is empirically justifiable. Exposure to war-related stressors is a construct that can be easily operationalized by a distinct set of readily defined events. The items on the AWES were carefully reviewed by experts from the target culture, and items of particular salience to the Afghan context were included. The AWES therefore has good face validity, as well as a high level of internal consistency; consequently, we believe that it served as an adequate measure with which to assess the construct validity of the ASCL.

Further support for the validity was found during a workshop we held on completion of the survey, with representatives of various Afghan and international community organizations doing mental health and psychosocial work in Kabul and other parts of the country. The findings of the project were shared with the group, and participants were asked whether our findings were consistent with their hands-on experience. The response was strongly affirmative, with numerous participants confirming the salience of the

⁷ In a separate article, we examine each of these categories of distress in greater detail. For interested readers, we provide here a very brief description of the two categories of distress that are not the primary focus of this article: biologically based disorders such as schizophrenia and possession by *jinn*s. Afghans generally recognize psychotic behavior—particularly hallucinations and delusions—as biologically rooted, although bizarre behavior may also be attributed to *jinn* possession. Psychotic individuals are generally regarded with a mix of compassion and discomfort, as their behavior clearly reflects an experience of suffering, yet they may also be a source of embarrassment and fear to family members. With appropriate explanation, families of psychotic individuals may be receptive to antipsychotic medication for their distressed relative; however, although such medications are available in at least some pharmacies in larger cities such as Kabul (often without a prescription), anecdotal evidence suggests that few individuals who might benefit from antipsychotic medication ever receive it. Numerous factors likely contribute to this unfortunate reality, including a lack of awareness that such medications exist, shame at acknowledging the presence of a psychotic family member, a lack of money to pay for medications, and a scarcity of psychiatrists or psychiatrically informed health care professionals in Afghanistan. *Jinn*s, in contrast, are believed to be mischievous spirits who may take any form and who may become highly malevolent when angered. Originally rooted in Koranic text, the belief in *jinn*s is deeply ingrained in Afghan culture. *Jinn* possession generally occurs when a *jinn* is angered; for example when an individual accidentally steps on a *jinn* or gets a *jinn* wet by inadvertently splashing it with dirty water tossed out the door. Symptoms of *jinn* possession are varied and may include intense bodily pain, agitation, catatonia, extreme contraction of the pupils, and self-destructive behavior such as biting, choking oneself, and suicide attempts, all accompanied by a sense that one has lost control of one’s body and mind. *Mullahs* (Muslim clerics) will often distinguish between psychosis and *jinn* possession, referring the former to medical doctors while treating the latter with religious incantations and rituals. Interested readers are referred to a discussion of Afghan beliefs regarding mental illness and *jinn* possession by Shorish-Shamely (2002).

indigenous items on the ASCL, as well as the greater vulnerability of women and of widows in particular. As a result of this workshop, a mental health task force was set up in Kabul to coordinate policy and intervention activities among the various nongovernmental and governmental organizations focused on mental health.

Finally, support for the construct validity of the ASCL may be inferred by noting the high degree of consistency between our findings and those of several recent studies of mental health in Afghanistan, all of which used conventional measures of psychopathology that had not been standardized for use with Afghans (CARE, 2004; Lopes Cardozo et al., 2004). Consistent with the findings presented here, those other studies found elevated levels of depression and anxiety, with women—and widows in particular—reporting the highest levels of distress. We recognize that the general consistency of our findings with those of studies using conventional Western measures may call into question the added value of an emic measure such as ASCL. After all, if Western measures are capable of assessing psychological distress among Afghans, what need is there for culturally specific instruments? In fact, we do not regard Western assessment tools as inherently irrelevant in non-Western contexts; on the contrary, we assume that any measure assessing core human psychological responses such as sadness or anxiety will capture at least some of the distress experienced by people in diverse cultural contexts. It is important to note, however, that Western measures cannot assess culturally specific indicators and idioms of distress such as those identified in this study, which are often of greater concern to local communities than Western constructs such as PTSD. The added value of emic approaches lies precisely in their capacity to identify the particular ways in which psychological distress is experienced and articulated in specific cultural contexts—information that is critical to the development and evaluation of culturally appropriate interventions.

