Cultural identity and trauma

Construction of meaning among Afghan and Iraqi refugees under treatment in Dutch mental health care

Groen, S.P.N.

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Simon Petrus Nicolaas Groen

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Cultural identity in the Cultural Formulation of Diagnosis is a somewhat unclear concept, that yet in clinical practice seems to potentially provide useful information for a better understanding of the patients' needs in mental health care. In this book, the concept of cultural identity is explored among traumatized Afghan and Iraqi refugees who were referred for specialized mental health care at De Evenaar, Centre for Transcultural Psychiatry. Using a mixed-methods approach, the author addresses the following main questions:

1. What is the relation between cultural identity and psychopathology?
2. Do experienced potentially traumatic events, post-migration living problems, acculturation problems and psychopathology affect cultural identity?
3. Does information about these experiences and problems and cultural identity lead to a better understanding of the needs of traumatized refugees?

Combining statistical analyses and an in-depth anthropological approach, this study addresses these main questions. A case study of a Somalian patient with surprising results was the reason to further investigate the relevance and utility of exploring cultural identity. Using the self-developed Brief Cultural Interview in abovementioned groups of refugee patients, cultural identity was divided into smaller parts to enhance understanding of its relationships to stress and acculturation. Problems after migration were added in the analysis of cultural identity confusion and psychopathology. Finally, a group of non-patients from Afghanistan and Iraq were included in order to search for resilience factors and how they are grounded in cultural identity. Altogether, the chapters of this book provide the reader with new insights into exploring the mental health of refugee patients through a better understanding of their cultural identity, which may be a new step in the development of transcultural psychiatry.

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In memory of dr. Kees Laban

Table of Contents

List of acronyms

AC	Aanmeldcentrum (Center for Registration)
AISSR	Amsterdam Institute for Social Science Research
APA	American Psychiatric Association
BCI	Brief Cultural Interview
CES	Centrality of Event Scale
CF	Cultural Formulation
CFI	Cultural Formulation Interview
CI	Cultural Interview
COA	Centraal Orgaan Asielzoekers (Central Body for Asylum Seekers)
CRM-BS	Cortes Rogler Malgady – Bicultural Scale
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
GAP	Group on the Advancement of Psychiatry
GGZ	Geestelijke Gezondheid Zorg (Mental Health Care)
HSCL-25	Hopkins Symptom Checklist – 25 items version
HTQ	Harvard Trauma Questionnaire
IND	Immigratie- en Naturalisatie Dienst (Immigration and Naturalisation Office)
ISAF	International Security Assistance Force
ISIL	Islamic State in Iraq and the Levant
NL	The Netherlands
OC	Opvangcentrum (Center for Reception)
OCF	Outline for Cultural Formulation
PMLPs	Post-Migration Living Problems
PMLP-CL	Post-Migration Living Problems – Check List
PTEs	Potentially Traumatic Events
PTSD	Post Traumatic Stress Disorder
SD	Standard Deviation
TVcN	Tolk- en Vertaalcentrum Nederland (Interpretation and Translation Center of the Netherlands)
US	United States
UvA	Universiteit van Amsterdam (University of Amsterdam)
VWN	Vluchtelingenwerk Nederland (Refugee Organization Netherlands)

Preface

When I started my professional career as an anthropologist at De Evenaar in 2004, I had never consciously met anyone who suffered from Posttraumatic Stress Disorder (PTSD), nor any refugees. De Evenaar is a center for transcultural psychiatry, a specialized mental health institute of GGZ Drenthe Mental Health Care in Beilen in the state of Drenthe, the Netherlands. In fact, I was quite 'green' (incidentally also my last name) in psychiatry altogether, and was nervous about engaging with refugee patients.

One of the first patients I met was a man from Somalia. The founder of De Evenaar, psychiatrist Kees Laban, had asked me to explore his cultural background, because his treatment was not progressing well. A little nervous about how the encounter would develop, I started by asking the man from Somalia about the clan he belonged to. Never will I forget his reaction: he was full of surprise, his eyes widened and his face lit up. "That is what it is all about," he responded. He started to tell me about his minority clan and its special position in Somalian society. I will elaborate on this in chapter two. His eagerness to talk about the subject was very different from what I had expected. I just had to keep the conversation going along the lines of the interview structure; this structure is presented in chapters 1 and 3.

The man's mental health problems appeared to be heavily influenced by the minority clan he grew up with, and by the tension in the magic rituals the clan performed to bring good fortune to other families. Both of these factors were also influencing his sense of identity as an asylum seeker in the Netherlands. We easily talked for more than one hour and ended our conversation cordially. The encounter had revealed crucial meaningful information for a better understanding of his mental health problems and his cultural identity. Afterwards, psychiatrist Kees Laban told me about the patient's sudden positive change of behavior and asked me what I had done. This experience triggered my curiosity about cultural identity in relation to mental health, and was the start of the study that is presented in this thesis.

I was not quite sure how to fulfill the main task that was assigned to me at the center, namely to transfer anthropological knowledge to mental health care professionals. An anthropologist at a mental health institute is not common in the Netherlands. There is no formal education preparing an anthropologist to work in a mental health care setting, there are no guidelines, and there is no professional association. Over the years, I have found ways to combine anthropological knowledge and practical clinical experience in co-operation with my colleagues at De Evenaar, and have developed some personal skills to contribute to what is called a 'culturally sensitive approach' towards refugees, asylum seekers and migrants with mental health problems. In retrospect, it has been an interesting and inspiring journey which has led to several publications in international journals and books, and

presentations at conferences and symposia in cities such as Amsterdam, Rotterdam, Berlin, Gdynia (Poland), London, New York City, Paris, Puerto Vallarta (Mexico) and Stockholm. Little of this did I suspect when I started working as an anthropologist at De Evenaar back in 2004.

Although an anthropologist working in a mental health care setting is not common in the Netherlands, there are a number of transcultural psychiatry centers that employ anthropologists: mainly mental health professionals who also studied anthropology, or as researchers or intercultural communication consultants. Particularly uncommon are anthropologists who contribute to the clinical assessment of mental health problems and therefore have frequent face-to-face meetings with patients.

But what is the role of an anthropologist in mental health care? To answer this question, an explanation of the distinction between medical anthropology as 'anthropology *in* medicine', 'anthropology *of* medicine' or 'anthropology *as* medicine' may help (Van Dijk, 2007). The contribution of applied anthropological knowledge to the diagnosis and treatment of patients in medicine is referred to as 'anthropology *in* medicine'. In this sense, as an anthropologist I gather information on cultural backgrounds and historical contexts, collect additional information concerning country of origin, ethnic group, religion or particular customs and habits, make patients aware of cultural differences regarding numerous topics between their country and the Netherlands, stimulate them to talk about what is really at stake beyond their medical story, and so on. In this role, I am also confronted with the way in which mental health care is organized and the norms and values that are typical for a mental health institute.

The way mental health is organized in an institute is saturated with culture, with limitations and possibilities regarding treatment, with norms and values about what is appropriate and what is not. Examining this is known as the 'anthropology *of* medicine'. In this role, I make clinicians aware of their own customs and habits, offer advice on how to approach patients, point at cultural differences between health care in the Netherlands and other parts of the world, demythologize and reframe stereotypes, stimulate looking beyond symptomatology, and so on.

When both roles – as information collector and as cultural broker between patients and a mental health institute – come together, this is called 'anthropology *as* medicine'. In these combined roles, next to being an interpreter of 'strange' stories, I may be an interpreter of ordinary daily life stories that go beyond the medical narrative.

The focus of an anthropologist is to obtain the 'native's point of view' on a certain topic from a holistic perspective; in transcultural psychiatry, this means that mental health problems need to be understood according to the patient's own perspective and, holistically, as part of his or her entire

meaning system. In a holistic perspective on mental health problems, therefore, the meanings that an individual attaches to mental illness cannot be regarded as isolated from the meanings that are attached to subjects other than mental illness. This perspective, common in anthropology, derives from the discipline of philosophy, the mother of all sciences, in particular the work of Austrian philosopher Ludwig Wittgenstein (1889-1951), who argued that language, thought, and reality are inextricably intertwined (Das, 1998). This philosophical perspective plays a major role in my work as an anthropologist in transcultural psychiatry. The attempt to contextualize mental health problems within the biographies of patients, the surroundings that make meaning to patients as they articulate them, and the socio-historical context of the causes of their mental health problems is also heavily influenced by Clifford Geertz's interpretation of cultures (1973). Geertz aims not only to interpret a single manifestation of a culture, but also to show how meanings attached to that manifestation are related to the signification of power relations, socio-cultural status and gender in a wider context. This manifestation does not stand alone, but also shows to some extent what it means to belong to a culture. Contextualizing such a manifestation reveals deeper layers of culture in language, thought and reality.

The native's point of view is commonly captured by anthropologists in their own 'home' surroundings, meaning that anthropologists conduct ethnographic fieldwork in the habitat of the people they want to study. Ethnographic fieldwork thus appears to be something quite different from speaking with patients in my office in Beilen. Nevertheless, I have the feeling that I have travelled many countries in the past fifteen years. Patients have revealed to me some wonderful insights into their cultural background; this was especially the case during the first period of my job, when I had the opportunity to make up to five appointments with one patient to discover what was so important about his or her cultural background in order to gain a better understanding of his or her mental health problems.
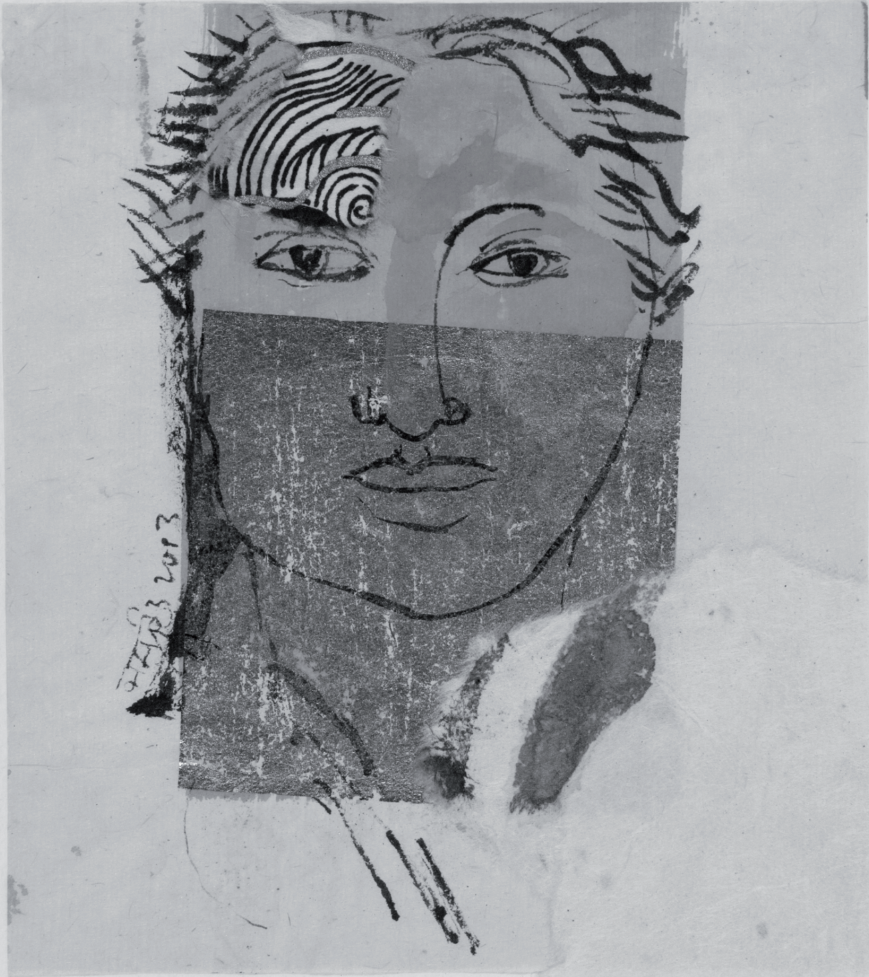
I believe that my work experiences and publications have confirmed that an anthropological approach, using for instance Erving Goffman's *The Presentation of Self in Everyday Life* (1956) or Clifford Geertz's *The Interpretation of Cultures* (1973) as inspiration, has proven to reduce the gap of understanding between the mental health professional and patient. In my view, however, an anthropologist in transcultural psychiatry does need to be pragmatic, in the sense that an in-depth exploration of the cultural context of mental health problems needs to be focused, due to time and financial constraints. In the role of a translator and narrator, the anthropologist is an intermediary between patient and clinician (Richters, 1991). If an anthropologist wants the message to be received, then, in my view, stepping out of the academic comfort zone, where observations and insights must always be related back to the core of anthropological theories is inescapable. Nevertheless, the anthropologist also needs to make clinicians aware of the risks of an essentialist, reductionist approach to culture.

Driven by the desire to make mental health professionals think more thoroughly about the cultural context of mental health problems, and in offering an anthropological understanding of mental health problems, I wanted to explore the cultural identity component in the Outline for Cultural Formulation in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994). Specifically, I wanted to make clinicians aware of the way in which culture may shape the identity of their patients from various countries; indeed, it may be considered the core of meaning making. I believe that in the field of transcultural psychiatry, meaning making with respect to (mental) health issues is the key to better understanding the way in which these issues are presented, the way patients from various countries deal with these issues, and the building of a trust relationship between patient and clinician.

How I would have wished that Kees Laban would have lived to witness the fulfillment of this PhD thesis. Unfortunately, he fell seriously ill and in October 2018 he passed away. During his illness, he assured me that he would do anything possible within his power to guide me through the process of fulfilling this thesis. And he did. Words cannot express my gratitude for all the opportunities that Kees gave me in terms of becoming an anthropologist in a transcultural psychiatry setting. Now it is my turn to do everything within my power to emphasize why it is important for mental health professionals to assess cultural factors that may have to be taken into account with regard to diagnosis and treatment, to advocate for a contextualization of the mental health problems that patients from various cultural backgrounds suffer from, and to keep building bridges between medical anthropology and transcultural psychiatry. I am driven by the strong desire to search for explicit and implicit meanings in sometimes horrific stories in order to contribute to helping those who suffer from mental health problems.

Simon Groen
Zwolle, June 8th 2019

Chapter 1

Introduction

*We are entirely made up of bits and pieces, woven together so shapelessly that each of them
pulls its own way at every moment. And there is as much difference between us and ourselves
as between us and others.*
De Montaigne, 1991 [1580]:244

This thesis focuses on cultural identity among refugees who have been referred to the specialized mental health institute De Evenaar, a center for transcultural psychiatry responsible for the treatment of refugees and other migrants in the northern part of the Netherlands. The main reason for exploring cultural identity is to enhance insight into the role of cultural background in the diagnosis and treatment of refugees who suffer from mental health problems. In contemporary psychiatry, there is broad consensus that cultural factors may influence or complicate diagnosis and treatment, especially in the case of refugees from war-ridden countries. Among immigrants and refugees, differences in language, culture, help-seeking behavior, and coping with mental health problems pose challenges for their prevention, recognition, and treatment (Kirmayer et al., 2011).

A focus on cultural identity ultimately boils down to the core norms and values that a person has internalized. These core norms and values together constitute what a person believes to be right or wrong, what is appropriate or not, what is normal or not, what is healthy or not, and so on. In transcultural psychiatry, cultural factors may be considered essential for understanding mental health problems, but often only in relation to symptoms. In medical anthropology, a more holistic view dominates. Norms and values that are related to mental health are not considered as isolated from norms and values that are related to domains that are apparently not health-related. An in-depth exploration of all norms and values that altogether constitute cultural identity and its role in understanding mental health problems is the central theme of this thesis.

We all have a cultural identity. Identity is culturally defined, because we are part of settings that contain certain norms and values which may be different from those in other settings. These norms and values are always related to the context of time and place, especially in the case of migration. We may not be constantly aware of having a cultural identity, and particularly not that our cultural identity is subject to norms and values in our sociocultural environment. Much of our cultural identity is taken for granted, because norms and values have long been internalized. These norms and values create an order that feels safe and makes things or experiences meaningful for anyone, if we regard human beings as cultural beings. We build our cultural identity from the moment we realize that "I" is different from the "Other," which is a core part of the process of growing up. The construction of our cultural identity is influenced by, amongst others, our ancestry, the way our parents raised us, contacts with other relatives and friends, the groups we belong to, education, work, our languages and dialects that provide words to give meaning to our cultural identity, and so on. Numerous other differences or characteristics of cultural identity may be mentioned, including that it is subject to change due to life stages, societal development, political preferences, sexual orientation, social status, etc. Several life events may influence the development of a cultural identity, especially shocking

events that may turn everything that is meaningful upside-down. For now, we may think of cultural identity as key for the understanding of the self in a cultural context, because through our cultural identity we construct our way of understanding what happens around us and we build security about what we consider to be right or wrong. According to Zaharna, who describes the painful effects of cultural identity confusion in sojourner adjustment in a literature review: "… [A]ny situation that alters the meanings for behavior has the potential for hampering the individual's ability to maintain consistent, recognizable self-identities" (1989:501). If meanings for behavior are altered through influential situations, then cultural self-identities are challenged and run the risk of becoming confused. As has been stated in the lemma at the top of this chapter, we are all made up of bits and pieces. All of these little bits and pieces together constitute our cultural identity, which may take various postures in various situations, as each of the bits and pieces pulls its own way at every moment.

Historical background of the concept of cultural identity in transcultural psychiatry
Cultural identity was introduced to psychiatric nosology as the first of five components in the Outline for Cultural Formulation (OCF) in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994). The OCF is an outline for a mini-ethnographic narrative assessment (Lewis-Fernández, 1996:136). Underlying the development of this outline is an analysis of cross-cultural literature on a variety of psychopathologies that aims to 'make culture more central to DSM-IV' (Lewis-Fernández, 1996:133). The OCF was the result of consensus between researchers and clinicians, psychiatrists, epidemiologists, psychologists, and anthropologists in the Group on Culture and Diagnosis, who gathered in a meeting of the National Institute of Mental Health in Pittsburgh in 1991 (Good, 1996; Lewis-Fernández, 1996; Alarcón, 1995). The reason for including cultural identity in the OCF, to the best of my knowledge, has never been revealed. Although the Explanatory Model theory that was introduced by psychiatrist and anthropologist Arthur Kleinman (1980) may be regarded as the core of the OCF, cultural identity was apparently required to meet this aim too. The content was only briefly described as:

> ' the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism)' (Lewis-Fernández, 1996:137).

Since then and over the years, several attempts have been made to either describe, list, or otherwise typify cultural identity as the first DSM-IV OCF component. In summary: 1. cultural identity is complex, multi-layered, and difficult to conceptualize (Rohlof, Knipscheer, & Kleber, 2009; Ton & Lim, 2006); 2. ethnicity is a key concept in cultural identity (Mezzich, Caracci, Fabrega

Jr., & Kirmayer, 2009; Ton & Lim, 2006); 3. multiple ethnic backgrounds in the same person are increasingly common and vary in relation to the community one resides in (Mezzich et al., 2009); and 4. cultural identity is unique for every individual, yet irrefutably connects to other individuals and the wider society (Taylor & Usborne, 2010; Mezzich et al., 2009; Group on the Advancement for Psychiatry, 2002). The cultural identity of one person from a certain country may vary from that of another person from the same country: "Two Hispanic persons may come from Mexico but may have different cultural identities depending on what socioeconomic status and geographical region from which they originated" (Lu, Lim & Mezzich, 1995:480). Other sociodemographic characteristics may distinguish the cultural identities of individuals from the same country as well, such as ethnic or ethnoreligious groups that in some countries might be in conflict with each other (e.g., Hutus vs. Tutsis in Rwanda, Sinhalese vs. Tamils in Sri Lanka, or Basques and Catalonians vs. their national government in Spain).

So many aspects altogether constitute cultural identity that the concept has been denoted as complex and multilayered (Ton & Lim, 2006). One reason for the complexity of cultural identity appears from the many aspects that constitute cultural identity development, as Lu and colleagues have described (1995:481): ethnicity, gender, race, age, country of origin, sexual orientation, language, religious and spiritual beliefs, acculturation, socioeconomic class, and education. In this study, we consider acculturation as distinct from cultural identity. Several studies have pointed at interrelations between acculturation and cultural identity (Schwartz, Montgomery, & Briones, 2006; Bhui et al., 2005; Bhugra, 2004). Acculturation is sometimes used interchangeably with a narrow understanding of (bi)cultural identity. Any preference for the norms and values that dominate in either the host society or in the society of origin may be found in any migrated individual and might influence thought and behavior, but do not coincide with cultural identity. In **chapters 4 and 5**, definitions of cultural identity and acculturation will be displayed.

The uniqueness of cultural identity for any individual is described by the Group on the Advancement for Psychiatry:

> Identity implies uniqueness, a set of special features coming together to form a whole. Cultural identity implies the characteristics shared by a group, a person's culture. Thus identity allows for a self-definition, involving self-esteem, special skills and talents, role in work and family, and place in social order (GAP, 2002:55).

The tension in this description is between "uniqueness" and "the person's culture" on the one side, and "shared by a group" on the other. Identity is unique to every person, but worthless without others with whom that person interacts and who might share some of the same cultural identity characteristics (or not). The cultural part of cultural identity refers to shared norms and values, which immediately connect one person to the other, in a group, or between colleagues, family, and society.

What is "cultural" here is the fact that local norms and values shape interconnections between individuals.

Fifteen years after the introduction of the OCF in the DSM-IV, its use and content was evaluated in a special edition of *Transcultural Psychiatry*. The use of cultural identity as part of the OCF was evaluated as well (Mezzich et al., 2009). One of the authors concluded that a discussion of cultural identity is needed in three ways:

1. [T]he meaning of the concept needs to be clarified;
2. The guidelines need to discuss how to approach patients' cultural identity in clinical situations and how to document it in medical records in non-stereotyping and non-discriminatory ways;
3. It would be interesting to know whether psychiatric assessment including an individualized [idiographic] cultural perspective increases the clinician's empathy for the patient in cross-cultural situations and how this may influence assessment and treatment plans (Bäärnhielm & Scarpinati Rosso, 2009:424).

These suggestions underlie the intentions of this current study, which are the core of this thesis.

In the following, culturally sensitive diagnosis and treatment, as established in the fifth edition of the DSM (DSM-5, American Psychiatric Association, 2013), and cultural competency are described. Then, the juridical situation of asylum seeking in the Netherlands is explained. After that, the historical background of the two countries from which the participants in this study originate, including the potentially traumatic events (PTEs) they may have experienced, will be presented. Next, post-migration stress and the acculturation problems they may experience in the Netherlands are delineated. Furthermore, the research setting of the mental health institute, De Evenaar in Beilen, is described. Finally, the structure of this thesis is presented.

Culturally sensitive diagnostics and treatment
In the DSM-5, the potential influence of culture on the diagnosis of mental disorders is described as follows:

> Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are the criteria for diagnosis (American Psychiatric Association, 2013:14).

For the first time, it is stated clearly that in the diagnosis of mental disorders, cultural, social, and familial norms and values cannot be ignored: "The current formulation acknowledges that *all*

forms of distress are locally shaped, including the DSM disorders" (idem: 2013, stress in the quote). Mental health professionals are urged to recognize local attributions to all mental disorders, which is a breakthrough in the history of the DSM. The definition of culture that is provided in the DSM-5 is as follows:

> Culture has been defined as dynamic systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations, including language, religion and spirituality, family structures, life-cycle stages, rituals, customs, and moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience (idem:749).

The stress in the quote is on cultures being open, dynamic, and hybrid, in the sense of being exposed to multiple cultures, giving the impression that cultures as systems are complex and ever-changing. Mental health professionals should be aware of stereotyping and should therefore take every individual patient as a unique person (Kleinman & Benson, 2006). The task that transcultural psychiatry sets to mental health professionals when it comes to culturally sensitive diagnosis and treatment seems infinitely challenging, with the risk of being perceived as impossible. However, mental health professionals do not necessarily need to know all about the cultural background of their patients. They do, however, need to be at least competent to retrieve the cultural background from their patients and to judge how elements of this background may be relevant for a better understanding of their health-related beliefs, behaviors, and values.

Culturally sensitive diagnosis and treatment are therefore inextricably connected to cultural competency, which will be a recurring theme in this thesis. Cultural competency has been defined in several ways with one similar aim: "... to make health care services more accessible, acceptable, and effective for people from diverse ethnocultural communities" (Kirmayer, 2012a:151). In order to achieve this aim, an attitude towards patients, in the sense of a willingness to accept the patient's illness narrative, is crucial when dealing with patients in multicultural milieus. Such an attitude does not mean that the mental health professional should uncritically follow the illness narrative, but that he or she should at least display the attitude of an interested listener (e.g. **chapter 2**) and be flexible towards meeting the health needs of his/her patients. In this sense, cultural competence may be at odds with evidence-based medicine. Standard medical practices mostly based on data from the majority population may have uncertain relevance for specific cultural groups. One of the possible solutions in transcultural psychiatry is to critically move beyond the limitations of evidence-based medicine and cultural competence, and instead to use "... a wide range of methods including those of the humanities and social sciences which can expose the historical roots, contextual meaning, and rhetorical force of particular ways of construing self and other, in health and illness (Kirmayer, 2012b:255)."

Refugees and asylum seekers in the Netherlands

In the Netherlands, asylum is granted to individuals whose safety is in danger in their country of origin, based on the 1951 Convention Relating to the Status of Refugees which states that every refugee has the right to protection (UN General Assembly, 1951). In recent years, the influx of refugees applying for asylum has shown a cyclical trend (figure 1). Some months after the start of data collection in this exploratory study, in June 2013, the total number of asylum applicants from the previous twelve months totaled 14,343 (Immigratie- en Naturalisatiedienst, 2013). The largest group was of Somalis (14%), followed by Iraqis (12%) and then Afghans (10%). At the end of data collection, in February 2015, the total number of asylum applicants, including first applications, repeated applications, and family reunification applications, had reached 29,958 (Immigratie- en Naturalisatiedienst, 2015). Syrian refugees were the largest group: 11,921 (40%). With a total of 1,577 refugees, Iraqis were fourth in number (5%), and with 972 asylum applicants, Afghans were the sixth largest group (3%). Although the proportion of refugees from Afghanistan and Iraq has decreased in the last years, they are still two of the largest groups in the Netherlands.

Asielzoekers en nareizigers
x 1 000

Eerste asielverzoeken   Nareizigers

Bron: CBS, IND
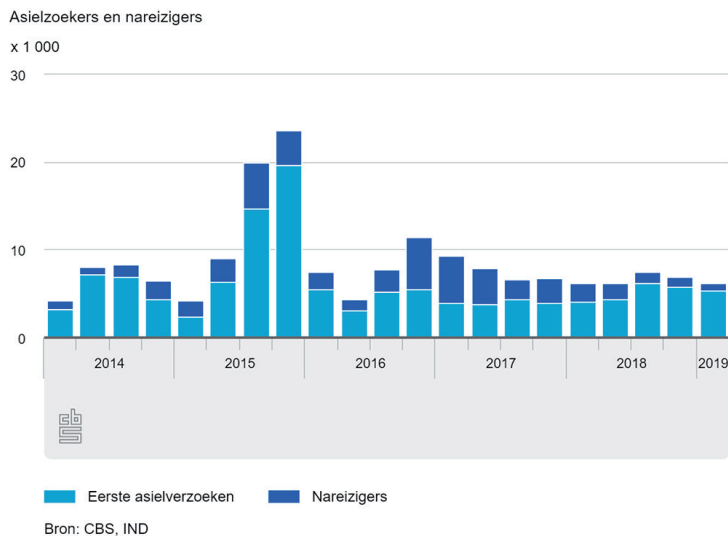
Figure 1. First asylum applicants and followers, 2014-2019 (Source: Werkwijzer vluchtelingen, retrieved from https://www.werkwijzervluchtelingen.nl/feiten-cijfers/aantallen-herkomst.aspx, May 28th,2019)

When a refugee enters the Netherlands, he or she holds the status of an asylum seeker and is initially housed in an application center (Aanmeldcentrum, AC) at Schiphol (near the largest airport in the Netherlands) or in Ter Apel (in the northeast of the Netherlands). Responsibility for accommodation as well as accompaniment and outflow from shelter locations lies with a governmental institution of the Ministry of Justice and Security, the Centraal Opvang Asielzoekers

(COA). Responsibility for the asylum procedure lies with the Immigration and Naturalization Service (Immigratie- en Naturalisatiedienst, IND). After identification and registration by the IND, the asylum seeker is translocated to another nearby center (Opvangcentrum, OC). During the asylum procedure, the applicant is assigned to an asylum seeker health insurance provider.

The applicant may be accompanied by an attorney and/or a representative of the national refugee organization (Vluchtelingenwerk Nederland, VWN). The IND judges the asylum application, taking into account the story of the applicant and the state of security in his/her country of origin. If the application is approved on the grounds that protection by the Dutch government is found to be justified, the asylum seeker is assigned a residence permit and offered housing. If the application is found not to be grounded, the applicant may appeal. During this procedure, the asylum seeker may stay in the Netherlands. Asylum seekers are accommodated in asylum seeker centers. Several asylum seeker centers are located in the region of the study. Some of these centers are deportation centers, where asylum seekers wait until the deportation procedure is prepared. If the asylum application is denied, asylum seekers are forced to leave the country and return to their country of origin.

From the moment that the asylum application is granted, refugees need to be relocated to a house, they need to have an individual health insurance provider and general practitioner, and they have the duty to follow a course focused on integration into Dutch society, including a course in the Dutch language, within three years. According to the National Ombudsman, the current integration system raises thresholds for integrators and almost half of the integrator students fail the course (report A False Start, 2018).

The political situation of refugees, especially those without a residence permit and who are undocumented, has changed dramatically during recent years and has caused societal polarization in the Netherlands (Laban & Van Dijk, 2013), as in other European countries (Bäärnhielm, Laban, Schouler-Öcak, Rousseau, & Kirmayer, 2017). On the one side, protests were organized against the intention to build new asylum centers. On the other side, undocumented refugees have been sheltered by private families and in some poignant cases some mayors have refused to cooperate with deportation proceedings. Between right-wing and left-wing political parties, "the refugee problem" has been one of the major issues in election periods. This political and societal unrest may have an impact on the mental well-being of asylum seekers and undocumented refugees.

Trauma and refugees

The respondents in this study were born in Afghanistan or Iraq, two countries that have been conflict-ridden for decades. In the decade prior to the start of this current study in 2012, refugees from these two countries of origin had been the two largest groups of refugees in the Netherlands

(Vluchtelingenwerk, 2018). They also still represent some of the largest groups of refugees in the study setting at De Evenaar. Below, I first briefly sketch the historical context of each country. This is followed by a few sociodemographic characteristics and a brief summary of psychiatry in each country in the period that the study participants could have experienced certain kinds of traumatic events. This is merely an overview; I do not claim to be exhaustive.

Afghanistan

Historical context

The Islamic State of Afghanistan was originally the land (-stan is Persian for land) of Afghans, as Pathans came to call themselves. Afghanistan has a long history of wars and other kinds of violence, which has displaced Afghans both internally within Afghan borders and externally to neighboring and foreign countries (Alemi, James, Cruz, Zepeda, & Racadio, 2014). After 1960, rural-urban migration increased as road systems improved and industrialization gathered pace (Dupree, 2004). As a result, distinctions between a few modernizing cities and traditional rural areas increased. Politically, opposition grew between communist Islamic and conservative fundamentalist movements. Afghanistan was a monarchy until 1978, when a coup was established with communist support and the Afghan army that was partly trained in the Soviet Union (Maley, 2010).

Following dissatisfaction in the Soviet Union about the new Afghan constitution, the Islamic Revolution in Iran, and support from the United States and Saudi Arabia for the Islamic fundamentalists the *mujahedeen* ("the ones who wage *jihad*," Ventevogel, 2016), Soviet troops entered Afghanistan and took Kabul, the capital city, in December 1979. During the ensuing ten-year war with the Soviet Union, millions of Afghans, mainly from the countryside, fled to neighboring countries such as Iran and Pakistan (Dupree, 2004). From 1978 to 1987, on average 240 Afghans were killed every day (Maley, 2010).

After the withdrawal of the Soviet Union in 1989, various *mujahedeen* groups fought for the rule of Kabul in a civil war, destabilizing the entire country along tribal, ethnic, geographic, and economic lines (Tanner, 2002:243). The Soviet-supported regime, led by President Najibullah, fell in 1992. From 1992 until 1996, several militia fought another civil war, mostly in the capital city of Kabul (Maley, 2010). However, schools were open and female teachers outnumbered males (Dupree, 2004). From Kandahar in the south, a new radical Islamic fundamentalist movement, called the Taliban ("the students," Ventevogel, 2016), emerged. In 1996, with military support from Pakistan and financial support from Saudi Arabia, the Taliban managed to capture Kabul. They proclaimed the Islamic Emirate of Afghanistan, which brutally ruled until 2001. Several massacres took place, directed against Shiite Muslims, such as the Hazara. The Taliban forced women to wear the burqa, excluded them from education, and rigorously separated men from women (Dupree, 2004).

Shortly after the 9/11 terrorist attacks by Afghan-based al-Qaeda suicide bombers in 2001, allied forces led by the United States invaded Afghanistan with the aim of helping the *mujahedeen* to expel the Taliban and establish a new democratic government under President Karzai, with the assistance of the United Nations Security Council and the International Security Assistance Force (ISAF). ISAF and Afghan troops fought the remaining Taliban, but did not succeed in achieving a full defeat.

In 2009, a Taliban-led shadow government rose in many parts of the country. Since 2015, fundamentalist groups have supported the Islamic State in Iraq and the Levant (ISIL) in the eastern part of Afghanistan (Ventevogel, 2016). Until now, Kabul and the provinces of Helmand, Kandahar, and Nangarhar are frequently shaken by car bomb attacks and other forms of violence, resulting in many victims. Afghanistan still has to overcome its weak governance, corruption, patronage, and alliances, and deal with the shift of international attention to other areas as well as growing insurgency (Maley, 2010).

Sociodemographic characteristics
Contemporary Afghanistan holds approximately 34.6 million inhabitants (2016, retrieved from https://www.who.int/countries/afg/en/, June 11th, 2019). The capital city Kabul holds approximately 2.5 million inhabitants. Other main cities are Herat in the west (350,000 inhabitants), Kandahar in the south (325,000), Mazar-i-Sharif in the north (300,000), and Jalalabad in the east (200,000). The main ethnic groups are Pashtun (42%), Tajik (27%), Hazara (9%) Uzbek (9%), while minority groups include, among others, Turkmen, Nuristani, Pamiri, Arab, Gujar, Brahui, Qizilbash, Aimaq, Baloch, Pashai, and Khyrgyz. Pashtun are dominant in the south and east, Tajik in the west and northeast, Hazara in the middle north, and Uzbek in the northwest. Almost all Afghans are Muslim: between 85% and 90% are Sunni Muslim while 10-15% are Shiite Muslim. The official national languages are Dari (80%) and Pashto (47%). Dari is a Persian language, similar to Farsi, the national language of Iran. The Hazara speak a Dari dialect, Hazaragi.

The CIA World Factbook mentions literacy rates for the entire population in Afghanistan as 38.2% (men 52%, women 24%; retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/af.html, May 28th, 2019). Life expectancy at birth for the entire population is estimated at 60.5 (women 61.9, men 59.3), thus ranking number 161 in the world (World Health Organization, 2015). Ongoing wars have resulted in poverty, lack of continuity in education, and decreased access to health care.

Trauma and psychiatry
PTEs that occur in Afghanistan are various, of which ethnoreligious violence committed by fundamentalist Taliban actors against Hazara and Shiite Tajiks is one of the most frequent. In certain

areas, there is a high risk of kidnapping, especially of adults who work for the US government or other armed forces, and of children. Refusal of a forced marriage is a main cause of violence against women, including sexual maltreatment and rape. Amnesty International claims that the Taliban now controls more of the country than before the interference of allied forces under US command in 2001 (Amnesty International, 2018).

Although the Dutch government has claimed that Afghanistan is a safe country to return to, ten human rights and children's rights organizations have taken action to stop the return of refugees because of the high number of casualties in the country and the high risk of torture, kidnapping, and murder. The health care system in Afghanistan was rendered totally deficient during and after Taliban rule, while mental health care in the country has always been poor (Ventevogel, 2016:27). Especially in rural areas, access to formal health care is almost impossible. There is one psychiatric clinic in the capital city of Kabul, Blossom Hospital. Healthnet TPO, an international non-governmental organization, runs several health care programs in Jalalabad in the eastern province of Nangarhar (Ventevogel, 2016). Although access to health services has increased since 2001 (Ventevogel, 2016:201-210), for many Afghans mental health care is inaccessible and/ or unaffordable. Furthermore, mental health problems are stigmatized: there is a general lack of recognition of mental health problems and family honor may be jeopardized if a family member suffers from such problems.

Iraq

Historical context
The name of the Republic of Iraq supposedly comes from the city of Uruk in what was previously known as southern Mesopotamia, the "land between rivers" (Hunt, 2005), 300 kilometers south of Bagdad. Uruk has been called the first civilized city, and the combination of urban development and written language has led scholars to consider Uruk to be the first civilization. The Hashemite kingdom of Iraq gained independence from Great Britain in 1932 under King Faisal I (Tripp, 2007:75-77). In 1958, an anti-monarchy coup with strong socialist elements led to military rule. In 1968, the pan-Arabic socialist Ba'ath party took up rule (Tripp, 2007:186). In 1970, an autonomous Kurdish region was approved by the Ba'ath national congress (Bengio, 2012:38). In 1979, Saddam Hussein came into power. Following the Islamic Revolution in Iran in 1979, Hussein declared war on Iran in 1980, which lasted until 1988 and became known as the First Persian Gulf War (Hunt, 2005:90-94). In 1988, the Hussein regime used chemical weapons against Iraqi Kurds in the Halabja massacre (Bengio, 2012:181). The regime invaded and annexed Kuwait – which had been separated under the British mandate, though this had never been accepted by Iraqi nationalists – in 1990 (Hunt, 2005:89). Allied forces under the rule of the United States, Great Britain, and Egypt invaded both countries in 1991 and ended this Second Gulf War.

Subsequently, in 1991, Shia and Kurdish Iraqis led several uprisings against the regime of Saddam Hussein, but they were successfully suppressed by Sunni elites in the government and the military, including through the use of chemical weapons (Hunt, 2005:102).

In 2003, an international coalition led by the United States and Great Britain invaded Iraq over allegations of possession of weapons of mass destruction. The Saddam Hussein regime was overthrown and a Coalition Provisional Authority was established, which expelled members of the Ba'ath party from the government and dissolved the largely Sunni Iraqi Army (Tripp, 2007:278-292). The ensuing leadership vacuum led self-entitled jihadist groups to target the coalition forces and caused inter-ethnoreligious violence between Sunnis and Shiites (Hunt, 2005:107-108). In 2004, the infamous Abu Ghraib prison became known worldwide through the publication of photographs showing the inhumane maltreatment of Iraqi prisoners by US guards.

Following a new constitution and parliamentary elections in 2005, fighting continued, the leader of al-Qaeda in Iraq was killed, and Saddam Hussein was sentenced to death in 2006 (Tripp, 2007: xviii-xix). In 2007, coalition forces started to withdraw from Iraq. However, fighting continued and Iraq remained politically unstable. Between 2014 and 2017, ISIL attacked several cities, including Tikrit, Fallujah, Sinjar, and Mosul, and controlled large parts of the country. In August 2014, ISIL killed thousands of Yazidi men in the Sinjar massacre and took their wives for forced marriage (Amnesty International, 2018). Since 2015, ISIL lost territory again and by 2017 had no remaining territory in Iraq.

Sociodemographic characteristics
Recent figures show that there are approximately 37.2 million inhabitants of the Federal Republic of Iraq (World Health Organization: Iraq, https://www.who.int/countries/irq/en/, figure from 2016, retrieved May 28th, 2019). There are approximately 9.5 million inhabitants in the capital city of Bagdad. Other main cities are Basra in the southeast (2.3 million inhabitants), Mosul in the northwest (2 million), Erbil (1.1 million), Kirkuk (1.1 million) and Suleymaniya (1 million) in the northeast, and Hilla (1 million) in the center of the country. Mosul, Erbil, and Suleymaniya are cities in the autonomous Kurdish region in the northern part of the country. Kurdistan also covers parts of Iran, Syria, and Turkey.

The main ethnic groups in Iraq are Arabs (75-80%), Kurds (15-20%), and Turkmen (5%). Smaller minority groups include Assyrians, Armenians, Yazidi, Sabean Mandaeans, Shabak, Kaka'i, Bedouins, Roma, Circasseans, and Persians. Since 2003, the city of Bagdad has designated city quarters for Sunnis and Shiites. Kurds could be Sunni, Shiite Faily, or Kaka'i. Christians mainly live in the south. Sabean Mandaeans have limited access to education

and are mainly goldsmiths. Religions are Shia Muslim (60-65%), Sunni Muslim (32-37%), and Christian (3%). Religious minorities include Yazidi, Sabean Mandaean, Christian orthodox, Baha'i, Zoroastrian, Hindu, Buddhist, and Jewish. The official language in Iraq is Arabic. Kurds speak various dialects of Kurmandji, such as Badini and Sorani. Other languages are the Turkmen dialect of Turkish, neo-Aramaic languages such as Chaldean and Assyrian, and Mandaic, Shabaki, Armenian, Circassian, and Persian.

According to the CIA World Factbook, literacy rates are much higher in Iraq than in Afghanistan, at nearly 80% of the entire population, and there are smaller differences between men and women (86% versus 74% respectively, CIA World Factbook, retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/iz.html, May 28th, 2019). According to the CIA World Factbook, life expectancy at birth is also much higher than in Afghanistan: 75 years for the entire population in Iraq (77 years for women, 72.5 years for men). The WHO's estimations (2015) point to a lower life expectancy – 69 years, rank 121 (women 72 years, men 66 years) – though it is still higher than in Afghanistan.

Trauma and psychiatry
PTEs in Iraq over the past three decades are as diverse as they are in Afghanistan, but they may vary in character. Car bombings, gunshots, kidnappings, and arrests are frequent. A study on the prevalence of PTEs and Post-Traumatic Stress Disorder (PTSD) among 284 Bagdad students in Iraq revealed that the most frequent traumatic events were the sudden death of a family member (55%), bomb explosions (50%), seeing someone being killed or injured (37%), and the killing of a family member (34%) (Al-Hadethe, Hunt, Thomas, & Al-Qaysi, 2014). The first major mental health survey in Iraq resulted in the estimation of a 56% lifetime exposure to traumatic events among 4,332 adults (Al Obaidi, 2013). Mental health services and professionals have historically been sparse in Iraq, with a mean of one psychiatrist per 300,000 inhabitants before 2003, followed by a drop to one per million (Sadik, Bradley, Al-Hasoon, & Jenkins, 2010). With the exception of some essentially medical out-patient facilities of general hospitals in some cities, the number of main centers for the treatment of mental illness has remained the same since the 1970s (Abed, 2003). The major mental health facilities are located in Bagdad in Al-Rashad Hospital. There are some acute psychiatric beds in Mosul in the north and Basrah in the south, but "... the remaining provinces have very little psychiatric resources' (idem:461). In a 2013 report, Médicines sans Frontières called for an expansion of mental health services and professionals; four psychiatrists per million residents is far below what is needed. The main component of Iraq's mental health services has been institutionalized care for those with chronic psychiatric disorders such as schizophrenia.