Limitations

There are several limitations to the present study. First, the AWES did not assess the full range of factors that may have contributed to the high levels of distress documented in the survey, particularly among women. The AWES is a measure of stressors related specifically to political violence and does not assess ongoing stressors such as poverty, unemployment, discrimination, and spouse abuse. Although the higher levels of distress we found among women on the ASCL can be at least partly attributed to their higher level of self-reported exposure to war-related violence and loss, we believe that women's elevated distress is likely also related to the multiple stressors associated with the harsh reality of systematic discrimination that women continue to experience in Afghanistan. Despite having greater freedom since the fall of the Taliban, Afghan women continue to experience oppression and discrimination in many spheres of life. Literacy rates for women have been estimated at about 19% (United Nations Development Program, 2005), among the lowest in the developing world; domestic violence is common and widely tolerated (Rubin, Hamidaza, & Stoddard, 2005); and women who are forced into unhappy marriages have few options but to accept their situation and cope as best they can; although Islam permits divorce, in practice, divorce is not an option available to Afghan women, and unlike men, they may not take an additional husband with whom they might be more compatible.

The mental health survey in Kabul was also limited by its reliance on self-report measures (the ASCL and the AWES), the validity of which can be affected by a variety of response biases (Bradburn, 1983), including demand characteristics of the data-gathering context itself (Miller, 2004). It is quite possible, for example, that men may have underreported their level of distress on the ASCL. Acknowledging emotional suffering is generally perceived as a sign of weakness among Afghan men, and in the relational context in which the ASCL was administered (i.e., male surveyors reading the questions aloud to male respondents), there may have been a tendency to downplay the frequency of certain expressions of distress (e.g., crying) in order to save face in the eyes of the surveyors. Unfortunately, low literacy rates in Afghanistan require that questionnaires be read aloud, and it would not have been culturally acceptable for the female members of our research team to have administered the questionnaires to men in the community; however, is it not clear whether female surveyors would have elicited more accurate responses from men.

Despite the possibility of underreporting of distress by male participants, the strong positive correlation between mental health status and exposure to war experiences (a consistent finding in the literature on war-affected populations), the resonance of our findings with the clinical experience of local organizational staff, and the consistency of our findings with those of other recent studies of mental health in Afghanistan, all lend support to the validity of our findings. It is also important to bear in mind that our primary purpose in this study was to field test a methodology for developing culturally appropriate self-report instruments that can be used for needs assessment and program evaluation by community-based organizations in conflict and postconflict situations. Despite their various limitations, we believe that self-report tools—when well constructed—represent a highly useful approach to gathering essential information quickly and inexpensively.

In emphasizing the value of culturally specific assessment measures such as the ASCL, we do not mean to suggest that such measures should replace etic or conventional Western measures of psychopathology in work with non-Western war-affected populations. Our concern is that researchers and clinicians have relied almost exclusively on such instruments, paying minimal attention to the cross-cultural validity of Western diagnostic categories and overlooking local expressions of well-being and distress among the communities in which they are working. As we suggested earlier, a strictly etic approach (i.e., the use of constructs and measures alien to a local culture) risks prioritizing diagnostic constructs that lack meaning or salience in specific cultural contexts. Consequently, etic approaches have a limited capacity to inform the development of effective mental health services, as they are likely to direct scarce resources toward problems that are incorrectly presumed to be critical (e.g., the treatment of PTSD) and away from those sources of distress that are of greatest concern to community members. In contrast, emic approaches, as we have noted, are highly useful for shaping mental health policy and practice because of their capacity to (a) assess the most pressing mental health concerns of specific war-affected communities and (b) identify the particular ways in which community members understand and talk about their distress. The development of culturally grounded measures such as the ASCL, together with more stringent efforts to appropriately evaluate and adapt instru-

ments for use in cultural contexts other than those in which they were developed, represent important foci for future research with war-affected populations. Such research can significantly enhance our ability to assess the mental health needs of communities affected by political violence and to develop interventions that address those needs in ways that are both clinically effective and culturally appropriate.