Post-migration stress

When refugees finally reach the Netherlands, often after a hazardous journey, they are expected to adjust to Dutch society and fulfill certain obligatory tasks, such as completion of an integration course within three years of receiving a residence permit. They may encounter stressful situations in the Netherlands, such as, in the case of asylum seekers or refugees who hold a temporary residence permit, the fear of being sent back to their home country, or frequent transportations to other locations. Asylum applications may take years to process, causing long periods of insecurity. Both refugees and asylum seekers may experience problems acquiring the Dutch language, thus they are often dependent on the availability of interpreters, during which time they are not able to express themselves emotionally and are only able to engage into new social contacts in a limited way. They may worry about the safety of family members who have been left behind in the home country or elsewhere. Another problem may be the experience of (perceived) discrimination or hostility in the host country, such as xenophobic reactions. Furthermore, not being able or allowed to work, struggling to get diplomas that were obtained in the home country certified in the Netherlands, and/or working below one's education level may also be perceived as problematic.

In a Dutch study among Iraqi asylum seekers, Laban and colleagues (2005) distinguished six clusters of post-migration stressors that were based on a post-migration living problems checklist: family issues, discrimination, the asylum procedure, socioeconomic living conditions, socio-religious aspects, and work-related issues. Except for socio-religious aspects, all clusters were significantly related to psychopathology, in particular anxiety, depressive, somatoform, and multiple psychiatric disorders.

In a study among refugees and asylum seekers in the United Kingdom, five other categories were distinguished: residency determination, healthcare, welfare and asylum, threat to family, adaptation difficulties, and loss of culture and support (Carswell, Blackburn, & Barker, 2011). Of the reported post-migration problems in the 47 refugees and asylum seekers in that study, the threat to family and adaptation difficulties were the most severe. Adaptation difficulties are a significant risk factor for PTSD, and loss of culture and support is a risk factor for anxiety and depression.

In this current study, post-migration stress was found to be a strong predictor of PTSD, while the number of experienced PTEs was no longer significant. In a study by Chen and colleagues among nearly 2,400 refugees with a permanent humanitarian visa in Australia, post-migration stressors such as poor social integration, economic problems, worrying about family or friends overseas, and loneliness were also prominent (Chen, Hall, Ling, & Renzaho, 2017). Even though the results of all of these studies may differ, it becomes clear that post-migration stressors deserve substantial attention in transcultural psychiatry.

Acculturation problems

Both refugees and asylum seekers may also have difficulties adapting to the norms and values in the host society, for example because the latter is more individually-oriented than the home society (Bhugra, 2005). Adapting to norms and values in a society other than the home society is called acculturation. Canadian psychologist John Berry defined this process as "… the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (2005:698). Berry developed a quadrant model of acculturation that is based on high or low preferences for the norms and values of the home versus the host society, and for social contacts with members from the home versus the host society.

When taking norms and values into consideration, those from the host society are sometimes referred to as the "dominant culture," while those from the home society are known as the "minority culture." When an individual has a preference for the norms and values of and social contacts with members from the home country now living in the host society, this is called "separation." When an individual has a preference for

Figure 2. Four acculturation strategies based upon two issues, in ethnocultural groups (based on Berry, 2005)

the norms and values of and social contacts with members of the host society, this is called "assimilation." When an individual equally values the norms and values of and social contacts with people from both societies, this is regarded as "integration." Negative attitudes towards the norms and values of and social contacts with members from both societies is regarded as "marginalization." A person may find oneself a stranger in relation to both the minority and the dominant culture. The acculturation process may therefore lead to acculturation problems, because an individual might not be able to find a satisfying balance between the norms and values of the home society and those of the host society.

The Berry acculturation model has been criticized for its lack of attention to similarities between the home and host societies (Schwartz, Unger, Zamboanga, & Szapocznik, 2010), for its arbitrary classification into high or low preferences based on a priori values in the quadrant model (Rudmin, 2009), and for the validity of the marginalization category (Del Pilar & Udasco, 2004). Similarities or differences between norms and values in the home versus the host society are called "cultural congruency" (Bhugra, 2005). Culturally congruent may be societies with collectivist norms and values, but if a person migrates from a collectivist society to an

individualist society, acculturation problems may arise. For example, a person from France who resettles in the Netherlands may experience less distance to Dutch norms and values than a person from Afghanistan. The experienced distance to Dutch norms and values may also depend on the person's personal situation, level of education, and personality.

Bhugra (2005) has pointed to differences between individuals who are members of the same society, namely egocentric and allocentric individuals. Egocentric individuals from a collectivist society may hypothetically experience fewer acculturation difficulties after migration to an individualist society than allocentric individuals. Distinctions between egocentric and allocentric individuals in individual or collectivistic societies are arbitrary, because these distinctions are much more complex than preferences for "I" versus "we." These distinctions may vary per topic, such as raising children, contacts with colleagues at work, or dealing with sexual orientation.

Berry has noted that "[T]hese cultural and psychological changes come about through a long-term process, sometimes taking years, sometimes generations, and sometimes centuries" (Berry, 2005:699). The quadrant model does not take these changes into account, because the model is supposed to be applied as a situational snapshot with a limited expiration date. The perception of norms and values of both the host and the home country may vary over time due to new experiences in the host country or life events such as discrimination, loss of employment, or anti-Islam sentiments following 9/11. The way migrants' children are raised, and the way they develop in school and their social contacts with Dutch peers, may alter their relationship with their parents.

The arbitrary classification of high or low preferences suggests that in any given sample, all four categories may or may not exist. The validity of the marginalization category, for example, is arbitrary, because the likelihood that a person will develop a cultural sense of self without drawing on his/her heritage or the host culture is low. However, if a person has the sense of being rejected by some members of his/her group, for instance by other Moroccans in the Netherlands, and has the sense of not being accepted by members of the host culture, i.e. the Dutch, this may understandably lead to feelings of marginalization. Such an understanding does not exclude the fact that an individual is driven by certain Moroccan norms and values and an appreciation of certain Dutch norms and values. Many refugees undergo acculturation processes other than the Berry model, and many of them have difficulties keeping track of all the possible acculturation strategies; such multiple possibilities may even be identified in one and the same family. This fascinating and timely topic is rather complex, but deserves close attention in psychiatric assessments, because of its potential threat to psychological well-being (Lorenzo-Blanco et al., 2016).

Post-migration stress, acculturation, and cultural identity

Acculturation problems may seem to be an integral part of post-migration stress, because acculturation problems may cause stress and arise after migration. The Post-Migration Living Problems Check List (PMLP-CL) gives a well-defined delineated conceptualization of post-migration stress (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). Some of the items of the PMLP-CL may have acculturation aspects, such as discrimination (if a person feels that he/she is perceived as not belonging to the Netherlands), housing problems (if a person feels that he/she is living in a house where he/she is not sufficiently able to live according to the norms and values dominant in the group to which he/she feels a sense of belonging), and a lack of social contacts with others that have the same religion (if a person does not feel at home because there are only a few persons with the same religion in the neighborhood). Language problems, discrimination experiences, and a perceived lack of social contacts are items in the PMLP-CL, although these items may also be perceived as acculturation problems. However, highly acculturated migrants may still experience post-migration living problems, as has been shown in a study among Chinese immigrant women in Philadelphia (Ying, Han, & Tseng, 2012). Nevertheless, to the best of my knowledge, studies that include both post-migration stress and acculturation are rare.

From what we know, acculturation may have far-reaching effects on psychopathology and on cultural identity. Integration as an acculturation style is known as a low risk for the development of psychiatric disorders, but migrants who tend towards separation and especially marginalization, with all of the aforementioned considerations about this acculturation style, run a high risk of experiencing mental health problems (Ince et al., 2014; Kamperman, Komproe, & De Jong, 2003). Refugees are distinguished from most other migrants because of their forced flight: they did not choose to build a new life in the Netherlands. It may therefore be expected that among this group of involuntarily migrating individuals, this risk is even higher. The notion that acculturation may also have far-reaching effects on cultural identity is supported by several studies. The norms and values that constitute cultural identity are seriously and intensely challenged in the process of adapting to the norms and values of the host society. This process of social and cultural change may cause stress and a feeling of alienation. After settling down, depending on the level of cultural congruency and personality type, refugees might ask the questions: "Who am I?" and "To whom do I belong?" The interrelationships between post-migration and acculturation problems, psychopathology, and cultural identity constitute a gap in the transcultural psychiatry literature; a gap that this study aims to contribute towards filling.

Research setting

De Evenaar is a center for transcultural psychiatry in the northern part of the Netherlands, which was founded in 2002. The center is situated in the municipality of Beilen in the state of Drenthe and receives patients from the northern states of Groningen, Friesland, Drenthe,

and the northern part of the state of Overijssel. Patients are referred to De Evenaar by general practitioners, psychiatrists, psychologists, or other mental health professionals. The main reasons for referral are suspicion of PTSD and/or anxiety and/or depression problems, cultural and/or language barriers during treatment, rehousing issues, unclear diagnostics, and second opinions.

The aim of establishing the GGZ Drenthe Mental Health Institute was to acquire and develop specialized mental health care for refugees, asylum seekers, and other migrants. Aside from including psychiatrists with a history of working in tropical medicine, and engaging psychologists, family therapists, and mental health nurses with a special interest in working with refugees and asylum seekers, the employment of a cultural anthropologist was also one of the prerequisites of the institute. I am the successor to the center's first anthropologist.

A questionnaire aimed at composing a cultural formulation for diagnosis and treatment, known as the Brief Cultural Interview (BCI), is included in the routine clinical assessment used at the center in order to elicit the cultural background of all referred patients, as well as potential cultural factors that might influence illness representations and complicate diagnosis (see **chapter 2**). Outcomes from this questionnaire are registered in the electronic patient files to enhance implementation of the cultural assessment for diagnosis and mental health care (Groen, 2008). Sociodemographic information from the countries of origin of the referred patients, as well as information concerning major recent historical events, the current standard of psychiatry in these countries, attitudes towards mental health problems such as the level of stigma, and frequently occurring illness representations and cultural syndromes are all gathered. In the cultural adaptation of the treatment program for group therapy, a module has been included based on intercultural communication (Shadid, 1998), with the aim of exchanging cultural values between patients and between patients and staff members, of appreciating the norms and values in the patient's home country, as well as in the host and other societies, and of appraising and amending negative attitudes towards the home society.

Enhancement of knowledge on transcultural psychiatry among staff has been established through regular expert meetings to which national experts in transcultural psychiatry are invited, and occasional international exchange programs. As the president of the Transcultural Psychiatry Section of the World Psychiatric Association, the medical director of the center, Kees Laban, has enhanced international collaboration. Researchers from the center have presented in international conferences around the globe and have published in leading academic journals in the field of transcultural psychiatry.

The center has incorporated a resilience-oriented model for treatment and strategies that include the internal factors of vulnerability and personal strength and the external factors of

stress and social support (Laban, 2015). Treatment plans are tailored to reduce vulnerability and stress factors and increase personal strength and social support. This model is based on the Conservation of Resources theory, which implies that if people are able to regain material, psychosocial, and financial resources after experiencing adversities, the risks of developing psychopathology decrease (Hobfoll, 1989). Regaining these resources potentially leads to stronger resilience. In a review of neurobiological and psychosocial factors in relation to depression and resilience to stress, several resilience factors were distinguished: positive emotions and optimism, humor, cognitive flexibility, cognitive explanatory style and reappraisal, acceptance, religion and spirituality, altruism, social support, role models, coping style, exercise, capacity to recover from negative events, and stress inoculation (Southwick, Vythilingam, & Charney, 2005).

On the other hand, refugees and asylum seekers often face problems in the acculturation process, intergenerational difficulties in this process, language problems, discrimination, financial problems, worries about the family in the home country or elsewhere, the lack of a solid social network, and in many cases unemployment. A resilience-oriented treatment program encompasses both trauma-focused therapy and multimodal intervention, including "… a range of interventions to address the complex array of psychological reactions … following multiple traumatic events, … psychosocial stressors, physical health problems and resettlement and acculturation challenges" (Nickerson, Bryant, Silove, & Steel, 2011:401). Results from the cultural assessment are used to contextualize and establish a person-centered approach, in addition to the clinical assessment that aims to determine mental health symptoms and classify mental health disorders. Empirical research, such as that presented in this thesis, aims to further investigate potential improvements to the assessment of cultural factors in the psychiatric assessment in order to facilitate culturally sensitive diagnosis and treatment.

Structure of this dissertation

In **chapter 2**, a single case study illustrates the rationale for this research on cultural identity and trauma. In the process of pioneering the conducting of cultural interviews that I undertook, it became apparent that entering into dialogue with patients on the subject of cultural identity results in the building up of a trust relationship with the patient and yields contextual information about the presented mental health problems for the clinician.

At the beginning, in 2004, when the Brief Cultural Interviews had just been introduced at De Evenaar, whether or not cultural factors that might influence the clinical encounter, diagnosis, and treatment were assessed depended on whether cultural factors were perceived as influencing the course of treatment. In the case presented in **chapter 2**, the psychiatrist asked me to investigate the cultural context of the mental health problems of a patient from Somalia. The patient was suffering from chronic PTSD (DSM-code 309.81), recurrent severe Depression Disorder (DSM-

code 296.33), Epilepsia partialis continua, obstructive chronic bronchitis with acute exacerbation, financial problems, work-related problems, other psychosocial and environmental problems, and living problems. Treatment included psychosomatic education, cognitive behavioral therapy, and medication, but the mental condition of the patient was not improving. An appointment with the patient was arranged and a brief investigation of the cultural factors that might be relevant for a better understanding of his case took place. In the case of this Somali man, clan structure appeared to be a relevant issue and questions about this topic presented a welcome opportunity to go deeper into his cultural background. After constructing a concise summary of the man's clinical history, and in order to avoid questions that might be painful and that might harm the building of a trust relationship, I decided to start the construction of a cultural formulation by asking about the clan to which he belonged. I had not met the patient before, but the psychiatrist assured me that he had agreed to talk about his cultural background.

In the next meeting that the patient had with the psychiatrist following his interview with me, he made a totally different impression than in all other previous encounters. He told the psychiatrist that he was full of plans, he had already begun to take action to become more active, and he was thinking about stopping smoking. What had happened, I asked myself, because I was convinced that I had not done anything special except to ask about his clan. After some time, I realized that recognizing his cultural identity by asking questions that had never before been asked since his arrival in the Netherlands had probably given him a positive impulse to start thinking beyond his mental health problems. Based on this and other experiences, I wanted to find out whether this instrument that we had used, the BCI, could benefit from some anthropological revision, and whether patients and clinicians could benefit from the outcomes more broadly, beyond individual cases.

In **chapter 3**, an anthropologically adapted version of the BCI is subjected to further analysis. In the chapter, I describe how the questions of the BCI were critically revised from the viewpoint that an anthropologist would have a different approach to asking questions to investigate the cultural background of patients. Furthermore, it was revised to be a more concise, practical, and, due to time constraints, shorter instrument, enabling clinicians to efficiently enter into dialogue with patients. The BCI's questions only serve as a guideline in order to facilitate a lively dialogue with a respectful, inquisitive attitude on the part of the interviewer (Mezzich et al., 2009), and do not need to be used literally as a checklist. Nevertheless, the revision of the tool was regarded as a vital next step in the process of enhancing a culturally sensitive basis for diagnosis and treatment. Therefore, questions from the original cultural interview (Borra, Van Dijk, & Rohlof, 2002) were revised, the wording was adapted, some questions were skipped, and others were combined. In order to ensure that the new briefer version of the cultural interview would still serve the aim of generating cultural factors that are relevant for a better understanding of

mental health problems, and would fulfill the promise that it would be better understood by patients than the original and longer version of the cultural interview, we analyzed the BCI for its feasibility, acceptability by patients, and clinical utility for clinicians.

In **chapter 4**, the supplementary module of cultural identity as part of the DSM-5 Cultural Formulation Interview (CFI) is described. The CFI is a core interview that contains sixteen questions and twelve supplementary modules (Lewis-Fernández, 2017). De Evenaar contributed to the international field trial of the CFI and to the translation into Dutch of both the core interview and the supplementary modules. Cultural identity remained the first component in the cultural formulation after its introduction in the DSM-IV. Other components were altered, for instance "cultural explanations of the individual's illness" became "cultural conceptualizations of distress," and "cultural factors related to the psychosocial environment and levels of functioning" became "psychosocial stressors and cultural features of vulnerability and resilience."

However, although the CFI is an operationalization of the cultural formulation, cultural identity is no longer the first component. In the CFI, questions concerning the role of cultural identity now constitute questions eight to ten. If further exploration of cultural identity is necessary or desired, the user of the CFI may turn to the supplementary module of cultural identity that contains 34 questions. This module was designed during an international collaboration of experts in the international field trial of the implementation of the CFI. The areas covered in this module are: national, ethnic, and racial background; language; migration; spirituality, religion and moral traditions; gender identity; and sexual orientation. The outlining of these areas is the result of international consensus during the process of developing the CFI, including mental health institutes in the United States, Canada, Peru, Kenya, India, and the Netherlands. It has been an honor and a tremendous pleasure to have had the opportunity to take part in such an intense international collaboration under the inspiring lead of Professor Lewis-Fernández. In this chapter, even though it is not founded on an ethnographic fieldwork, an anthropological approach towards cultural identity is nevertheless promoted. In the next chapter, an empirical analysis underlying this promotion is undertaken.

Chapter 5 presents an empirical study containing a qualitative content analysis of cultural identity in the BCI reports of 85 Afghan and Iraqi refugee patients. This chapter offers the opportunity to find out what patients are actually saying about their cultural identity and how what they say may be relevant for diagnosis and care, and to enhance the n=1 study of **chapter 1**. The aim of the analysis is to unravel the complexity and multiple layers of cultural identity in order to enhance our understanding of its relation to experiences of traumatic events and acculturation. The BCI patient reports were qualitatively analyzed in detail for components of cultural identity that were potentially useful for culturally sensitive diagnosis and treatment. In this sense, this analysis was

different from the international consensus exercise on the supplementary module covered in the previous chapter, as it led to a division into smaller identity components in order to enhance our understanding of the way in which experiences of aversive events and cultural adaptation may influence norms and values in a person, and his or her relation to the sociocultural environment and the wider local society. Enhanced understanding leads to a greater comprehension of the role of cultural identity in all of the processes described above. Moreover, this part of my research aims to better understand the relevance of the core values of self-identification among referred patients, as well as how to translate this type of knowledge into recommendations for further diagnosis and a treatment plan.

In **chapter 6**, the relationship between cultural identity and psychopathology is further explored. Again, we include post-migration stress and acculturation preferences in the analysis, because based on the previous chapter it appears that they are inextricably intertwined with the mental health problems of refugee psychiatric patients and therefore need to be addressed in the assessment of psychiatric disorders in this population. This time, we employed a mixed-methods approach with newly referred patients, including a statistical analysis of post-migration living problems, acculturation preferences, psychopathology, and sociodemographic confounders. The latter is important to ensure that the associations are not confounded by age, gender, marital status, having children, education level, social position in the home society, current employment, length of stay, or being a refugee with or without a residence permit (asylum seekers). Take the case, for instance, of a migrant woman who predominantly stays at home, where she potentially has little chance of experiencing post-migration living or acculturation problems. Taking gender into consideration in the analysis would make a difference, since we could compare women with men, instead of (or in addition to) comparing Afghans with Iraqis. Equally, when differences between refugees and asylum seekers are too large to ignore, the discussion concentrates on insecurities during the asylum procedure and subsequent mental health problems.

The reason for including structured questionnaires was to find possible associations between all of these variables. In other words, we wanted to find out how strongly risk factors were connected to PTSD, anxiety, and depression symptoms, or, to test our assumptions, whether one or more of these risk factors appeared *not* to be related to these symptoms. The assumption was that the quantitative analyses would give us a much more solid basis for the discussion of the results. Concurrently, qualitative analysis of the same risk factors in the BCI reports took place. The assumption here was that this analysis would provide multiple angles to the complex interplay of all processes.

In **chapter 7**, we added the Centrality of Event Scale (CES) into the equation of risk factors for psychopathology and psychopathology itself. The CES measures the extent to which the memory

of traumatic events is a reference point for identity. The creators of this 20-item questionnaire postulate that memories of traumatic events are so dominant in the mind of the beholder that they influence every aspect of daily life, and that these 20 items may prove this to be the case (Berntsen & Rubin, 2006). Traumatic memory thus plays a part in new experiences in daily life, which may have no connection to experienced traumatic events, or they may automatically lead to reflections on the differences or similarities with present experiences. The questionnaire thus examines whether the traumatic event has become part of a person's identity.

Because we wanted to find out whether we could apply this assumption to cultural identity, we needed the BCI once again in order to analyze cultural identity along the same procedures as in the previous chapter. In addition to this, a group of non-patients was included in order to compare patients with Afghans and Iraqis who were not in mental health care. Quantitative comparison was first required to find out whether both groups differed according to all parameters, namely the specific risks for psychopathology and psychopathology itself. The gathered qualitative data offered the opportunity to compare possible cultural identity confusion between both groups. Furthermore, if cultural identity was found to be less confused in the "healthy" group, then the question would arise about which factors contribute to this lesser confusion. These factors would indicate resilience factors. The analysis of cultural identity and resilience would thus provide insight into how resilience factors may be grounded in cultural identity.

In the closing **chapter 8**, I bring together the main research findings from the published articles following the red line of an enhanced understanding of cultural identity in refugee psychiatric patients for the purpose of the development of culturally sensitive diagnosis and care. To keep track of the complexity of the processes that the refugees who were the subjects in my research went through, I used the following schematic representation:
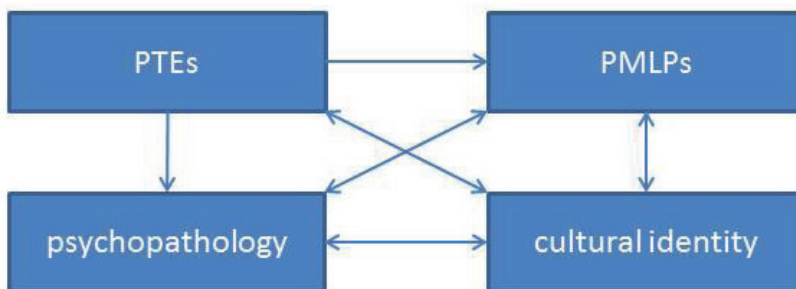
Figure 3. The complex interplay between potentiall traumatic events (PTEs), post-migration living problems (PMLPs), psychopathology, and cultural identity

The research questions were:

1.   What is the relation between cultural identity and psychopathology?

This question aims to explore how cultural identity and psychopathology cohere in refugee patients with mental health problems, mainly PTSD and anxiety/depression disorders. The cultural identity of refugees is considered in more detail and in relation to presented mental health problems. The focus of this question is to find out what cultural identity consists of and whether its multiple layers could be distinguished and considered in relation to the traumatic experiences and acculturative changes patients have endured.

2.   What is the relation between potentially traumatic events and post-migration living problems on the one hand, and cultural identity on the other?

In this question, potential risk factors for the development of psychopathology in the country of origin and in the host country are thoroughly examined by means of statistical analyses. The quantitative results are compared to the results of the qualitative analysis of potential risk factors and cultural identity, as examined in the first question. The focus of this question is to find out which of these factors influence cultural identity, and to what extent.

3.   What are the implications of the answers to the first two questions for mental health professionals, with respect to person-centered and culturally sensitive diagnosis and treatment?

In this question, the implications for diagnosis and treatment of the results from both of the previous research questions are gathered. The focus of this question is to enhance the cultural competency of mental health professionals when they deal with refugees who have mental health problems.

Altogether, these questions aim to provide valuable insights into the complex concept of cultural identity and its relation to psychopathology in refugees, in order to contribute to a contextual understanding of the role of culture in mental health problems in the field of transcultural psychiatry.

Chapter 2

Recognizing cultural identity in mental health care: Rethinking the Cultural Formulation of a Somali patient

Abstract

Although there are many ways to produce a cultural formulation that facilitates a culturally sensitive diagnosis and treatment for asylum seekers and refugees in mental health care, it is essential to gain trust and 'recognize' the patient. One way to achieve this recognition is through a cultural interview, in which cultural references of the health care provider and the patient are exchanged. This paper presents an example of such a process with a Somali migrant to the Netherlands, whose passivity and inactivity puzzled the psychiatrist. Gaining his trust and recognizing his cultural roots as a member of a Somali ethnic group revealed more about his motives, concepts and attitude. This example suggests the importance of cultural identity as a way to explore the meanings of illness and the interrelationship between the patient and health care provider. The cultural identity of the patient is a basis on which meanings can be exchanged in an ongoing way and starting points for effective treatment can be found.

2

What role does the cultural identity of an individual play when he is forced to leave his country, to desert the ground beneath his feet? How does such a patient handle his past and his losses in order to engage his future among new surroundings in a host country? How does his identity in his home country help or hinder attempts to redefine himself in a new setting? This article addresses these questions by focusing on a striking example from a series of hundreds of interviews designed to produce a cultural formulation (CF), which the author carried out at a center providing mental health care to refugees and asylum seekers in the Netherlands. This article employs an in-depth description of a single case – that of a Somali immigrant – in order to offer some insights into the ever-changing process of identification in a cultural context.

One aim of the CF is to elicit explanations of illness other than those common in local mental health care (Lewis-Fernández & Diáz, 2002). Cultural identity may point toward the specific cultural explanations of illness held by the individual but it may also constitute an area of clinical attention in its own right in situations of migration, acculturation and intergenerational conflict. Here I take as a point of departure Keesing's interpretation of cultural identity: 'a sense of one's self . . . as a bearer of a particular cultural heritage' (Keesing, 1981:512). In conducting cultural interviews, information is gathered about the effects that processes of acculturation have on the cultural identities of asylum seekers and refugees. This information broadens clinicians' understanding of the consequences which traumatic events have on patients' ideas about themselves, their position in a society, their worldview and their relation to others. This article examines how recognizing the cultural identity of patients, by contextualizing their positions and ideas, offers unexpected opportunities to improve treatment approaches.

The first section introduces the case of a Somali patient by briefly describing what was known about his background, his complaints and his initial diagnosis, at the time of his first cultural interview, and by outlining my relationship with him. The second section of the article contextualizes the patient's position in Somali society by putting his story into social-historical perspective. In the third section, the article returns to the patient's current position as a Somali refugee in Dutch society. In the final section, the implications of the patient's cultural identity as part of the CF in the process of treatment are described. The article concludes with a discussion of the reasons why the in-depth knowledge of a patient's cultural identity may lead to more effective treatment.

Intake report: Clinical starting points

The patient in question was receiving day treatment at De Evenaar, A Center for Transcultural Psychiatry for asylum seekers and refugees that is part of a nation-wide mental health institute (GGZ). Patients mainly come from war-affected areas and follow a program two days a week. The Centre also offers out-patient treatment. When this Somali patient entered my office

for a cultural interview, little was known about his life prior to his arrival in the Netherlands. Because of complaints about a lack of concentration and memory, having difficulty falling asleep, anxieties and depressed feelings, he had been referred to De Evenaar by his general practitioner, who suspected posttraumatic stress disorder (PTSD). The intake report depicted a man in his forties who lived in isolation and whose daily functioning was very poor. This had puzzled the psychiatrist: what are his motives, what does he do, what does he want? All the patient seemed to do during the day was to stay in his room, watch television, and sleep. However, the patient also explained that he did not sleep for two to three weeks because of nightmares. He had no contact with other Somalis or to other inhabitants of his residence, a center for asylum seekers. His fellow countrymen could not do anything for him, the patient claimed. He had started a program to learn the Dutch language, but could not continue. Because he could not stop thinking about the past, he was unable to concentrate. He was a heavy smoker, which could be recognized from his yellow teeth.

Little was known about his life in Somalia, the ground beneath his feet. His father had died when he was a young boy. His mother had raised him with the help of his father's friends. According to the patient he went to military school for 12 years. For seven years he had served in the army, where he was in command of several soldiers. On one occasion he refused a military order and he was immediately imprisoned. In the end, this had caused him to flee the country. He was married, but his wife disappeared at the beginning of the war in 1990 or 1991. There were no children. The patient suspected that his wife had died, because the village to which she moved had been bombed. His mother was murdered in 1996.

Clinical indications were that he suffered from PTSD and depression. The Harvard Trauma Questionnaire (HTQ) offered too little solid information for a valid score. He experienced problems falling asleep, nightmares, concentration and memory problems. On the Hopkins Symptom Checklist Depression Scale (HSCL-25) there were also several gaps, however the patient reported the maximum scores on faintness, heart pounding, trembling, headache, feeling restless, lack of energy, loss of sexual interest, difficulty falling asleep, and feeling hopeless, lonely and suicidal. There were many physical complaints, ranging from headaches and stomachaches to lung problems and dizziness. During treatment the neurologist had diagnosed the patient with epilepsy. The seizures seemed to increase in frequency when the patient's level of tension rose. Due to his smoking habits his physical condition was very poor.

After the intake procedure the psychiatrist suggested day care treatment, and the patient agreed. After a few appointments the psychiatrist asked me to talk to the patient about this past and to offer insights into his motivations.

Setting the tone by defining roles

During our first appointment the patient came across as humble, timid, somewhat frightened and tense. The two of us had not met before the appointment, but the psychiatrist told me the patient had agreed to meet knowing only that we were to talk about his culture. He did not seem to fully understand what this meant or perhaps he feared that I would dig too deeply into his troubled past. The language barrier seemed quite marked: although he had been living in the Netherlands since 1997, there was not a single sentence of Dutch that he could fully understand, so we spoke with the help of an interpreter in the Somali language.

I decided to take some time to explain the purpose of our conversation again and to leave aside the standardized questionnaire for the cultural interview (Borra et al., 2002). My expectations were modest: I had never seen a patient from Somalia before, and it was difficult to reach a mutual understanding regarding the goals of our meeting. Presenting myself as an anthropologist who speaks to patients about their culture, I explained that I hoped to get to know him better by talking about the kinds of behavior that were common to him, but not to me. I also explained that we expected to be able to offer better care for him when we knew about his cultural background. The aim of this conversation was to first gain his trust, to establish some common ground by allowing him to be the expert on his culture, while positioning myself as an interested listener.

The ideas of Clifford Geertz and Johannes Fabian provide a useful theoretical framework for conceptualizing this dialogue of cultural expert and listener/care provider. Geertz's well-known reinterpretation of Max Weber's words, 'man is an animal suspended in webs of significance he himself has spun', offers insight into the social and cultural human being who both 'produces culture' and is an ever-changing 'product' of culture (Geertz, 1973). Everyone is his or her own expert in interpreting webs of significance, while the cultural context is a *perpetuum mobile*, always moving, always changing. Johannes Fabian (1996) offers a clear example of this *emic* approach in his discussion of the painter Shibumba Kanda Matulu who, by painting historical scenes and explaining them, gave the anthropologist a history of Zaire that linked his personal experiences to historical events. Through his expertise he not only depicted the nation's history, but also himself, his social-historical position and his relation to others.

Similarly, it emerged that the patient enjoyed playing the role of Somali expert. During the course of our conversation he became increasingly animated and enthusiastic. Because of my limited knowledge of his life in Somalia and his passive attitude in the Netherlands, it was decided to spend the rest of the interview getting a clearer picture of his position in Somali society.

Ethnicity as part of cultural identity

In most East African countries tribal origin largely determines the course of one's life. In Djibouti and Somalia marrying outside one's tribe or clan can be regarded as betraying one's family. Being part of a large and important tribe offers one more opportunities to obtain the education and to secure a position on the labor market. Much like a caste system, this tribal system governs the rules of social structure. Before the revolution in Somalia, conflict among the tribes was intense and as a consequence important men in powerful tribes were the ones who took decisions. After the revolution Somalia became a socialist country and political authority was monopolized by the military regime. However, the power of the old ethnic structures reemerged in the aftermath of a mid-1990s coup. Given the cultural significance of ethnicity in this region, I decided that tribal and ethnic origin would be a fruitful starting point from which to explore the Somali patient's personality and cultural identity before and after PTSD (Berntsen & Rubin, 2006, 2007; Jobson & O'Kearney, 2008).

Having explained that an 'ethnic group' is a group one belongs to, or one's tribe, I asked the patient about his ethnic origin. He answered that one's 'ethnic group is the only thing that counts'. Hesitant as he might have been when we first met, his eyes began to shine as he told me that he is a Yibir. He explained that the Yibir are known for their rituals at family occasions, such as births, marriages or deaths. In Somalia, these liminal phases in human life must be marked by ritual in order to avoid danger, to keep away the evil eye and to guarantee prosperity. To this end, the Yibir visit families during these occasions, perform a ritual and offer an amulet. Auspicious spirits having been invoked, the family should have a healthy child, a good and fruitful marriage or a safe final journey for a departed family member. For their ritual role the Yibir receive money, food or clothes. However, as the patient explained, a part of the Somali population is convinced that Yibir rituals are black magic that must be kept away from one's doorstep as forcefully as possible. In these cases the Yibir may be sent away from a household, or even chased or beaten. While the patient had accompanied his parents several times when they paid visit to a family, he had not performed a ritual himself. All of his experiences with Yibir rituals took place before he had turned 18 years old, when he had joined the military academy.

By our second meeting, the patient greeted me as an old friend, a person he had shared intimate information with, and told more about this dangerous and unstable balance between belief and disbelief, fortune and misfortune, thanks and threat. After the Yibir family had performed their ritual and received a reward, it was always possible that something unfortunate could happen: a child could die, a wife could leave her husband, or some other misfortune could occur. In this situation, a Yibir family would fear for their lives, and would have to move to another city or part of the country, because killing a Yibir was often seen as a means of regaining the balance of fortune and returning prosperity to a family. Indeed, some Somalis believed that

one had to kill a Yibir at any birth, marriage or death of a family member in order to call on prosperity. However, not all Somalis of other tribes were hostile to the Yibir, as the patient told me. Friends of his father's, who belonged to other tribes, had helped his mother in raising him. When asked whether these family friends were afraid of or hostile towards the cultural role of the Yibir, the patient answered: 'people are not the same everywhere, despite their ethnicity'.

The patient argued that most families wanted the rituals to be performed out of fear. The Yibir are said to possess both white and black magic: they can protect one from bad luck, but if one turns them away they can also bring bad luck. However, the patient explained that he himself did not think that the Yibir were able to influence people's lives: they 'did' nothing concretely through their rituals, it was simply the local belief that they brought prosperity. Moreover, he explained, the Yibir are small in number and a small tribe has little to say and fewer opportunities in Somalia than a big tribe. He compared the Yibir ritual with the process of female circumcision: neither could bring a prosperous life.

Ethnic division in Somalia

The patient declared that his ethnicity had made it impossible for him to attend university. The historical roots of these structural limitations date back to colonial times. At the end of the nineteenth century the region of Somalia was divided into areas controlled by different colonial powers. France was in control of the area around Djibouti (French Somaliland), Great Britain took over the northern part (British Somaliland) and an Italian colony covered a southern part of the region. The western areas fell under the control of Abyssinia (now Ethiopia) and the far south came under British jurisdiction in Kenya. Under Italian colonialism, Somalia became an authoritarian centrally-organized state with a highly decentralized and stateless political tradition, as a variety of different tribes were held together by the strong hand of Italian leaders. In 1960, first British Somaliland and a few days later Italian Somalia gained independence. These two entities united to form the independent Somali Republic.

The motive behind unification was a Pan-Somali ideal of reuniting under a single state all Somalis who had been separated in different political units during the colonial period. Although an attempt was made while forming a united government to strike a balance between northern and southern regions, as well as between important clans, members of the northern, formerly British, region felt that they did not have enough power. The Pan-Somali ideal failed. Great Britain did not give autonomy to Northern Kenya and Ethiopia was supported militarily by the US in its refusal to cede the Ogaden region. Somalia appealed for the help of the Soviet Union. The failure of the Pan-Somali ideal and dissatisfaction with the authoritarian regime led to the nonviolent coup in October 1969 of Colonel Mohammed Siyad Barre. Since 1992 state power has been divided between numerous political groups, which struggle for or claims control over various regions of Somalia.

With this troubled historical context in mind it is easy to understand the significance of one's ethnic origin for participating in Somali society. The divisions of power in the Somali regions and the struggle to maintain central power in Mogadishu have left Somalia in a state of indecisiveness, characterized by a lack of control and poverty. In addition to the political struggle for power, there were scare resources due to periods of extreme drought and the most powerful clans had more access to the available resources. To be a member of a big clan also meant that one had easier access to opportunities for paid labor, education, healthcare, and so on. Entering a powerful clan by marriage is also not easy as, in most cases, one is meant to marry within one's tribe. Moreover, according to Mahmood Gaildon (2004) the Yibir are at the bottom of this complex social and class order. In this context the patient's words about his Yibir ethnicity are particularly salient: 'it is the only thing that counts'.

Ethnicity in the context of the refugee setting

Being a Yibir gave the patient a sense of pride at the same time as it limited his sense of agency in the Netherlands. No one had ever asked him questions about this part of his identity which appeared to be central to his daily life activities (which would be measured in psychiatric terms on the Global Assessment Functioning scale). His enthusiasm also resulted from feeling recognized in his ethnicity, his sense of being, his inner motivation and his outer self-presentation. Thus far he had 'only' been a traumatized Somali in the Netherlands, now he was a member of the Yibir tribe in Somalia.

As the patient explained, the negative consequences of his Yibir identity in Somalia were not limited to being turned away from the homes of certain families. It also meant that, despite his successes in school, he could not enter Mogadishu University to study medicine or economics. This left him with two choices: he could be forced into the army as a soldier during the civil war or he could join the military academy in order to at least become an officer. So at the age of 18, he made the latter choice and enrolled in the military academy.

At the end of our conversation, the patient remarked: 'to be a Somali refugee in the Netherlands is the same as being a Yibir in Somalia'. Given what he had explained about the position of the Yibir in Somali society, this comment offered me the opportunity to ask some questions about Somalis in the Netherlands. The patient told me that once, when he was sick, Somalis he knew did not come to visit him, as they would if another countryman were in the same situation. He explained that this was because these other Somalis were from the North. They ignored him when they met. Given the historical context, as well as the dynamics of Somalis in the local context of the Netherlands, there was a logic to the patient's suspicions. However, after our second conversation he seemed more eager to get into contact with other Somalis.

I called a Somali foundation in Groningen, the largest city in the northern part of the Netherlands. The man I spoke to explained that there was a communal room where Somalis could meet, and I asked whether they knew where these Somalis came from, in order to find out whether there was a majority of a particular clan. His answers may have been motivated by political correctness: there were Somalis from everywhere, and furthermore, it did not matter which tribe one originated from. This did not convince the Yibir Somali patient at first; he did not contact this Somali foundation or its counterpart in Amsterdam. Moreover, the patient seemed to have another goal in mind for initiating contact with other Somalis.

He had been often remarking that he was getting older and that he had not achieved much. Not achieving much had a lot to do with his decision to join a military school, despite the fact that he had few other opportunities. As an officer in the Somali army he had been in charge of a battalion. During the civil war he had been confronted with situations he had not wished for himself. It is likely that he had killed other Somalis. After his wife had disappeared and his mother had been murdered, he found himself in a situation where was unable to obey a particular order from a higher-ranked officer. This act of insubordination had eventually caused his flight from Somalia. Once in the Netherlands he decided that he had made the wrong decision in 'choosing' to join the army, because it had only brought him trouble.

Along with his 'choice of career,' he questioned his position as a single man in his forties. He had been married in Somalia, but his wife had disappeared and it was assumed that she had been murdered. The position of a single Yibir Somali man was a heavy burden on his shoulders, in that he was not fulfilling what he saw as his reproductive duties. During our second conversation he said that his Yibir identity was important to him and that he was obliged to start a family or else he would die. In his words: 'I have to search my family'. Because he said this in the context of looking for a Yibir wife in the Netherlands, I understood that he was not referring to his lost wife in Somalia. He emphasized that he had to marry a Yibir woman and not marry another Somali woman. However, he also felt that his age (42) would make it very difficult to find a wife, marry and have children. Another obstacle was that he estimated the number of Yibir in Somalia to be between 60 and 80. According to estimates Yibir make up around 0.5% of the total population of seven million inhabitants of Somalia, or approximately 35,000 people. However, the patient's conviction that the number is much smaller, made the search for a potential wife in the Netherlands like looking for a needle in a haystack.

Implementation of the Cultural Formulation
I met with the patient three times following the second interview, during which time I considered what advice to give his psychiatrist concerning. Part of the job was already completed: the patient had been recognized in his cultural identity. Offering him the space to talk about the tribe he was

born into and to which he felt he belonged, had awakened a part of him. This was particularly significant because as a Somali asylum seeker in Dutch society no one had ever asked him about his specific cultural roots before. The patient took great pride in his ethnicity. When asked how the Yibir find a family in which a birth had taken place or where someone was to get married, he smiled and answered that the Yibir would always know. They had to, because it was an important source of their subsistence. Despite the dangers of their cultural role, the Yibir took pride in their special position, and it seemed that the pressure placed on this liminal group may have increased social cohesion. While the patient did not believe in the special powers of the Yibir, he seemed to derive a great sense of pride from the respect and status with which other Somalis received members of his tribe. This sense of pride, or at least the recognition of his cultural identity, gave him new energy that amazed both him and his psychiatrist.

The patient's observation that living as a Yibir in Somalia was similar to living as a Somali in the Netherlands was particularly important because it made clear why he was not participating in Dutch society. The patient was aware of the presence of other Somalis in other Dutch cities and he had information about Somali foundations in the Netherlands. However, because he had never been recognized as a Yibir, he had never brought up the possibility that other Somalis might ignore him. The liminal position of the Yibir in Somali society made his interactions with other Somalis seem potentially dangerous. I tried to introduce some gradation to his thinking about Northern Somalis by using the example of the friend of his family who was not a Yibir but who had helped his mother to raise him. I also used his statement that people were not the same everywhere despite their ethnicity to convince him that Northern Somalis were not the same everywhere, especially in the context of the Netherlands. One bad example did not prove the hostility of all Northern Somalis. Moreover, he was now able to see the problems he had with his choice of career in a new perspective: at the time he had joined the military academy he had few other options.

His change of attitude and his new level of energy surprised both the patient and his psychiatrist. While he did not stop smoking, he smoked far less than he had done previously. He no longer stayed in his apartment the entire day. At the Center for Transcultural Psychiatry he became an appreciated member, increasingly gaining confidence to communicate with others. He even spoke about picking up running as he had always done in Somalia. At lunch, a few weeks later, he told me that he had been 'sleeping' for 16 years and that he now felt that he had woken up. He asked for contact information of Somali foundations again, as he was now convinced that he would meet other Somalis. The psychiatrist related that he was finally able to understand the motives and attitude of his patient. With some knowledge about the sociocultural context of his life in Somalia, the psychiatrist now had the tools to offer the patient some perspectives on participating in Dutch society, just as he was about to gain refugee status. The patient still has a long way to go, but he is progressing every day.

Discussion

The cultural formulation of this Somali patient is an example of what we have found with many other cases in the work of our Center for Transcultural Psychiatry in the Netherlands: the recognition of cultural identity alone results in a more active and engaged attitude by the patient. This recognition greatly improves the relationship between patient and the care providers and provides a basis for treatment. What exactly makes this work? Why would someone's cultural identity be so important to the process of clinical engagement and treatment?

When a patient and a clinician meet, there is an encounter of two cultural frames of reference in which the symptoms and the complaints are central. In many cases, the clinician's frame of reference dominates, and the interaction remains restricted to a focus on the patient's symptoms or illness. Undoubtedly, this approach can be of great value to diagnosis and treatment when information is being exchanged about explanations outside the frame of cultural reference. However, without thorough knowledge about the cultural identity of patients treatment might be less successful. In the case described here, the psychiatrist could have given the Somali patient advice on becoming more active, leaving his room and engaging with others, but without a clear understanding of the patient's identity and his motivations he would have made little progress. Both the process of exchanging cultural information and the content of that information are crucial in establishing a long-term clinical relationship, a culturally sensitive diagnosis and a successful treatment.