References

- Bolton, P., & Tang, A. (2002). An alternative approach to cross-cultural function assessment. *Social Psychiatry and Psychiatric Epidemiology*, 37, 537–543.
- Bracken, P., Giller, J., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science and Medicine*, 40, 1073–1082.
- Bradburn, N. (1983). Response effects. In P. Rossi, J. Wright, & A. Anderson (Eds.), *Handbook of survey research*. Orlando, FL: Academic Press.
- CARE. (2004). *Prevalence of self-reported depression symptoms among the beneficiaries of the Kabul widows humanitarian assistance program*. Kabul, Afghanistan: CARE International Afghanistan.
- de Jong, J. (Ed.). (2002). Public mental health, traumatic stress, and human rights violations in low-income countries. *Trauma, war, and violence: Public mental health in socio-cultural context* (pp. 1–93). New York: Plenum Press.
- Denzin, N., & Lincoln, Y. (2000). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Englund, H. (1998). Death, trauma, and ritual: Mozambican refugees in Malawi. *Social Science and Medicine*, 46, 1165–1174.
- Farias, P. (1991). Emotional distress and its socio-political correlates in Salvadoran refugees: Analysis of a clinical sample. *Culture, Medicine, and Psychiatry*, 15, 167–192.
- Fiola, W., Bjorck, J., & Gorsuch, R. (2002). The Religious Support Scale: Construction, validation, and cross-validation. *American Journal of Community Psychology*, 30, 761–786.
- Goodson, L. (2001). *Afghanistan's endless war*. Seattle: University of Washington Press.
- Handwerker, W. P. (2001). *Quick ethnography*. Walnut Creek, CA: Alta Mira Press.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J., Kesler, J., et al. (2002). Measuring trauma and health status in refugees: A critical review. *Journal of the American Medical Association*, 288, 611–621.
- Hubbard, J., & Pearson, N. (2004). Sierra Leonean refugees in Guinea: Addressing the mental health effects of massive community violence. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 95–132). Mahwah, NJ: Erlbaum.
- Jenkins, J. (1996). Culture, emotion, and PTSD. In A. Marsella, M. Friedman, E. Gerrity, & R. Scurfield (Eds.), *Ethnocultural aspects of post-traumatic stress disorder* (pp. 165–182). Washington, DC: American Psychological Association.
- Kakar, H. (1995). *Afghanistan*. Berkeley: University of California Press.
- Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-culture on illness. *British Journal of Psychiatry*, 151, 447–454.
- Lopes Cardozo, B., Bilukha, O., Gotway Crawford, C., Shaikh, I., Wolfe, M., Gerber, M., et al. (2004). Mental health, social functioning, and disability in postwar Afghanistan. *Journal of the American Medical Association*, 292, 575–584.
- Miller, K. (2004). Beyond the frontstage: Trust, access, and the relational context in research with refugee communities. *American Journal of Community Psychology*, 33, 217–227.
- Miller, K., Kulkarni, M., & Kushner, H. (2005). *Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations*. Manuscript submitted for publication.
- Miller, K., Weine, S., Ramic, A., Birkic, N., Boskailo, E., Djuric-Bijeid, Z., et al. (2002). The relative contribution of war experiences and exile-related stressors to levels of psychological distress in Bosnian refugees. *Journal of Traumatic Stress*, 15, 377–387.
- Miller, K. E., & Rasco, L. M. (Eds.). (2004). An ecological framework for addressing the mental health needs of refugee communities. *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 1–64). Mahwah, NJ: Erlbaum.
- Mollica, R., McInnes, K., Pham, T., Fawzi, M., Smith, C., Murphy, E., et al. (1998). The dose-effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. *Journal of Nervous & Mental Disease*, 186, 543–553.
- Omidian, P. (2000). Qualitative measures and refugee research: The case of Afghan refugees. In F. Ahearn, Jr. (Ed.), *Psychosocial wellness of refugees* (pp. 41–66). New York: Berghahn Books.
- Physicians for Human Rights. (1998). *The Taliban's war on women: A health and human rights crisis in Afghanistan*. Retrieved from http://www.phrusa.org/campaigns/afghanistan/af_exec1.html
- Rashid, A. (2000). *Taliban: Militant Islam, oil, and fundamentalism in Central Asia*. New Haven, CT: Yale University Press.
- Rubin, B., Hamidzada, H., & Stoddard, A. (2005). *Afghanistan 2005 and beyond*. The Hague, the Netherlands: Netherlands Institute of International Relations “Clingendael.”
- Russell, D. (2002). In search of underlying dimensions: The use (and abuse) of factor analysis in *Personality and Social Psychology Bulletin*. *Personality and Social Psychology Bulletin* 28, 1629–1646.
- Scholte, W. F., Olf, M., Ventevogel, P., de Vries, G.-J., Jansveld, E., Lopes Cardozo, B., & Gotway Crawford, C. A. (2004). Mental health symptoms following war and repression in eastern Afghanistan. *Journal of the American Medical Association*, 292, 585–593.
- Shorish-Shamely, Z. (2002). *The self and other in Afghan cosmology: Concepts of health and illness among the Afghan refugees*. Unpublished dissertation, Department of Anthropology, The University of Wisconsin—Madison.
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected countries. *Social Science and Medicine*, 48, 1449–1462.
- United Nations Development Program. (2005). *Security with a human face: Challenges and responsibilities*. Retrieved from <http://www.undp.org/dpa/nhdr/af-files/ForwordPrefaceinto.pdf>
- van de Put, W. A. C. M., & Eisenbruch, M. (2004). Internally displaced Cambodians: Healing trauma in communities. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 133–160). Mahwah, NJ: Erlbaum.
- Weine, S., Razzano, L., Ramic, A., Brkic, N., Miller, K., Smajkic, A., & Djuric-Bjedec, Z. (2000). Comparing the clinical profiles of Bosnian refugees who have presented for mental health services versus those who have not. *Journal of Nervous and Mental Disease*, 188, 416–421.
- Wessells, M., & Monteiro, C. (2004). Internally displaced Angolans: A child-focused, community-based intervention. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 67–94). Mahwah, NJ: Erlbaum.