The meanings that this patient assigned to his identity as an unmarried, failed, discriminated against and tormented member of a small controversial tribe in Somalia and as a refugee in the Netherlands appeared to be crucial to the treatment process. The effects of my identity – including age, ethnicity (Dutch origin) and marital status – on the clinical encounter have not been closely evaluated. My being male might have made it easier for the patient to reveal information about his not being married and the cultural consequences. It was certain that defining our respective roles – mine as an anthropologist and his as an expert on his culture – made it much easier for him to open up. The focus of this intervention was to explore why the patient isolated himself from others and what were the motives for his inactivity. It was not only the painful past, the nightmares and his anxieties that made him numb, but it was also his self-representation that withheld him from a more active life. None of this had been discussed since his arrival in the Netherlands. It was through his self-representation that the patient engaged the world around him and addressed questions about what had happened to him. Speaking about his cultural identity for the first time in 16 years allowed him to open up his isolated position and make room for change. This would likely have not come about had the intervention focused solely on the cultural explanations of his illness, rather than examining his identity and his relationship to

cultural norms and expectations. In this respect, cultural identity in the CF is more than just the background to cultural explanations of the illness of the individual.

Note

1. The patient consented to my writing this article, including his story and his age, on the condition that I not discuss his family.

Chapter 3

Implementation of the Cultural Formulation through a newly developed Brief Cultural Interview: Pilot data from the Netherlands

Abstract

The Outline for a Cultural Formulation (OCF) has remained underutilized in clinical practice since its publication in the DSM-IV in 1994. In the Netherlands, a Cultural Interview (CI) was developed in 2002 as a tool to facilitate use of the OCF in clinical practice. The time needed to conduct the interview, however, prevented its systematic implementation within mental health institutions. This article presents the development of a shortened and adapted version, the Brief Cultural Interview (BCI), and a pilot study on the feasibility, acceptability, and utility of its implementation with refugee and asylum seeking patients in a Dutch centre for transcultural psychiatry. Results show that the brief version scores better on feasibility and acceptability, while utility for clinical practice remains similar to that of the original CI. These results support the systematic use of the OCF in psychiatric care for a culturally diverse patient population through the application of a relatively brief cultural interview. A secondary finding of the study is that patients' cultural identity was considered by clinicians to be more relevant in the treatment planning sessions than their illness explanations.

Introduction

Cultural formulation (CF) is a systematic method for eliciting and evaluating cultural information during a clinical encounter (Lewis-Fernández & Díaz, 2002). It aims to help clinicians who provide care to patients from diverse ethno-cultural backgrounds to assess the impact of cultural factors on all items of psychiatric illness, render a culturally sensitive diagnosis, and formulate treatment plans that are acceptable to the patient and (as is often relevant) to the family. There is a great need for culturally sensitive diagnostic procedures (Zandi et al., 2008) or additional cultural consultation services (Kirmayer, Thombs, Jurcik, Jarvis, & Guzder, 2008). However, fifteen years after the introduction of the Outline for Cultural Formulation (OCF) in the Diagnostic and Statistical Manual for Mental Disorders IV (DSM-IV, American Psychiatric Association, 1994:843-844), Lewis-Fernández (2009), one of its proponents, concluded that since its publication the OCF remained underutilized in actual clinical practice. This underutilization is, according to him, "likely due to limited dissemination efforts towards practicing clinicians and because of the time required for its implementation" (ibid:379). Where the OCF has been used, we know little about its effects on diagnosis and treatment within mental health care due to limited research on the issue (Bäärnhielm & Scarpinati Rosso, 2009; Caballero Martínez, 2009). In addition to the time factor, this too jeopardizes the continuation and expansion of use of the OCF in clinical practice.

Contributors to the special issue of *Transcultural Psychiatry* on the DSM-IV OCF (Lewis-Fernández, 2009) all commented on the key topics of relevance for an evaluation of its general applicability in clinical practice. Mezzich et al. (2009a) criticized the OCF for not containing any guidelines and for lacking in uniformity for implementation. Alarcón et al. (2004) had already voiced similar views. Since then, several instruments have been developed to redress this through the formulation of a number of questions that relate to each of the first four OCF components (see below) (Caraballo et al., 2006; Groleau, Young, & Kirmayer, 2006; Saint Arnault & Shimabukuro, 2012). However, as far as we know, these instruments have not yet been comprehensively tested or reviewed in a field trial to study their contribution towards achieving a culturally sensitive diagnosis and the formulation of a relevant treatment plan.

Fortuna, Porche, and Alegría (2009) refer to the positive outcomes of the use of the OCF derived from the Patient-Provider Encounter Study (Alegría et al., 2008). In this study, almost two-thirds of clinicians found it important and meaningful to include a patient's social and cultural context within diagnostic formulation for posttraumatic stress disorders (PTSDs) using components of the OCF. In order for this to be effective, however, training and supervision opportunities are necessary, and the OCF needs to become an integral part of DSM-IV criteria-based diagnosis (Fortuna, Porche, & Alegría, 2009:445-446).

As a response to the lack of guidelines on how to use the DSM-IV OCF in clinical practice, a Cultural Interview was developed in the Netherlands in 2002, followed in 2006 by a Brief Cultural Interview, and a Cultural Formulation Interview (CFI) in 2013 in the fifth edition of the DSM (DSM-5, American Psychiatric Association, 2013). This CFI contains a core questionnaire with sixteen questions (Aggarwal et al., 2014) with the possible use of twelve supplementary modules. In the discussion section below, the CFI will be compared to the Brief Cultural Interview (Groen, 2009).

The Cultural Interview

The original Cultural Interview (CI) developed in the Netherlands in 2002 was intended for use as a tool in the construction of a cultural formulation in psychiatric practice (Borra et al., 2002). The CI has 48 questions addressing the first four components of the OCF: (1) the cultural identity of the individual (12 questions); (2) cultural explanations of the individual's illness (11 questions); (3) cultural factors related to the psychosocial environment and levels of functioning (19 questions); and (4) cultural elements of the relationship between the individual and the clinician (6 questions). Just over half of the questions are open-ended (25 out of 48). Open-ended questions offer the opportunity to provide detailed information and to build adherence to treatment. An example of such a question in the CI is: "What do you consider the most important element of your culture?" Less than half of the questions are closed questions (23 out of 48), most of which are followed by sub-questions whereby a more detailed explanation is requested (16 out of 23). An example of such a series of questions is: "Do you miss people who have the same cultural background as you? Can you explain this?"

At the end of the interview a report is generated. This report contains a summary of the personal background and medical history of the patient as presented in the medical records, the answers given to the CI questions, observations made by the interviewer, and a translation of the answers into an assessment of the cultural elements that should be taken into account in psychiatric diagnosis and care.

Research setting: A Dutch centre for transcultural psychiatry

De Evenaar, a Dutch centre for transcultural psychiatry, offers mental health care services to people from a range of cultural backgrounds, including asylum seekers, refugees, and migrant workers, most of whom are diagnosed as suffering from anxiety disorders, depression, and/or PTSD. Patients are referred to the Centre by general practitioners, psychiatrists from other mental health institutes, psychologists in private practice, psychiatric nurses at asylum seekers centres, and a variety of other health care workers. The Centre offers inpatient as well as outpatient care. Inpatient care consists of several biweekly day-treatment programmes offered to one orientation and observation group, two treatment groups, and two rehabilitation groups. Outpatient care consists of individual consultations with a psychiatric nurse or a psychologist, and in addition

a number of consultations with a psychiatrist. Outpatients can also be referred to a range of therapies.

Background of the research

"Make us understand them better" was the core of the task set in 2002 for the new specialized centre for transcultural psychiatry in the Netherlands. At the time, disappointment among health workers in the northern part of the Netherlands about the results of treatment offered to asylum seekers and refugees was strong. New initiatives were fostered to improve the effectiveness of psychiatric care for this category of patients. One of the recommendations was to integrate anthropological knowledge and skills into the team at the specialized centre, which resulted in 2004 in the employment of an anthropologist, who would conduct CIs one day a week.

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One year of conducting such interviews demonstrated that patients had difficulties with the length of the interviews, particularly when they suffered from concentration problems. In addition, it was hard to justify that the interview could take up to two hours, while psychiatric consultations generally lasted only half an hour. This problem had already been identified in a publication with a collection of cultural formulation case studies written by Dutch professionals (Borra et al., 2002:235). Another problem was patients' only partial comprehensibility of all CI questions (for examples, see below). Some of these questions contained a Western bias in dealing with mental health problems, such as the 'mentalization' of such problems. The CI also gave rise to a formal clinical encounter in which the standard meaning of certain concepts and approaches to mental health problems were taken for granted. Adaptations in the phrasing of certain questions seemed necessary in order to obtain the cultural information that a CI aims to elicit from patients, in a way that could be easily understood.

In order to overcome the limitations of the CI, a new version was developed, aimed at facilitating an anthropological encounter (Csordas, Dole, Tran, Strickland, & Storck, 2010) and reducing the time needed to administer a CI. To distinguish between both versions, we use the original CI version (2002) in addition to the more recent BCI (Brief Cultural Interview, 2006). This article aims to contribute to the challenge of implementing the BCI by:

1) presenting information on the systematic implementation of the OCF by developing a less time-consuming culturally sensitive instrument in a centre for transcultural psychiatry, the Brief Cultural Interview (BCI);
2) presenting evidence of the feasibility, acceptability, and utility of the BCI;
3) discussing the value of instrumentalizing the OCF in response to arguments related to its underutilization.

Methods

Development of a brief version of the Cultural Interview (BCI)
Use of the original version of the CI in clinical practice created the impression that refugee patients did not understand all of the questions. In the BCI, questions were reformulated so that interviewees could understand them more easily and would feel encouraged to offer an account grounded in their own cultural perspectives of the life events that may have influenced their psychopathology. In particular, questions that were considered to be too formal, direct, abstract, or prone to misunderstanding were reformulated. An example of such a question in the original CI is: "To which ethnic group do you officially belong? Do you feel that you do belong to this ethnic group, or to another one? Does this ever change?" In response, patients asked what an ethnic group was, and what it meant to "officially" belong to such a group. In the BCI, the ethnicity questions were reformulated to: "Do you belong to a group in your country that is different from other (ethnic) groups? Are your parents from the same group?" The latter sub-question was added because it came to light that many patients had encountered troubles in their home country as a result of their parents coming from different ethnic or ethno-religious descent; for example, having mixed parentage such as Azeri-Armenian or Sunni-Shia Muslim. Furthermore, based on the experience of conducting the CIs, some questions were excluded from the BCI since no relevant information for treatment plans was acquired from them. Other questions were combined with the aim of improving the progression of the interview. The final BCI was composed of 11 main questions concerning cultural identity, six main questions concerning cultural explanations of illness, seven main questions concerning cultural factors in the psychosocial environment and functioning, and one main question concerning cultural elements affecting the relationship between patient and clinician.

Research design
For practical reasons, only inpatients from the day-treatment programmes were included in the study. Inclusion criteria required that patients be 18 years or older, have no drug dependency, and display no current psychosis. To ensure that the group was representative, both asylum seekers and refugees, from a variety of countries and of both genders and different age groups, were selected. At first, 13 CIs were conducted between April and September 2006 using purposive sampling to represent the patient population in day-treatment. BCIs were conducted with 11 other selected patients between June and October 2006. All questions of both the CI and the BCI were asked by the same interviewer word-for-word and in the same sequence. For both interviews, the time required for reporting included taking a brief clinical history, and making observations, a cultural assessment for diagnosis and care, and recommendations for the clinician. In the CI group, six interviews were conducted in Dutch and seven with the assistance of an interpreter. In the BCI group, five interviews were conducted with an interpreter, four in

Dutch, and two in English. The possible effect of the use of an interpreter (Arabic, Azeri, Dari, Farsi, Papiamentu, Russian, Serbo-Croatian) during the interviews was not controlled.

Following this, the implementation of the BCI in the Dutch center was tested in terms of feasibility, acceptability, and utility. Feasibility was measured in terms of the time required to ask all interview questions and comprehensibility of the questions. During all interviews, patients' reactions were noted. Further notes were made on whether or not questions were understood or had to be repeated or clarified, and whether they were answered, answered clearly, or skipped.

Acceptability was measured in terms of the patients' evaluation of the BCI, compared to patients' evaluation of the CI. After each BCI and CI, patients were asked to fill in a form responding to five statements about their evaluation of the interview on a three-point scale: agree, neutral, or do not agree. These statements were: 1) I experienced the interview as positive; 2) I understood all questions; 3) The interview gave me more tension than I expected; 4) The interview taught me more about myself; 5) Now that I know about the interview, I would do it again.

Finally, utility was measured by noting which and how often items of the BCI reports, compared to the CI reports, were discussed by clinicians during treatment plan evaluations. Clinicians were unaware of whether the reports had been composed following a BCI or a CI. The composition of the multidisciplinary team of clinicians did not vary during these sessions. The researcher registered which cultural items clinicians discussed. This resulted in a list of 14 cultural items. For each item, the researcher evaluated whether, during treatment planning meetings, the information provided by a particular patient was perceived by care providers as relevant to take into account in his/her treatment. The aim of this final step was to find out whether the BCI resulted in at least as much useful information for treatment as the CI, despite the reduction in the number of questions. Ethical approval was obtained for the study at the University Medical Center Groningen of the University of Groningen (2012.404).

Results

Respondents
Table 3.1 presents the demographic characteristics of the respondents. All patients suffered from PTSD with a comorbidity of either anxiety or depression disorder. No changes in the diagnosis or treatment were reported during the research period. The national, ethnic, and gender composition of both groups varied because the composition of the treatment groups varied during the recruitment period.

Table 3.1. Demographic characteristics of respondents to BCI or CI

Variable	BCI (*n*=11)	CI (*n*=13)
Age (years)		
20-29	1	3
30-39	5	5
40-49	4	4
50-59	1	1
Mean (SD)	37 (7.87)	38 (8.46)
Gender		
Male	9	7
Female	2	6
Country of origin	Afghanistan	Afghanistan (2)
	Armenia (2)	Bosnia
	Azerbaijan	Guinea
	Belarus	Iran
	Croatia	Kosovo
	Curacao	Lebanon
	Egypt	Syria (3)
	Sierra Leone (2)	Ukraine
	Somalia	Uzbekistan
Education		
Low (primary)	4	4
Middle (high school)	5	7
High (> high school)	2	2
Religion		
Christian	4	2
Jewish	0	1
Muslim	4	8
Catholic	2	1
Not religious	1	1

The mean age and level of education of the respondents in the first and second group were comparable. There were relatively more men in the BCI group. There was a large variety in terms of country of origin between both groups, and also within the groups. There were more Christians in the BCI group, while in the CI group there were relatively more Muslims.

Feasibility: Time needed and comprehensibility

The feasibility of the BCI was measured in terms of the time needed to conduct the interview and make the report. It took the interviewer on average 80 minutes (SD 15.6) to complete the entire BCI compared to more than two hours for the entire CI (mean 126 minutes, SD 27.9). For the CI, for 11 respondents second appointments had to be made, because the time available for the interview per contact was only 90 minutes. When using the BCI, one second appointment had to be made. Reporting on the interviews for the BCI took 71 minutes on average (SD 22.3; range 45-120 minutes), while for the CI it was 143 minutes (SD 42.2; range 75-210 minutes).

Comprehensibility was assessed through notes taken of each question that caused some problems, or when no answer was given at all (Table 3.2). In the BCI, the respondents did not understand 14 questions (5% of all questions posed to the total group; 95% CI 2.5-7.8). For the CI, the respondents did not understand 112 questions (or 18% of all questions posed to the total group; 95% CI: 15-21). The questions in the CI that respondents most often did not understand were: "Do you miss other people having the same cultural background as yourself? (If yes:) Explain", "To which ethnic group do you officially belong?", and "How would your family and surrounding people explain your symptoms?"

Acceptability

Regarding acceptability, 5 out of 11 BCI patients and 10 out of 13 CI patients responded to the written statements after the interviews. Over half of the respondents in the BCI group agreed that it had been a positive experience, while this was the case for exactly half of the CI group (3/5 compared to 5/10). In terms of understanding the questions, respondents were considerably more positive after the BCI (4/5, compared to 5/10 after the CI). Four out of five respondents reported that the BCI had made them more tense (CI: 6/10). After the BCI, two out of five respondents had learned more about themselves (CI: 2/10). There were no differences in terms of willingness to participate: no respondent would refrain from being interviewed again.

Utility

The utility of the BCI was measured in terms of the prevalence of aspects or domains of culture that were considered useful in treatment planning sessions (Table 3.3). Clinicians themselves initiated discussions of which aspects they had found relevant in the treatment planning meetings. When the BCI was used, all domains were more often mentioned as useful compared to when the CI was used, with the exception of 'gender', 'religion', and 'stigma', which were mentioned more often in relation to the CI. The BCI resulted in 100% usefulness for three cultural domains: 'place of origin', 'contact with family', and 'shame'. The domains 'self-image', 'position in the family', and 'social contacts' were also conceived of as highly useful for clinicians when the BCI had been used (10/11). The domain 'place of origin' led to the highest score in terms of

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relevance among patients who had been interviewed with the CI (12/13), followed by 'position in the family', 'contact with the family', 'social contacts', and 'shame' (11/13). Clinicians considered 'illness explanations' to be a not very relevant component of the four OCF components in treatment meetings (only one respondent in each of the groups found it useful).

Table 3.2. Comprehensibility of the questions of the cultural formulation during BCI and CI

Category	Questions	BCI (n=11)		CI (n=13)	
		n	%	*n*	%
Cultural identity					
(BCI= 11 questions,	Not understood	2	2	16	10
CI= 12 questions)	No single answer	1	1	6	4
	No answer	1	1	5	3
	Repetition question	5	4	31	20
	Confirmation question	0	0	7	4
	Total	9	7	65	42
Cultural explanation of the illness					
(BCI= 6 questions,	Not understood	1	2	5	3
CI= 11 questions)	No single answer	3	5	10	7
	No answer	0	0	1	1
	Repetition question	0	0	12	8
	Confirmation question	0	0	6	4
	Total	4	6	34	24
Cultural factors related to psychosocial environment and functioning					
(BCI= 7 questions,	Not understood	0	0	1	0
CI= 19 questions)	No single answer	0	0	0	0
	No answer	1	1	1	0
	Repetition question	0	0	3	1
	Confirmation question	0	0	3	1
	Total	1	1	8	3
Cultural elements of the relationship between individual and clinician					
(BCI= 1 question,	Not understood	0	0	2	3
CI= 6 questions)	No single answer	0	0	0	0
	No answer	0	0	1	1
	Repetition question	0	0	1	1
	Confirmation question	0	0	1	1
	Total	0	0	5	6

Utility

The utility of the BCI was measured in terms of the prevalence of aspects or domains of culture that were considered useful in treatment planning sessions (Table 3.3). Clinicians themselves initiated discussions of which aspects they had found relevant in the treatment planning meetings. When the BCI was used, all domains were more often mentioned as useful compared to when the CI was used, with the exception of 'gender', 'religion', and 'stigma', which were mentioned more often in relation to the CI. The BCI resulted in 100% usefulness for three cultural domains: 'place of origin', 'contact with family', and 'shame'. The domains 'self-image', 'position in the family', and 'social contacts' were also conceived of as highly useful for clinicians when the BCI had been used (10/11). The domain 'place of origin' led to the highest score in terms of relevance among patients who had been interviewed with the CI (12/13), followed by 'position in the family', 'contact with the family', 'social contacts', and 'shame' (11/13). Clinicians considered 'illness explanations' to be a not very relevant component of the four OCF components in treatment meetings (only one respondent in each of the groups found it useful).

Table 3.3. Prevalence of cultural domains in treatment sessions for each component of the cultural formulation after BCI and CI (in %)

	BCI (*n*=11)	CI (*n*=13)
Cultural identity		
Place of origin	100	92
Ethnicity	73	69
Acculturation	82	69
Life stage	64	46
Self-image	91	77
Gender	27	38
Position family	91	85
Psychosocial environment and functioning		
Contact with the family	100	85
Social contacts	91	85
Religion	45	62
Cultural explanations of the illness		
Illness awareness	64	38
Illness explanation	9	8
Cultural elements individual-clinician		
Shame	100	85
Stigma	27	62

Discussion

The implementation of a culturally sensitive questionnaire in a Dutch center for transcultural psychiatry has been shown to be useful. The brief version of the questionnaire (BCI) was found to be more feasible and acceptable than the original longer version (CI), while its utility remained equal. The BCI took about two-thirds of the time to complete as the CI, while reporting on the results of the BCI took less than half the time of the CI. We found a better comprehensibility among patients of the BCI compared to the CI, which is relevant given the goal of the OCF, namely to bridge the cultural gap between health professionals and patients with different ethno-cultural backgrounds. Ten percent of the CI questions on cultural identity were not understood, while this was only two percent for the BCI. In addition, patients required considerably less clarification for BCI questions, which may have contributed to the shorter duration of the interviews. The reasons for not understanding some CI questions may have been caused by their formal character, by a lack of social contact with members of their same ethnic group or cultural background, by a lack of contact with their family, or by lack of knowledge of mental health problems within the family.

While the time needed to conduct the interviews was reduced considerably through use of the BCI compared to the CI, the average time investment required to conduct a BCI is still relatively large for most mental health institutes. While in this study all questions of the BCI had to be asked for reasons of comparison, which may have contributed to the relatively high mean interview duration of 80 minutes, in clinical practice a maximum of 45 minutes is scheduled for the BCI at the Dutch Center for Transcultural Psychiatry. Greater experience in completing the BCI report after the interview has also led to a reduced average duration of 60 minutes. The question remains whether this time investment at the beginning of treatment will indeed pay off in later stages of the treatment, in terms of reduced drop-out rates, improved medication adherence, and better understanding between patients and clinicians. Additional empirical research is needed to prove this, with specific consideration given to the time needed and the overall feasibility of such an instrument. The BCI is also still evolving as used in the Centre, for instance towards the inclusion of a guide to the interviewer containing introductory questions for further probing.

The acceptability of the BCI among the respondents was higher than that of the CI, especially in terms of comprehensibility of the questions. A higher number of the BCI respondents than CI respondents answered on the evaluation form completed afterwards that they were positive about the interview, and said that they had understood all questions. This finding is supported by a better comprehensibility of the questions observed *during* the BCI. These results have to be interpreted with some caution, however, since the number of responses to the evaluation form was relatively low. Patients were allowed to take the form with them to fill in after the interview

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and three out of thirteen CI respondents, and five out of ten BCI respondents never returned it. Further bias might have arisen due to the fact that the interviewer (who had developed the BCI), was also evaluating his own method. Finally, in considering the dynamics of having to repeat or confirm questions, patients' problems with the Dutch language and their mental status during the interview may also have influenced the results.

Compared to the utility of the CI, the BCI was considered equally as useful for treatment. The utility of the BCI was tested in terms of the number of cultural items from the reports that were considered to be relevant in the respondents' treatment plans. We found it crucial that the reduction in the number of questions did not lead to a reduction in the amount of information found to be useful for the treatment plan. In general, the same cultural items from both interviews were considered relevant during treatment sessions. Some items of the BCI were more often discussed (acculturation, self-image, illness awareness, contact with family, shame) than others, as were some items of the CI (gender, religion, stigma). Although it was not proven that these items remained useful to pay attention to during the course of treatment, we can conclude that the BCI did not result in reduced utility for treatment. The feasibility and acceptability results affirm that, compared to the CI, the BCI is easier to understand and more positively evaluated by patients.

One of the unexpected results in terms of the utility of both interview forms was that in treatment plan sessions, the items of cultural explanations of illness appeared to be less useful than items of cultural identity, such as place of origin, ethnicity, acculturation, and self-image. This implies that cultural information on a person's identity could be more useful to clinicians than how that person explains her or his illness (Groen & Laban, 2011; Groen, 2009). This implication is supported by Bäärnhielm and Scarpinati Rosso (2009), who, based on research conducted in Sweden, recommend focusing less on cultural explanations of illness and more on migration and acculturation issues, since they have such a strong impact on the mental well-being of refugee patients. Furthermore, the authors stress that the meaning of the concept of cultural identity needs to be clarified and guidelines should include how to approach refugee patients and how to document their history without stereotyping and discriminating.

The results from our study support this latter recommendation, since cultural explanations of illness were considered of limited usefulness in treatment plan meetings, while acculturation and its impact on cultural identity were considered by clinicians to be highly useful. The likelihood of change in cultural identity through acculturation has been explored by Schwartz, Montgomery, and Briones (2006), as well as its relationship to mental health (Bhugra, 2004). These issues may be hard to address using the concept of cultural identity in the DSM-IV OCF, which includes a limited number of subcomponents with unclear interdependence: cultural reference group,

language, cultural factors in development, involvement with culture of origin, and involvement with the host culture (Lewis-Fernández, 1996). In the BCI, the meaning of cultural identity for the person is explored in more depth. However, because of the limited number of participants in this study, more research on differences between the usefulness of cultural identity compared to cultural explanations of illness is required in order to make more firm statements, or confirm our results.

The BCI proved to be a practical tool, partly because of its relatively limited length and good comprehensibility. In the Dutch centre for transcultural psychiatry, the outcomes of the BCI have been incorporated into the standard clinical assessment and are included in patients' medical files. Since the completion of the research project in 2006, the role of the BCI in the centre has increased. In 2010, 99% of patient files included a BCI (incomplete assessments and re-entries excluded). As a consequence, every update of a patient's treatment evaluation is made with consideration of the cultural assessment of the OCF.

Based on psychiatric evaluations of the OCF in Spain, Caballero Martínez (2009) suggests that even within a limited timeframe, a minimal procedure is still necessary in order to obtain cultural information during standard clinical assessment and to incorporate the information acquired into clinical reports. Caballero Martínez (2009) states that clinicians need to have a baseline level of cultural knowledge about the patient, asking empathically when cultural doubts are detected, and planning an extra interview when cultural doubts remain (2009:511). The author also criticizes the lack of "clear connection between the OCF and other formulations of psychiatric cases" (2009:510), on the basis that this leads to it being more of an academic exercise than a practical tool. In the Dutch centre where this research took place, the BCI is administered following a psychiatric assessment. A summarized assessment of the BCI is then made and supplemented with recommendations for diagnosis and treatment, which is then incorporated in the medical files. Both assessments (psychiatric and the BCI) are discussed in formal multidisciplinary team meetings, leading to the initial treatment plan. The BCI therefore, has a practical application in this clinical context. Furthermore, apart from its use in transcultural psychiatry centres, the BCI is also being applied in more general health care practice in the Netherlands; how this is done, and to what effect, is something must be investigated further.

The BCI is not merely a set of questions; we consider it a tool to be used for clinical ethnographic exploration, in accordance with how others regard the OCF (Bäärnhielm & Scarpinati Rosso, 2009; Lewis-Fernández & Díaz, 2002). This implies that the interviewee is the potential cultural expert and that the interviewer must ask questions to encourage the interviewee to speak about his or her cultural background. The BCI is meant to be the starting point of a conversation, leaving space for patients to enhance their answers, especially when the

interviewer notices a strong emotional response to the questions. When used in an ethnographic way, the interview starts from the microcosm of the interviewee in order to gather a holistic view on mental health problems and the context in which they have been generated and maintained. In this study, the interviewer was restricted to administer all questions literally; in ethnographic research, however, the interviewer uses his or her own words to enter into a dialogue. In future development, a guide to the BCI questions, including the main topics of the OCF and the purpose of the questions, could be included in the general BCI tool.

Although the BCI has a similar aim as the Cultural Formulation Interview (CFI) included in the DSM-5 (American Psychiatric Association, 2013), there are important differences. First, the CFI is meant to be used prior to the psychiatric assessment, while the BCI is used afterwards. The CFI begins with questions concerning the cultural definition of the mental health problems for which a patient is seeking help, while the BCI initiates with questions concerning cultural identity, the first component of the OCF (Aggarwal, 2016). Mental health problems, in this context have already been elicited through a psychiatric assessment. Second, the CFI offers a broad overview of the influence of culture on mental health problems through sixteen questions, which can be supplemented by a selection of twelve supplementary modules on different CFI topics, while the BCI offers a broad scope on the cultural context of mental health issues through 27 questions. The core of the CFI therefore aims to achieve a broad overview of a cultural contextualization of mental health problems, which could be expanded upon using supplementary modules, while the character of the BCI is that of an in-depth analysis of the cultural context. Third, in the field trial of Aggarwal and colleagues (2013), the time required to complete the CFI was 15 minutes (excluding the use of any supplementary modules), while the BCI in this study needed 80 minutes (for practical reasons, in clinical practice today it is scheduled for 45 minutes).

In sum, the CFI aims to draw an inventory of the cultural background of patients' mental health problems in fifteen minutes prior to a psychiatric assessment, while the BCI offers an in-depth cultural focus taken after the mental health problems have been elicited, and takes three times longer than the CFI to complete. It should be taken into account, however, that when a clinician conducting the CFI choses to use the supplementary module on cultural identity, which contains 34 questions, probably more time will be needed than for the BCI. Finally, the BCI has proven its usefulness in clinical practice for more than ten years, while clinical evaluation of the CFI still needs to be published. A comparison between a CFI group and a BCI group is recommended for further research.

The promising results in our study have to be interpreted in light of at least four limitations. Firstly, the number of patients was insufficient to test for statistically significant differences between the BCI and the CI. The small sample also calls for expansion of the number of patients

used in future inquiries. Secondly, there was a bias in terms of the involvement of the developer of the BCI, who was also the coder for the comprehensibility section of the BCI and CI questions. Another limitation was that the research location is a mental health care centre exclusively for refugees, asylum seekers, and migrant workers, who are not representative of a general patient population in transcultural psychiatry. As such, the data might have been biased by the nature of the psychopathology that these particular patients showed. Many of them had been referred to the centre after years of mental health care in non-specialized mental health care units. Disappointment over previous treatments might have influenced their judgement of the BCI. A final limitation was the difficulty in generalizability and the lack of representativeness: the limited duration of the research period for data collection resulted in the inclusion of a selection of patients who do not represent the entire actual patient population of the centre, while the ethnic origin of both samples of patients differed considerably (as the ethnic composition of the refugees in the Netherlands differed between both periods of data collection). There may also have been a bias due to the interpreters that were used. The limitations of this pilot study call for a replication and expansion of the study in future inquiries.

Conclusion

This research has shown that the objection that implementation of a questionnaire that leads to a cultural formulation takes too much time to be used in clinical practice can be addressed through use of the shorter BCI. This implies that it is possible for mental health institutes to implement the OCF. The BCI is still a lengthy assessment tool, though the time needed to administer it is much reduced compared to the CI, and the time spent is justified by the wealth of information obtained about the cultural context of patients' mental health problems. This study has given evidence that, without losing its usefulness for the sake of valid diagnosis, the BCI offers higher feasibility than the longer CI. Despite the worldwide underutilization of the OCF, in a Dutch centre for transcultural psychiatry we have managed to incorporate the BCI into the standard clinical assessment procedure for more than ten years. A fully employed cultural anthropologist conducts several BCIs every day, resulting in almost complete coverage of OCFs among patients who have been referred to the centre. The promising results of these pilot data could offer an encouraging impulse for the culturally sensitive treatment of mental health problems, though it requires confirmation from other studies around the globe.

Appendix

(also: *https://www.mcgill.ca/iccc/files/iccc/**Interview**.pdf for full text of BCI)*
Brief Cultural Interview (BCI)

Summary of personal background and medical history
Taken from the medical records before the interview:
1. Biography (personal and social details)
2. History of current health complaints
3. Previous treatment
4. Psychiatric disorders in the family
5. Course of the illness

3

Introduction

Aim: To explain and set the tone for the interview
"We see people from a whole range of countries in our clinic. Every country and every culture has its own traditions and customs. You only really notice this if you leave your own country and go to live abroad. The people look different, they speak a different language and behave and express themselves differently. You sometimes feel as if no-one understands you. Have you ever felt like this?"

(If so: let them give a brief explanation. "We shall be discussing this later on in the interview". If not: "Perhaps you'll understand what I mean if we return to this later on".)

"One of the reasons for communication problems is a lack of knowledge about cultural differences. As we want to help as much as we can, it is important that we know something about your country or your culture; for instance, what your customs are, how people treat each other in your culture, and what it means to be ill in your culture. So I shall now ask you a few questions about your culture and your symptoms."

A. Cultural identity of the individual
Language
1. Which language did you speak when you were growing up? Did you also speak another language?
2. Which language do you speak at home now?
    [If applicable: With your spouse/partner? With your children? With your friends?]

3. How well do you think you speak Dutch?

   [If this is unclear: How would you grade yourself on a scale of 1 to 10?]

4. Can you explain in Dutch what you mean?

Ethnicity and culture

5. Do you belong to a group in your country that is different from other (ethnic) groups?

   Are your parents from the same group?

6. What makes this group different from other groups? Which customs, opinions, position of the group compare to other groups in society?

7. How important is belonging to this group to you?

8. Are you still in contact with people from this group or your culture?

   If so: how important to you is this?

   If not: would you like to?

9. What do you consider to be the most important element of your culture?

   [For example: eating customs, respect, family, holidays, honour]

10. How do you think your culture differs from Dutch customs and opinions?

    Is that important to you?

11. Do you think you fit in well in the Netherlands? Do you talk to Dutch people? Do you have any Dutch friends or acquaintances?

B. Cultural explanation for the illness

Symptoms in cultural perspective

12. You have told me about your symptoms: how would you describe them (in your language)?

13. How would people in your native country explain your symptoms?

14. How would people deal with these symptoms?

15. Do you think that your family and those around you understand you?

16. Do you think that the people treating you understand you?

17. Which part of the treatment that you have received so far do you think has helped the most?

C. Cultural factors in the psychosocial environment

Family

18. How would you describe your relationship with your spouse or partner? Do you talk to him/her about your illness?

19. Is there anyone in your social circle or family who listens to you and gives you advice?

20. Who did you turn to for help previously?

Faith and religion

21. Are you religious?

22. Do you pray? Do you go to a place of worship (e.g. church / mosque / synagogue / temple)?
23. Is it different from your native country?
24. Does your faith give you strength? Was that always the case?

D. Cultural elements affecting the relationship between the patient and the clinician

25. Is it important to you that the person providing help is a man or a woman, or shares your faith?
26. What was your job [in your home country]?
27. Do you accept everything that the doctor who is treating you says, or do you ask questions?

3

E. Observations

What was the patient's mood before, during, and after the cultural interview? How did he/she respond to the questions? Which questions evoked the most emotions? Which moments during the interview were significant?

F. Summary for the treatment plan evaluation

Overall cultural assessment for diagnosis.

Chapter 4

Aspects of cultural identity related to national, ethnic, and racial background, language, and migration

Ton and Lim (2006) define *cultural identity* as follows:

> a multifaceted core set of identities that contributes to how an individual understands his or her environment. Ethnic identity is often a crucial facet of an individual's overall cultural identity, but many other facets may contribute to it as well. The greater the amount of detail a clinician is able to ascertain about the individual's cultural identity, the better understanding he or she will have of the individual's perspectives on health, illness, and the mental health system (2006:10).

The Cultural Identity supplementary module of the Cultural Formulation Interview (CFI) (provided in Appendix C in the DSM-5 Handbook on the Cultural Formulation Interview) offers an opportunity for clinicians to explore the complexity of patients' cultural identity by unpacking its various elements. Here, in addition to evaluating the problem presented, we examine the first three parts of the module in an attempt to explore the clinical relevance with respect to identity: national, ethnic, and racial background; language; and migration. Finally, we provide suggestions on how to use this portion of the module.

National, ethnic, and racial background
Questions 1-7 of the Cultural Identity module ask questions about the patient's national, ethnic, and racial background.

National identity
National identity expresses the feeling of difference one person has from another based on the conceptualization that they belong to different nations or to distinct national groups within a multi-cultural setting (Smith, 1993). When clinicians elicit the national identity of individuals with mental health problems during diagnosis and treatment, they may need to be aware of the patient's sense of belongingness, which could include the patient's relationship to national symbols, language(s), the nation's history, national values, politics, religions, national media, music, food habits, and so on. The awareness of difference is addressed by the question "who are we?" as opposed to "who are they?" Anderson (1983) introduced the concept of *nation* as a socially constructed imagined community as conceived by the persons who believe themselves to be a part of that community. The community is "imagined" because "the members of even the smallest nation will never know most of their fellow members, meet them, or even hear of them, yet in the minds of each lives the image of their communion" (Anderson, 1983:49). It is important to bear in mind that national, geographical, and cultural boundaries are not coterminous.

For the clinician, it is useful to explore the individual's notion of that imagined community. A nation's history and the everyday values prized by the group have developed over time, and this history plays a major role in the socio-cultural construction of the national identity

of its community members. Cases in point are the dramatic socio-historical changes after the independence of formally colonized nations in Africa and Asia in the 1960s, the Islamic Revolution in Iran in the 1980s, and national development of former Soviet satellite states in the 1990s. There are also more distant events, such as the origin of the U.S. as a nation in the struggle against the British, and the historical development of Latin American countries opposed to Spanish rule. In psychoanalytic literature this is known as *large-group identity*, which is based on chosen victories and chosen traumas (Volkan, 1999). A clinician does not have to be aware of the entire historical development of her patient's nation or community. However, when eliciting a patient's national background (questions 1-6), understanding the historical context is helpful for eliciting his or her life story in a culturally sensitive manner.

Place of birth is an important aspect of identity (question 1). Cultural differences based on regional distinctions are common. For instance, if a patient is born in Iraq, it matters whether he or she is from Baghdad, Kirkuk, or Basra. Baghdad has a multi-ethnic population that is mainly divided into Sunni and Shiite districts. In the current moment, Baghdad is a city with frequent ethnic conflicts, car bombings, and other forms of violence. Kirkuk, a city in northern Iraq, is economically one of the most important municipalities in the autonomous region of Kurdistan, mostly populated by Iraqi Kurds. Basra is the most important city in the Shiite-dominated south-eastern part of Iraq that was heavily involved in the Iran-Iraq war in 1980-1988. The differences between these various localities may be more important to the patient at times than their commonalities as part of the more recent nation-state of Iraq.

In Europe, many immigrants were born in the former Yugoslavia, the Punjab, or Bengal before geopolitical partitions, and these places of origin have evolved over time both politically and culturally. As another example, if someone is from the southern Indian State of Tamil Nadu, it may be relevant to establish if the patient is of Tamil or Sinhalese origin from Sri Lanka, because this fact may provide clues to social exclusion or experiences of military trauma and genocide. In many countries, urban and rural areas differ in important ways. This is the case in many African nations: rural areas have less access to mental health care, different knowledge of psychopathology, and variation in adherence to indigenous belief systems, secret societies, witchcraft, ideas about ghost or spirit possession, and other supernatural concepts.

In many countries, especially those populated by diaspora cultures, identity is shaped by parental place of birth (question 2). If one or both parents were born in another nation or culturally distinct area, this often influences a person's identity. A Chinese American man whose parents were born in China, and who himself was born in California, may see himself more as Chinese at times or more as American at times, depending on the context. If the parentage is mixed, especially if parents are from areas in conflict with each other, such as individuals

of Bosnian-Serbian, or Azeri-Armenian heritage, this can pose substantial challenges: these individuals run the risk of being rejected, threatened or even chased and murdered by those whose parentage are not mixed.

As these examples show, identity is an active process of representing oneself to others. Someone's place of birth (question 1), parentage (question 2), and national, ethnic, and/or racial background (question 3) play important roles in self-representation in everyday life- that is, how that person describes himself or herself to others (question 4).

Ethnic identity

Ethnicity refers to the classification of people as belonging to a group that claims a common descent, frequently attributed to a specific geographical region; usually a common language and other cultural characteristics; and possibly a common religion (Eriksen, 1993). Such group identities are always defined in relation to nonmembers of that group (Barth, 1969). Ethnic groups within a nation may differ from each other in terms of primary language, religion, rituals, values, symbols, clothing, and food. Of course, within ethnic groups, subgroups also vary in terms of these characteristics, but the point of the concept of ethnicity is that it minimizes these particular differences in the name of the postulated group similarities. For example, Puerto Ricans may speak English or Spanish as their primary language, given the extent and duration of their U.S. migration experience, but this difference is minimized in the name of a common Puerto Rican ethnicity. A nation may contain several ethnic groups; for instance, Ethiopia has more than 80 such groups. Alternatively, an ethnic group may span more than one currently defined nation-state. The Kurds, for example, live in parts of Iraq, Turkey, Iran, and Syria. In most African countries the word *tribe* is more common than *ethnic group* in everyday speech. In Somalia, there is a complicated *clan* genealogy with major clans and many subclans. Somalis may recognize each other's lineage by their double last names. The clan or subclan to which a Somali belongs to can influence educational and work opportunities as well as experiences of protection and discrimination (Groen, 2009). The U.S. Census distinguishes only one *ethnicity*, Hispanic/Latino, and five *races*, White/Caucasian, Black/African American, Asian, American Indian and Alaskan Native, and Native Hawaiian and Pacific Islander. The distinction of Latino-ness as an ethnicity is a recent development, stemming from political recognition of the diversity of characteristics usually considered racial that characterize the Latino group; Latinos can be of European, African, Native, or Asian descent but are supposedly unified by their cultural similarities, including language and Latin American geographical background. Obviously, Latinos also differ markedly from each other, underlining the primarily political aspect of the definition of ethnicity.

In some nations, there are violent conflicts between ethnic groups. For example, there were large-scale warlike conflicts between Hutu and Tutsi in the late 1980s in Rwanda, between

Azeri and Armenians (the Nagorno-Karabakh conflict) also starting in the late 1980s, and among Bosnians, Croatians, and Serbs in the former Yugoslavia during the 1990s. There may also be less intense conflicts between mainstream and minority ethnic groups regarding whether or not the latter belong to the larger national group. The Pashtun claim the Hazara are not real Afghans, other Angolans claim the Bakongo are not real Angolans, many Congolese claim the Banyamulenge belong to Rwanda. The position of ethnic groups varies across different states and time periods; currently, Kurds are relatively safe in the autonomous region of Kurdistan in northern Iraq, but they are sometimes persecuted in Iran, Syria, and Turkey. Canadians may define their ethnic identities in terms of the complexities of their colonial past; also as a result of a common history of colonialism and foreign domination, the Irish may see themselves as a separate ethnic group but define themselves as politically aligned with the Black population in the United Kingdom.

Racial and "racialized" identity

The term *race* has no scientific or biological basis; it is instead a social construct that acquired its modern form in the eighteenth to nineteenth centuries. *Racialized identity* is an alternate social construct that highlights the point that the experience of race is based on the *perception* of having a common heritage with a particular group defined in racial terms (Helms, 1993). A commonly defined racialized identity is that of skin color. This popular folk notion often clumps people into blacks, whites, reds or yellows. Responses and attitudes towards skin color vary across and within countries. In the United States, being part of a racialized community, such as White Americans, American Indians, or African Americans, may play a crucial role in defining one's cultural identity, particularly if viewed by others as a "true" characteristic of a person. Therefore it is important to ask patients how they locate themselves with respect to racialized identities prevailing within their community or culture. Many patients of African, Asian, and Afro-Caribbean background may think their mental health problems are misunderstood by local white British clinicians. They may feel that they have been wrongly diagnosed, or have been treated in a culturally insensitive manner, which may result in poor adherence to care (Littlewood & Lipsedge, 1997). The reverse may also apply to clinicians in other countries providing consultations to local White British or White U.S. patients. In many regions, such as in India, the term *race* or *racial identity* may not resonate with local ideas of identity. Instead, *caste* (*jāti* or *varna*) or social class may constitute the core of a person's or community's cultural identity. In such contexts, caste and class identity of both patient and clinician may hinder or facilitate access to care and engagement with treatment. Therefore, clinicians eliciting a person's "racial background" need to be sensitive to locally prevalent notions of "racial identity" and the manner in which these terms are expressed and understood in different contexts and cultures (Jadhav & Jain, 2012).