(Appendix follows on next page)

Appendix

Afghan Symptom Checklist

English Version

Sex _____

Age (best guess) _____

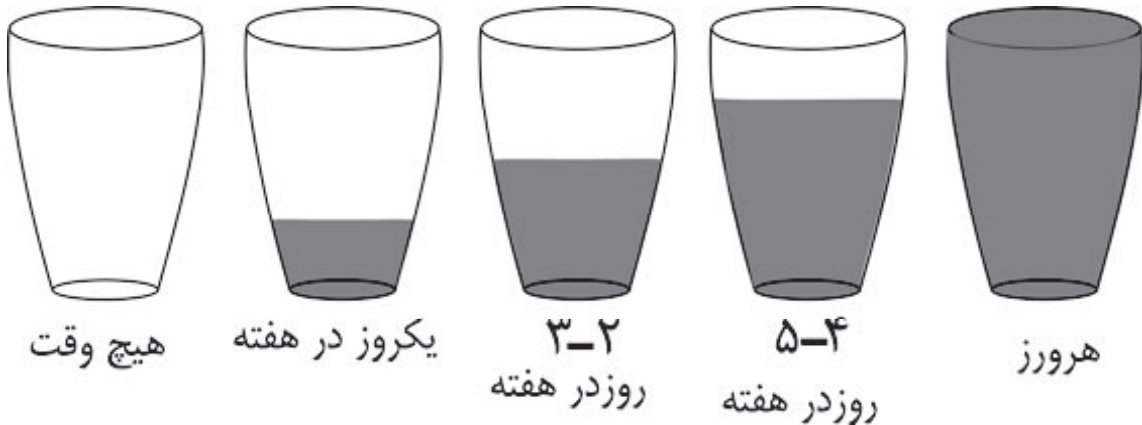
District _____

Marital status: Married _____ Single _____ Widowed _____

Number of children _____

Did you leave the country during the war? _____ Yes _____ No

Please think about the last 2 weeks for each of the following questions. For each question, please select the best answer. You can point to the cup that best describes your answer. The empty cup means "never," the next cup means 1 day each week, the middle cup means 2-3 days each week, the next cup means 4-5 days each week, and the full cup means "everyday."



1. During the last 2 weeks, how many times have you cried?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

2. During the last 2 weeks, how many times have you had a lack of appetite?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

3. During the last 2 weeks, how many times have you had difficulty falling asleep?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

4. During the last 2 weeks, how many times have you had a quarrel with a family member?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

5. During the last 2 weeks, how many times have you had a quarrel with a neighbor or friend?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

6. During the last 2 weeks, how many times have you felt hopeless?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

7. During the last 2 weeks, how many times have you beat someone in your family?

1	2	3	4	5
never	1 day/week	2-3 days/week	4-5 days/week	everyday

8. During the last 2 weeks, how many times have you isolated yourself socially?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
9. During the last 2 weeks, how many times have you felt sad?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
10. During the last 2 weeks, how many times have you become *jigar khun*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
11. During the last 2 weeks, how many times have you had a headache?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
12. During the last 2 weeks, how many times have you had a nightmare?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
13. During the last 2 weeks, how many times have you felt irritable?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
14. During the last 2 weeks, how many times have you felt easily startled? For example, how many times have you become afraid when you've heard a sudden noise?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
15. During the last 2 weeks, how many times have you experienced bad memories you can't get rid of?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
16. During the last 2 weeks, how many times have you been thinking too much?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
17. During the last 2 weeks, how many times have you experienced *asabi*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
18. During the last 2 weeks, how many times have you had trouble remembering things?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
19. During the last 2 weeks, how many times have you beaten or hurt yourself?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
20. During the last 2 weeks, how many times have you felt *fishar Bala* or *fishar payin*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
21. During the last 2 weeks, how many times have you had trouble concentrating?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |
22. During the last 2 weeks, how many times have you had difficult meeting your responsibilities at home or at work because of *jigar khun*?
- | | | | | |
|-------|------------|---------------|---------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| never | 1 day/week | 2-3 days/week | 4-5 days/week | everyday |