Language

Questions 8-13 of the Cultural Identity module evaluate language with respect to identity. Language is a key component of identity and serves as a marker of belonging to a certain cultural group. Consider the following statement by an Iranian woman from Tabriz in the province of East-Azerbaijan in northeastern Iran that is populated by Turkish, Turkmen, and Bulgarian Iranians:

> As long as I know, my family has been in Tabriz. Because my parents did not have many opportunities to go to school, they hardly spoke Farsi. We spoke Azeri at home. In primary school, until fifth grade, the books were in Farsi, but the teachers taught in Azeri. From fifth grade on, they started to teach in Farsi. I felt I was different from others, because I was fluent in Azeri, but not in Farsi.

This example shows how language influences the sense of belonging. For this woman, speaking a certain language marks her sense of being different from others. The language a person speaks can vary across situations: at home, on the street, in school, or in official documents. In some places during certain time periods, the languages of particular national subgroups have been forbidden in public space, such as the Kurdish language Kurmandji in Turkey or Catalan in Franco's Spain. People may refrain from speaking their mother tongue in public if they are afraid to be recognized as a member of a particular group.

After people migrate, the languages they speak at home often vary depending on speaking partner (question 10). For instance, parents may feel most comfortable speaking their native language with each other but may mix their language with the language of the host country when speaking to their children. Sometimes, the children do not learn the language of the host country until they go to school. Frequently, the children are more fluent than the previous generation in the language of the host nation, and may have to help their parents read letters or official documents. At times, children may forget their native language. This may pose communication problems with their parents and also contribute to inter-generational conflicts. Parents may find upsetting that their children are no longer able to speak with family members left behind in their home country and may feel that they have lost touch with their culture of origin.

Some migrants are proud of their fluency in the host language. This may become clear during their interaction with clinicians in mental health care (question 12). Using an interpreter in such a situation could be regarded as an insult and as a refutation both of their progress and of their acculturation to the host country. However, when expressing intense emotions, these patients may well be more fluent in their native language. In such instances, a clinician could point out the benefit of speaking in the native language but express respect for their language acquisition in the host country.

Some patients refuse an interpreter because, despite confidentiality regulations, they do not trust other members from their cultural group, particularly when the migrant community is composed of diverse subgroups, some of whom were in conflict in the culture of origin. Some patients from tightly knit communities may refuse interpreters due to concern over the risk of disclosure leading to stigmatizing consequences for their family, including decreased marriage prospects for their children. Alternatively, interpreter refusal may be the result of the realistic or imagined fear of being identified and thus persecuted after escaping from their countries of origin for cultural and political reasons. The clinician should respect and address all of these concerns during treatment.

Language literacy may also be an important aspect of identity. For example, whether a person can read and write in his or her native language may indicate a certain socio-cultural status in the home country (question 13). For example, many Afghan women, particularly those in rural areas, are forbidden to go to school and therefore are usually illiterate. This situation can become a major obstacle to their efforts to integrate within the host country.

4

Migration

Questions 14-22 of the Cultural Identity module evaluate migration in relation to identity and the problem presented. For immigrants, a major stressor is leaving loved ones and a familiar socio-cultural context and having to develop a new life in the host country. Migration may be forced or due to personal choice. Both types result in cultural displacement and dislocation. However, migration may not always be detrimental to the person's health because his or her experiences are also shaped by responses from members of the host society. Migration and post-migration living problems- for example, due to experiences in transit to the host nation or events in the host nation such as the asylum procedure- may be the most important causes of distress, (Laban, Gernaat, Komproe, Van der Tweel, & De Jong, 2005). The clinician needs to know how long the patient has lived in the host country, what was the reason for leaving the country of origin, and how his or her life has changed as a result of the migration process (questions 14-16). For example, for individuals originating from a collectivistic society, adapting to a more individualistic culture might add new dimensions to their mental health problems. Having been accustomed to the group taking care of its members' problems, they may feel alienated in the new setting because they are responsible for their own individual health care-seeking choices. Equally, there may be intra-cultural variations between individuals from a collectivistic society, as they might be primarily *allocentric* (other focused) and others may be *egocentric* (self-focused) (Bhugra, 2005). For clinicians, it is important to use the Cultural Identity module to distinguish a patient's individual characteristics and not to fall into the trap of stereotyping on the basis of fragmented knowledge about the person's country of origin.

Using the supplementary module

Using this supplementary module in clinical practice is best illustrated by a clinical vignette. The vignette does not address all of the questions in the module but touches on its key components.

Case vignette

Amir, a 39-year-old Iraqi man who had worked as an interpreter for Western allied forces in Iraq, was referred to mental health care in a European country for severe depressed mood and nightmares after suffering a traumatic exposure. His most pressing concern was that he felt his problems were not acknowledged by the government of the country where he found refuge. He mentioned that he worked quite hard for the army of occupation. He thought it would bring him great respect. But over time, he came to feel like a traitor to his country and had great difficulty proceeding with his life as usual. During the early phase of treatment, the clinician and patient elaborated on what Amir meant exactly by this statement. He explained that he hoped that by becoming an army interpreter he would bring prosperity and freedom for his people. This idealistic view of his activities eroded over time, as he felt increasingly that he was exploited and trapped in a power dynamic in which he could not participate any longer. He came to feel that he was used as a tool for the suppression of his own people. Moreover, when Amir made a return trip to Iraq from his host country, he was regarded as a traitor by his fellow countrymen (questions 1–7).

He told the clinician that his family in Iraq was in great danger because of his interpreter work and was viewed as an enemy by the Iraqis opposing the Western occupation. When asked what he would do if they attacked his family, Amir turned very pale and said, "I would kill myself, because it would be my fault and I would not be able to cope with my guilt." He stated that in his culture, family meant everything. On another occasion, he said that he was proud to be an inhabitant of his "new" country; now he felt that if asked to choose, he would want to remain there. This was because in Iraq he felt physically unsafe and he would also feel controlled by his family. Amir appreciated the possibility for further educational development and other opportunities to advance his life because of the support he had received in his "new" country. As a result of his conflicting feelings, his cultural, national, and ethnic identity had become intensely mixed and chaotic (questions 8–22).

This vignette demonstrates how national and migration issues are intertwined with multiple aspects of cultural identity. A person's cultural identities mutually influence and shape each other. In addition, different aspects of identity may come to the fore depending on the context in question. This man is an Iraqi by national identity, but his work and experiences in the

host country after migration changed his attitude towards his country of origin and his fellow countrymen. The case illustrates the dynamic aspect of identity. What is crucial for the clinician to explore is the value a patient attaches to the various dimensions of identity and how these dimensions influence his or her sense of belonging, self-esteem, and other elements of self-experience that are important clinically. The Cultural Identity supplementary module can help the clinician perform a relatively thorough evaluation of identity if the clinician approaches the assessment with an inquisitive and respectful attitude in an atmosphere of open exchange. When conducting a cultural assessment, it is important that the clinician not forget the cultural identity of the individual, but also not to forget the individual in the culture.

Conclusion

Because eliciting the multifaceted cultural identities of culturally diverse patients enhances the clinician's understanding of their individual perspective on the mental health problems, the issues of national, ethnic, and racial background, language and migration are included in the supplementary module on Cultural Identity. Here we focused on these issues, how they could relate to mental health problems, and how they could be addressed by clinicians.
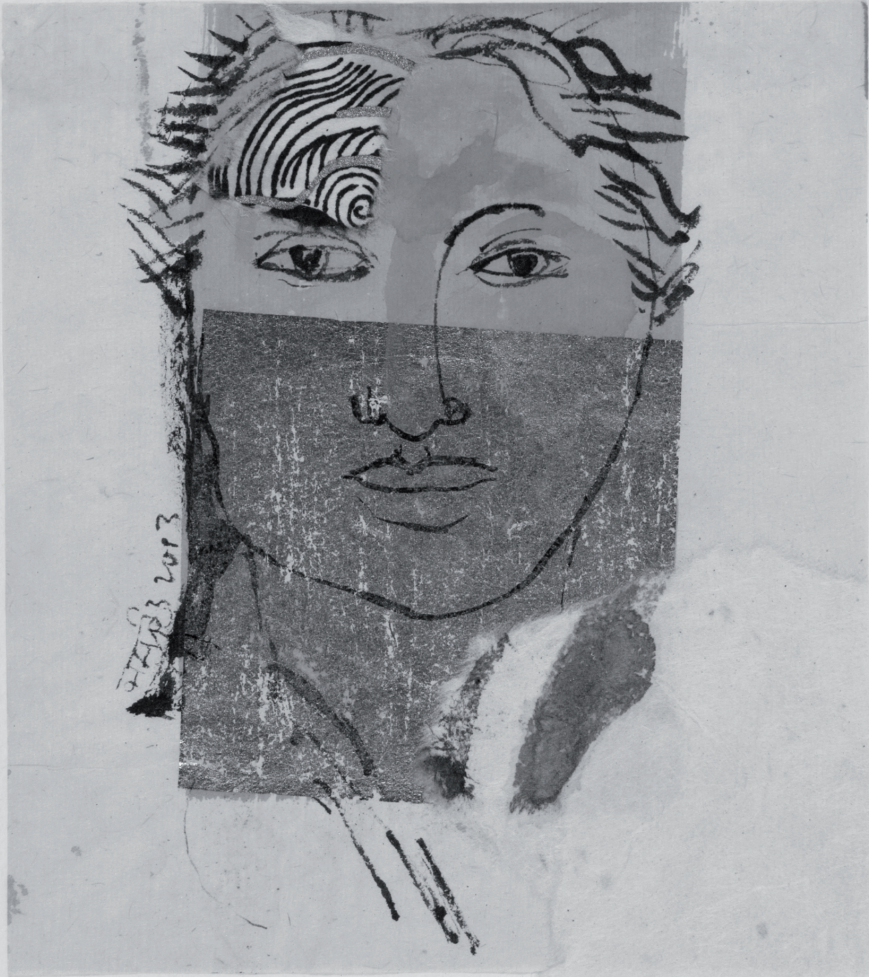
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Chapter 5

Cultural identity among Afghan and Iraqi traumatized refugees: Towards a conceptual framework for mental health care professionals

Abstract

Cultural identity in relation with mental health is of growing interest in the field of transcultural psychiatry. However, there is a need to clarify the concept of cultural identity in order to make it useful in clinical practice. The purpose of this study is to unravel the complexity and many layers of cultural identity, and to assess how stress and acculturation relate to (changes in) cultural identity. As part of a larger study about cultural identity, trauma, and mental health, 85 patients from Afghanistan and Iraq in treatment for trauma-related disorders were interviewed with a Brief Cultural Interview. The interviews were analysed through qualitative data analysis using the procedures of grounded theory. The analysis resulted in three domains of cultural identity: personal identity, ethnic identity and social identity. Within each domain relationships with stress and acculturation were identified. The results offer insight into the intensity of changes in cultural identity, caused by pre-and post-migration stressors and the process of acculturation. Based on the research findings recommendations are formulated to enhance the cultural competency of mental health workers.

Introduction

Cultural identity in relation to mental health is of growing interest in the field of transcultural psychiatry. In 1999, Bhugra et al. stated that clinicians underestimate the relation between cultural identity and mental health, and concluded that there is an urgent need for placing cultural identity back at the core of the individual's well-being. Similarly, but more recently, attention has been drawn to the need for health professionals to take cultural identity into account when trying to understand social and individual functioning of migrants with mental health problems (Mezzich, Ruiperez, Yoon, Liu, Zapata-Vega, 2009). The most obvious way in today's cultural psychiatry to address that need is the use of the Outline for Cultural Formulation (OCF) in the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV, American Psychiatric Association 1994), which holds cultural identity as its first component. Cultural identity '... serves as an introduction to the rest of the Cultural Formulation' (Lewis-Fernández & Díaz, 2002:278), which includes cultural explanations of the individual's illness, cultural factors related to the psychosocial environment and levels of functioning, cultural elements in the patient-clinician relationship and an overall cultural assessment. In the OCF, cultural identity is divided into three subheadings: individual's ethnic or cultural reference group(s); degree of involvement with both the culture of origin and the host culture (for immigrants and ethnic minorities); and language abilities, use, and preference (including multilingualism) (Lewis-Fernández, 1996:137).

Although cultural identity is frequently employed with respect to culturally diverse patients, a complete or precise understanding of what is understood by cultural identity is hard to find. There have been several elaborations of cultural identity after the one in the OCF, of which two are mentioned here. For some authors cultural identity includes more than the OCF implies: ethnicity, race, country of origin, language, acculturation, gender, age, sexual orientation, religious or spiritual beliefs, and socioeconomic class and education (Lu et al. 1995; Ton & Lim, 2006). Basing cultural identity on a list of aspects only is a so-called "trait list approach", which risks stereotyping and is avoided in ethnography (Kleinman & Benson, 2006). Our ethnographic approach to cultural identity focuses on norms and values that constitute an image an individual holds of him or herself, which urges an individual to decide what is right or wrong, what kind of behaviour is appropriate or not; as well as on norms and values that are negotiated within the (ethnic or ethnoreligious) group the individual belongs to; and within local society. In our view, cultural identity includes a broad range of ethnic and social characteristics, which may be unique in each individual's situation and his or her perception of this situation. These characteristics are often underexposed in mental health care. In the case of refugee patients, cultural identity could be regarded as fluid, multiple, ever-changing, a *perpetuum mobile*, in a certain microcosm, especially changing through potentially traumatic events (PTEs), migration, and, as a consequence, acculturation into a new society (Rohlof et al., 2009; Ton & Lim, 2006; Bhugra, 2005).

For immigrants, cultural identity is inclined to change in the process of acculturation in the host society. The impact of acculturation on people's cultural identity alone may contribute to stress among refugees (Bhugra, 2004; Bhugra & Becker, 2005). Acculturation refers to the degree of identification with the host culture and/or with the culture of origin. Positive identification with both cultures among immigrants results in lowest risk for mental distress, while negative identification with both cultures leads to the highest risk (Fassaert et al., 2011; Kamperman et al., 2003). It should be noted that refugees distinguish themselves from general immigrants, because most were forced to leave their country of origin and the majority experienced PTEs which cause higher risk for mental health problems (Gerritsen et al., 2006; Laban et al., 2005; Porter & Haslam, 2005).

Traumatic stress also has a strong impact on cultural identity, because experiencing one or more PTEs, and also loss, grief, and bereavement that result from PTEs, may have a devastating effect on identity development. The memory of PTEs tends to form a cognitive reference point for the organization of other memories leading to an enhanced integration of these PTEs in a person's understanding of him- or herself and the world (Berntsen & Rubin, 2007:427). This personal understanding may vary between different cultures, for instance between so-called independent and interdependent cultures, as Jobson and O'Kearney (2008) have shown in a study among immigrants suffering from posttraumatic stress disorder (PTSD).

Because traumatic memory is so central for a person's identity, crucially informed by culture, clarity about the patient's cultural identity is expected to be necessary for most types of trauma treatment and crucial for mental health care professionals (Bäärnhielm & Scarpinati Rosso, 2009). The elaboration of the concept of cultural identity increases the need for further clarification of the concept for clinicians in their clinical encounter with culturally diverse patients. The ability to profit from insight in cultural identity for better understanding of the illness seems to depend on the cultural competency of the clinician. A challenge for cultural competency is overcoming differences in cultural knowledge and various items of cultural identity (Kirmayer, 2012a; Kleinman & Benson, 2006). For trauma survivors, all the personal and social losses, grief, and bereavement that result from PTEs and migration are inextricably connected to identity (Eisenbruch, 1991). Reducing the meaning of a patient's story to psychiatric symptoms may increase the risk of misunderstanding between patient and clinician and systematic misjudgements in diagnosis and treatment (Lewis-Fernández & Díaz, 2002).

Aim of the study
The aim of this study is to unravel the complexity and many layers of cultural identity in traumatized asylum seekers and refugees in mental health care, to assess how stress and acculturation relate to (changes in) cultural identity and how cultural identity can be organized into domains that could be useful for mental health workers in their diagnosis and treatment of those patients. To contextualize the results of this study that took place in the Netherlands, the reader should know that in the research period,

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islamophobia was increasing with the consequence that all migrants were under pressure to assimilate quickly, especially newcomers. More recent the DSM-5 Cultural Formulation Interview (CFI, American Psychiatric Association, 2013) was introduced. This interview includes three questions in its core version on cultural identity as well as a supplementary module on this topic. This study was conducted prior to the introduction of the CFI. We will refer to this latest development in the discussion section.

Methods

In a cross-sectional design patients who were referred to a Dutch center for transcultural psychiatry 'De Evenaar' were interviewed using a Brief Cultural Interview (BCI) (Groen, Richters, Laban, & Devillé, 2017). The BCI is a standard part of the diagnostic assessment of the centre. It is a semi-structured questionnaire based on the DSM-IV's OCF domains that are listed above. The BCI is used in a narrative fashion, in which the 27 questions serve as a guideline leaving space for dialogue, in line with methodological recommendations for use of the OCF that include a graceful flow of questions and answers, an open inquiry, and an attitude of empathic concern (Mezzich et al., 2009a). The aim of this methodological approach is to stimulate clinician-patient interaction. Eleven questions concern cultural identity (see Appendix). In line with Kleinman and Benson (2006) we opt for an ethnographic approach of a more encompassing understanding of cultural identity than a trait list approach. An 'emic' account of cultural identity was a result of the dialogue between patient and interviewer. All interviews were conducted in the Dutch centre by the same anthropologist (first author). They were not tape-recorded. The interviewer reconstructed interview reports post hoc. Ethical approval has been obtained at the University Medical Centre of the University of Groningen (2012.404).

Sample
The BCI's were conducted among 43 Afghan and 42 Iraqi refugee patients from February 2006 until April 2011. All patients were diagnosed with PTSD, and/or Anxiety and/or Depression Disorder. To prevent too much cultural diversity in the study group, only adult respondents from Iraq and Afghanistan were selected. They represented the largest groups of asylum seekers and refugees in the Netherlands at the time. In the Netherlands, asylum seekers await the decision of granting a residence permit in asylum seekers centres. Refugees are residence permit holders. Patients with a psychotic disorder or substance-related disorders were excluded. Among the respondents, 34 Afghans needed a Dari interpreter, while 30 Iraqis required an Arabic (21), Sorani (7), or Turkish (2) interpreter. Only official interpreters were used (TVcN Interpretation and Translation Centre of the Netherlands). All other interviews were conducted in Dutch. It was checked whether fluency in Dutch was sufficient during the earlier psychiatric assessment. No reticence of female Muslim patients towards the male interviewer was noticed. Apart from age and gender we registered ethnic group, place of birth, religion, length of stay in the Netherlands, refugee status, and family situation (Table 5.1).

Table 5.1 *Socio-demographic characteristics of Afghan and Iraqi patients under treatment between 2006-2011*

	Afghans *n*=43	Iraqis *n*=42	Total *n*=85
Age			
Mean in years (SD)	35 (12,74)	37 (8,82)	36 (15.05)
Range	17-81	17-58	17-81
Gender			
Male (%)	44.2	59.5	50.6
Female (%)	55.8	40.5	49.4
Ethnicity			
Tajik	15		
Pashtun	5		
Hazara	5		
Arabic		23	
Kurdish		13	
Turkmen		3	
Mixed*	3		
Other	5	3	
Religion			
Muslim**		16	16
Shiite	14	10	24
Sunni	10	4	14
Mixed***		2	2
Christian	3	3	6
Not known****	16		16
Family			
Single	5	7	12
Single with children NL	3	1	4
Single with family NL	5	4	9
Partner NL, no children	1	1	2
Partner abroad, no children	1	0	1
Partner and children NL	24	19	43
Partner and children abroad	3	5	8
Partner and children NL/abroad	1	3	4
Divorced with children	0	2	2
Juridical status			
Asylum (%)	66.7	42.9	54.8
Refugee (%)	33.3	57.1	45.2
Stay in NL (years)*****	4.44	5.51	4.96
Male	6.11	5.52	5.77
Female*****	3.00	5.50	3.97

* One of the parents was Tajik, the other Pashtun
** Number of patients who did not want to say whether they were Shiite or Sunni
*** One of the parents was Shiite, the other Sunni Muslim
**** Respondents either did not want to say, or it was not asked.
***** The length of stay in the NL of 2 female patients from Afghanistan and 3 female patients from Iraq were not known

Qualitative analysis

A grounded theory approach was used for the qualitative analysis of the narrated data (Glaser & Strauss, 1967). The main thrust of grounded theory is to generate theories regarding social phenomena and to develop a level of understanding that is grounded in a systematic analysis of data (Lingard, Albert, & Levinson, 2008). From the collected data in the 85 BCI reports a series of open codes assigned to narrative reconstructions were identified based on our ethnographic definition of cultural identity, using Atlas.ti, version 6.2 (ATLAS.ti Scientific Software Development GmbH, Berlin). Open coding means that in the reports first cultural identity items were broadly distinguished. This resulted in a list of codes that were further assigned to narratives in subsequent BCI reports. Codes were added until the point of saturation was reached. The coding process was then refined by further analysis of the narratives and detecting additional cultural identity items. The codes were analysed and then clustered into subgroups, shifting back-and-forth between codes and narratives (Gibbs, 2007). Next, subgroups were grouped into domains of cultural identity that form the basis of our conceptual framework. Finally, for each item per domain the relation with stress and acculturation was deducted from the interviews. A topic referring to a stressful event (e.g., forced marriage) was connected with a designated identity item (e.g., among adolescents). The same procedure was followed when a problem was clearly linked to acculturation (e.g., illiteracy hampering integration – women were not allowed schooling).

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Results

The initial coding process of the interviews in Atlas.ti resulted in 70 different codes. Redefining and clustering the codes led to 56 codes (e.g., education of the children in the Netherlands, education in the home country, and education in the Netherlands were clustered into 'education'). These codes were aggregated in 18 subgroups (e.g., Dutch, mother tongue, other languages, languages among children and literacy were categorized as 'language'). These subgroups were further classified into three main domains of cultural identity each containing six items: 1) personal identity (age, gender, marital status, education, work, social class/position; 2) ethnic identity (general ethnic values, language, ethnicity problems, political activity, ethnoreligious problems, physical features; and 3) social identity (family, role/position within family, social status, social relations, relationships, social contacts). Each of the domains represents the current personal situation of patients at the time they were interviewed and cultural connotations as they were conceived by the individual, by others in the same ethnic group, and/or by others in local society. For example, 'age' is not only biological age, but concerns the cultural meanings that are attached to an individual of a certain age, expectations of a certain age in a specific ethnic group, and local norms and values attached to that age in contact with others. Similarly, in an ethnographic understanding of cultural identity, 'gender' is regarded as meanings an individual ascribes to a

sense of femininity or masculinity for her or himself, as a female or male member of an ethnic group, and in relation to others beyond the ethnic group.

Tables 5.2, 5.3, and 5.4 present each one of the three domains of cultural identity and their specific relation to stress and acculturation for each item. The cultural aspects in all tables should be regarded as examples, not as generalizations that apply to every respondent in every situation at any given point in time.

Personal identity and relation with stress and acculturation
In the BCI reports, cultural items of personal identity depict the personal situation in the home country, often related to stress, and imply change through the acculturation process in the host society. Combinations of these personal identity traits make an individual unique compared to others.

Age is divided into life stages (child, adolescent, adult) that relate to certain PTEs in the country of origin. When PTEs have been experienced within the family during a respondent's childhood resulting in flight, the main relation to stress in the reports is the unawareness of the flight reason, because trauma is silenced. Young respondents often experience an unclear cultural identity, because they feel not to belong to the culture of origin, neither to the host culture. The main relation to stress for adolescents is kidnapping for boys and forced marriage for girls:

> After the death of my father I was sent to a mosque when I was between 10 and 12 years of age. After that I kept myself busy with traditional sewing and embroidery. At the age of 16 I married my husband, whom my grandfather and the oldest village inhabitants had identified as a suitable spouse for me. I could not oppose to that marriage, because as a girl I was not entitled to do so. (Afghan woman, 31 years old, interview in Dari with interpreter)

Many respondents experience difficulties identifying with Dutch peers, who grew up with different norms and values regarding freedom of choice (e.g., marriage, study) and negligible risk of being kidnapped or other violence (e.g., "they do not know the dangers in my country, that is why I am different"). There may be several cultural differences in life stages (e.g., age to marry, to have children). For adults, exposure to PTEs in general has caused stress. Many respondents fail to connect to Dutch society, because of mental health problems or conflicting norms and values.

Gender distinguishes male and female respondents in relation to stress and to acculturation problems. The example of a 23-years old Sunni Pashtun woman who at the age of six fled from Kabul to Jalalabad in the far east of Afghanistan and ran away from forced marriage points out that a forced flight in childhood changed her perspective on norms and values within her country concerning the role of women:

Table 5.2 Personal identity: Narrated cultural identity items divided into personal items in interviews with Afghan (*n*=43) and Iraqi (*n*=42) patients

Items	Subdivision	Relation with stress	Relation with acculturation
Age	Childhood Adolescence Adults	- unaware of flight reason - forced marriage, kidnap - exposure to PTE (war periods)	- living between two cultures - differences with Dutch peers - feeling disconnected from Dutch society
Gender	Women Men	- vulnerability of women - forced to stay at home - no schooling - kidnap from work or failure in male duties - unable to fulfill duties - partner/father role	- wanting same rights as Dutch women - ambivalence towards more freedom for women - illiteracy hampers communication - differences between men and women in NL - decreased sense of masculinity - increased distance to children and partner
Marital status	Single Married Widowed	- loneliness - mixed marriage - stalking single/widowed women	- failing to connect to Dutch peers - difference between partners in adaptation to NL - feeling unsafe among nationals
Education	Low Middle High	- difficulty establishing position society - disparity with Dutch middle educated - loss of education achievement - threats by Taliban	- difficulty establishing position in NL - feeling distance to Dutch peers - feelings less appreciated in NL - feeling less worth than Dutch high educated
Work	Low class Middle class High class	- difficulty finding new job - fear of losing one's job - unable to regain similar level of work	- feeling powerless in NL - feeling different than Dutch workers - dissatisfaction with work in NL
Social class/ position	Low Middle High	- vulnerability - feeling bereft of social position - loss of social status	- feeling unable to participate in NL - feeling unable to profit from opportunities offered in NL - feeling worthless compared to home society

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My earliest memory is that of being a witness to murders on the street, hiding in a safe place and sometimes having nothing to eat for days. The move to Jalalabad was a great cultural shock, because women were not allowed free choices by the Taliban. One of the consequences was that my mother had to stop working. I felt that women were treated as animals, unlike in Kabul where women had more opportunities. I asked my parents many times why things changed, without getting any answer. At the age of nine I had to stop school. I tried to pursue my education at home while being responsible for the entire household as I was the eldest daughter and my mother suffered from severe diabetes. (Interview in English)

The stress of failing as a Muslim daughter and a role model for her younger sisters, is accompanied by experiencing difficulties identifying with Dutch peers for whom equal

rights for women is the norm. Many girls in Afghanistan were not allowed schooling, which complicates their acculturation in Dutch society because of illiteracy and a cultural gap between less and more freedom for women. Girls in Iraq are more often educated, although there may be differences between Arab and Kurdish girls and they are mostly not as much educated as their Dutch peers. Afghan men's main relation to stress in the home society is being kidnapped because of their work for the government, or because they could not "control their wives". In Iraq, many male respondents suffer from stress because of changes after the fall of the Saddam Hussein regime in 2003. They feel unable to fulfil their duties as a partner and/or a father, which affects their cultural sense of masculinity, and leads to emotional distance to their nuclear family. Failing as a partner and/or a father also results in a lack of self-confidence to integrate into Dutch society.

Marital status carries cultural connotations attached to roles that are rooted in all kinds of local attitudes to, for example, being single or widowed, and conflicts, for instance related to mixed ethnic or religious marriages. Many single or widowed Afghan women experience stress being stalked by Afghan men. Consequently, they feel unsafe and do not want to go out of the home, which hampers participation in Dutch society. Partners of ethnically or religiously mixed marriage experience differences in level of acculturation: mostly the wife integrates more easily.

The level of education and the kind of work include deeply rooted cultural expectations associated with pride, shame, feeling (in)secure, and being a meaningful person in society:

> In the Netherlands I first went to school in the asylum seekers centre to learn the language. I had no contact with other Iraqis. After six months we moved to another city, where I first entered an international class and then a class to prepare for entering a Dutch school. Contact with the other children was difficult. I had another mentality and my way of thinking was different from my classmates. They had things, while I did not. (Iraqi man, 27 years old, interview in Dutch)

Those respondents with little or no educational attainment may find it stressful to establish a new position or job in Dutch society and experience a cultural gap with the Dutch. In the respondents' sample, Afghans had often less educational attainment compared to Iraqis. Middle class workers are afraid to lose their job, and high class workers are unable to regain the same or a comparable level of work in the Netherlands. This results in acculturation problems of feeling powerless, feeling different from Dutch colleagues and dissatisfaction in Dutch society.

Ethnic identity and relation with stress and acculturation
Cultural items of ethnic identity were specifically related to pre-migration stress in the BCI reports. Ethnicity refers to problems respondents encountered because of their belonging

to a specific ethnic group, especially to an ethnic minority, in their home country. Religion is classified under ethnicity because, mostly, it distinguishes one ethnic group from the other, although religion is not equivalent to an ethnic group.

General ethnic values concern values that distinguish one ethnic group from the other, in some cases differentiated in the upbringing of the self and/or the children. Problems that have arisen may have an extensive history of ethnic conflict, as the case of a 41-year old Kurdish woman illustrates:

> My first memory of my Kurdish identity was the planes of Saddam that I saw flying over when I was ten years old. Bombings followed, that made my family run into the mountains. I have also been a witness to the beheading of my neighbour's son. The neighbours cried. When I was 17 or 18 years old I joined in demonstrations against the Arab ruler and donated blood to the victims. A friend of mine had to go to prison. I worked for the Kurds a lot and I worked as a teacher in a boy school. Because of those experiences I hate Saddam and Arab people. At school all children had to cheer "long live Saddam", but nobody wanted to. You always had to be careful what to say. There was no freedom of speech. One day a teacher was taken away by "a car from Saddam". I never saw that teacher again. It came out that the cleaning lady from school worked for Saddam. (Interview in Dutch)

These general ethnic values implicated stress in the home country because of political problems, that affect the ethnic identity, but not for all respondents. In some cases, ethnic problems continue in the host country. A considerable number of respondents avoid social contact with nationals who belong to another ethnic group and some report still feeling discriminated in the host country. For a few, this avoidance means having no social contacts with nationals at all, because they are the only person from a specific ethnic group in a village in the host country.

Ethnic problems between groups are often the reason for flight, in some cases because of mixed ethnicity within the family. These problems lead to stress in the shape of (death) threats and suppression. Many Hazara respondents from rural areas have been confronted with regular conflicts with local Taliban, who claim that Hazara are not true Afghans:

> There were many Pashtun around, who sometimes abducted [Hazara] boys, who were then raped. They had to give money and food to Pashtun. Pashtun, who were all Taliban, vituperated and ridiculed Hazara. Villagers could not pass through Pashtun territory. Once, twelve Hazara were killed when they accidently encountered Pashtun. (Afghan man, 21 years old, interview in Dutch)

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Table 5.3 Ethnic identity: Narrated cultural identity items divided into ethnicity items in interviews with Afghan (*n*=43) and Iraqi (*n*=42) patients

Items	Subdivision	Relation with stress	Relation with acculturation
Ethnic values general	Values	- stress in relation to other ethnic groups	- avoiding contact with other ethnic groups
	Upbringing	- fear of other ethnic groups	- discrimination by other ethnic groups
Ethnicity problems	Ethnic group	- tensions with another ethnic group	- avoiding contact with other ethnic groups
	Ethnic position	- oppressed as ethnic minority	- feeling marginalized in NL
	Ethnicity parents	- mixed ethnic/religious groups led to threats	- not belonging to either parent's groups
	Ethnicity partner	- other ethnic/religious group led to distress	- not being accepted by own/ partner group
Ethnoreligious problems	Religion home	- fear of other religious groups	- avoiding contact with Iraqis/ Afghans
	Religion NL	- fear other religions, conversion to Christianity	- avoiding contact with Sunnis/ Muslims
Language	Dutch	- fear of not being understood	- perception of not being understood in NL
	Mother tongue	- fear to speak in public (Kurdish)	- unable to speak to other nationals
	Other languages	- threat because of mixed marriage parents	- not feeling accepted by nationals
	Children self	- not being able to understand children	- fear of children loosing their mother tongue
	Literacy	- fear of not being able to learn Dutch	- less able to learn Dutch compared to others
Political activity	Activity home	- on black list because of ethnic power changes	- wanting to stay quiet/under cover in NL
	Military home	- ethnic and religious discrimination in army	
	Political situation	- trauma due to political change home country	
Physical features		- ethnicity is easily recognized	- not being accepted by other ethnic groups in NL
		- shame, withdrawal, avoidance	- not wanting (much) social contact in NL

'Why am I born as a Hazara?' one other respondent asked. Avoidance of social contact with other ethnic nationals in the host country is being expressed as feelings of marginalization and non-belonging.

Language is a category in the narratives that contains mother tongue, other languages, Dutch, language between parents and children, and among children themselves, and literacy. Stress in relation to language comes to light at the level of fear for lack of understanding in the interviews:

> It bothers me that I do not speak Dutch well. I prefer not to have contact with the Dutch, because I am afraid that they will think that my Dutch is bad. (Iraqi woman, 40 years old, interview in Dutch)

Language problems lead to all kinds of communication problems in the host country, also within the nuclear family. Several respondents complained about not being able to understand their children.

Military and political activity are included in ethnic identity, because power in both countries changed to another ethnic group, which caused severe problems for some ethnic groups. Political change in the home country arouses stress for specific ethnic groups, especially for ethnic minorities who suffer from ethnic discrimination. In their acculturation process, if ethnicity was a problem in the home country, most are hesitant in, or refrain from social contacts.

Ethnoreligious problems play a significant role in the cause of PTEs for many respondents, which can be at odds with a presumed overarching cultural identity and lead to frustration, fear, and sometimes conversion in the host country. In Afghanistan, mostly Shiites suffer from ethnoreligious violence, especially Hazara who can be recognized by their physical features. In Iraq, violence could be directed towards ethnoreligious minorities such as Christian minorities, and Sunnis, in some cases mostly concerning high functioning government officials. Remarkably, some Iraqis in the study sample claimed they were "just Muslim", and tended to distance themselves from the political divide between Shiites and Sunnis, while Afghan respondents did not. Fear of other religious groups continues in the host country, but to a lesser extent, except for those who converted to Christianity. In many cases, this fear leads to avoidance of social contacts with other ethnoreligious groups.

Social identity and relation with stress and acculturation
Cultural items of social identity express the transformation of respondents as social beings in relation to relevant others. In the reports, cultural items of social identity were numerous, with emphasis on social loss in the host society leading to stress and acculturation problems.

Family and social relations, at the time of residence in the home country, and in the host society, are extremely important in the BCI reports. Many respondents describe having problems living without their family, not being able to contact family members, or not even knowing where they are, as missing parts of themselves. Many single young males from Afghanistan declared that living without their family is "having no life at all". The relation to stress consists of worries about the family in the home country, who might have been murdered, killed in action, or missing family members while residing in the home country and worries about change of overall well-being or mental health of various family members in the host country. This stress leads to 'mental absence' in the host society, feelings of being different because most Dutch families are complete. It also results in worries about the prosperous acculturation of children, who are losing their mother tongue. These children adapt to Dutch norms and values more easily, which may lead to a cultural distance to their parents.

Within the family, respondents experience a depreciation of their social roles (e.g., being a father). In particular, being the eldest son is conceived as troublesome because of responsibilities towards the family, the risk of failing to meet social obligations, and not being a good role model for other family members:

> I tried to take care of my younger brother and sister as good as possible. I tried to let my little brother go to school, because I could not. I was and I am responsible for them. (Afghan man, 22 years old, interview in Pashto with interpreter)

Being a son or a daughter is sometimes crucial for one's cultural identity, because the father preferred a son over a daughter, or a mother is being laughed at for only having daughters. Stress is perceived as feeling unable to fulfil tasks, powerlessness, to fail, or meaningless.

Social status depends on the profession of the parents and/or the partner in the home country, and the social position in the host country. Many women experienced stress that is connected to a high social status of their partner, while in a minority of cases a high social status of the wife was subject to stress for the husband. Stress of feeling at the margin, feeling guilty, or having to live as a single woman because of the murder of one's husband due to his social status is experienced among both Afghans and Iraqis. Concerning their social position in the host country, many respondents feel deprived of their social status, lost in the host society, and/or trapped between two cultures.

Intimate relationships have altered in many cases. For some respondents, stress concerns missing their partner who is killed or left in the home country, or, in some cases, stress about the safety of their partner. For those respondents with a partner in the host society, stress concerns relationship problems, and/or being overloaded with household tasks, because their partner is (mentally) ill. In most cases, these problems result in loneliness. When female respondents experienced PTEs such as sexual trauma, fear of men continues in the host society. Male respondents more often fear to fail with regard to participation in the host society in comparison with their wives.

Lower level of social contacts (e.g., family, peers, Dutch) leads to stress both within and outside the family. Parents often feel dependent on their children for communication in the host society. Worries about the family in the home country often lead to homesickness:

> Following the news makes me sad, because then I think of my family. I cannot go to sleep. Already a car bomb has exploded in front of my house there. All windows were broken… Physically I am in the Netherlands, but mentally I am in Iraq. I feel very lonely, because there is nobody who sympathizes with me. I wonder how long I will be separated from my family. This has made me desperate and confused. To be there means death, to be here means being without my family. That is why I hate life. (Iraqi man, 41 years old, interview in Arabic with interpreter)

Table 5.4 Social identity: Narrated cultural identity items divided into social items in interviews with Afghan (*n*=43) and Iraqi (*n*=42) patients

Items	Subdivision	Relation with stress	Relation with acculturation
Family	Home now	- worries about family in the home country	- thinking more about home than about NL
	Home then	- murdered/killed/missing family members	- feeling distant to Dutch with complete families
	Family NL	- worries about family in NL	- losing norms, values and mother tongue
Role/position within the family	Father role	- feeling unable to fulfill father tasks	- avoiding social contact in NL
	Mother role	- feeling to fail as a mother	- avoiding social contact in NL
	Position family	- feeling powerless, meaningless	- feeling to fail in NL
Social status	Profession parents	- social drop, negative change of social status	- loss of social status in society
	Profession partner		
	Social position NL	- fear for risks of high status partner	- feeling lost in NL
		- marginalized, feeling guilty, single woman	- trapped between culture NL and home society
Social relations	Children home	- children missing, children in home country	- failing as parent hampers integration
	Children NL	- stress about health situation child	- language problems with children
	Parents home	- worries about parents in home country	- feeling lack of support in NL
	Parents NL	- stress with parents concerning upbringing	- differences in acculturation with parents
	Other family	- fear of family in law, lack of support	- differences in acculturation with other family
Relationships	Partner home	- missing partner, stress about safety partner	- loneliness, women afraid of men in NL
	Partner NL	- relationship problems, overloaded with tasks	- loneliness, acculturation differences partner
Social contacts	Children	- stress about friends of children in NL	- dependent on children for communication
	Family home	- grief over parents, lack of establishing contact	- homesickness
	Family in NL	- few contact because of stress within the family	- family more important than integration
	Fellows	- ethnic problems, afraid of curiosity	- avoiding contact with peer group
	In NL	- acculturation stress	- experiencing social distance to the Dutch
	With Dutch	- not sufficient concentration to learn Dutch	- few opportunities to communicate in Dutch

Respondents experience stress in social contacts with different ethnic groups, due to acculturation stress, and concentration problems that hamper learning Dutch. Many respondents experience social distance to the Dutch, because of differences in norms and values such as pride, respect, and other relevant issues.

Discussion

Thorough analysis of cultural identity in 85 interviews with Afghan and Iraqi refugee patients resulted in a subdivision of personal, ethnic, and social identity that is potentially relevant in intercultural encounters. Moreover, the extent to which each identity relates to stress and to acculturation problems points at the relevance of understanding various aspects of cultural identity in relation to mental health problems. The results of this study therefore support the inclusion of cultural identity in the Cultural Formulation Interview in DSM-5 (American Psychiatric Association, 2013) and a supplementary module (Lewis-Fernández, Aggarwal, Hinton, Hinton, Kirmayer, 2016). The supplementary module on cultural identity, which is not based on empirical results, also includes national and racial background, spirituality, religion and moral traditions, and gender and sexual orientation identity, which were not particularly found in this study, except for ethnoreligious problems. More research in different settings among different populations is needed, but reasons for underutilization of the DSM-IV OCF, 'due to limited dissemination efforts towards practicing clinicians and time required for its implementation' (Lewis-Fernández, 2009:379), indicates that a simplified framework could enhance utilization. In case the particular situation of a specific patient requires more elaboration, for instance in the case of problems related to race or sexual orientation, mental health professionals could opt for the supplementary module.

Personal identity offers the clinician information about the personal characteristics and circumstances of the individual patient that are subject to change under the influence of stress and acculturation. Results regarding ethnic identity show how crucial ethnic belonging is to stress in the home country. Around social identity, stress is felt around the family, both in the home and in the host country, inability concerning social expectations within the family that have altered, and the diminished level of social functioning, for example by stress in social contacts. Social identity is of particular interest for this group, because of migration from an interdependent society to an independent society which, in many cases, leads to feelings of alienation. The uniqueness of the findings complicates comparison to other research, because used concepts might contain other elements than found in this study.

Interaction of personal identity with stress and acculturation
Experienced PTEs result in an affected integrity of cultural personal characteristics of the refugee patients in this study. There may be typical life threatening risks specific for a culture that affect the kind of person someone believes to be, for example regarding safety for children and women, but also for men who are not able to fulfil duties according to local norms in the society of origin. Change in personal identity is certainly due to the transition from an interdependent to an independent society, which is often quintessential for recovery from stress (Jobson & O'Kearney, 2008). However, our results indicate how loss of personal achievements affects the individual.

Stress and acculturation impact personal identity in three main ways. Firstly, chronic stress reinforces difficulties for successful integration of the individual. Personal identity was relatively clear in the society of origin, but when loss, grief, or bereavement have affected that clarity, confrontation with norms in the host society causes an even more unclear personal identity. Secondly, difficulties in the acculturation process, on their turn, seem to reinforce stress at the personal identity level, because of cultural differences refugee patients encounter in contact with the Dutch. Thirdly, loss of education achievements, work and social status deprive a person of self-esteem and being a meaningful person in the host society. On a personal level, respondents in this study appear to acknowledge that "mental disorder inevitably challenges traditional ideas about personal identity since, as the notion of disorder suggests, it can profoundly alter and transform its sufferer, disrupting the smooth continuity uniting earlier and later parts of subjectivity and, viewed from the outside, of persons and lives" (Radden, 2004:133). The results of our in-depth study show *how* stress and acculturation may alter and transform traditional ideas about personal identity through the items in table 5.2. The ubiquity of stress caused by PTEs in thinking about the self as a meaningful person is clarified through a variety of personal roles in various new situations.

Interaction of ethnic identity with stress and acculturation
In the respondents' stories, ethnicity plays such an important role in suffering from PTEs, stress and acculturation problems, that ethnic identity should be distinguished from social identity. Theoretically, ethnicity might be considered a special kind of social identity (Schwartz et al., 2006), but our study shows that special attention to ethnicity would enhance understanding of suffering, coping, and acculturation of, in this case, traumatized refugee patients. Ethnic identity has been considered "... a crucial facet of an individual's overall cultural identity" (Ton & Lim, 2006:10), but the distinguished items of ethnic identity in this study indicate *how*, for instance, being Kurdish in Iraq or a Shiite Tajik or Hazara in Afghanistan may be crucial for vulnerability to PTEs. Our study results underline earlier findings of vulnerability to exposure to PTEs and a higher risk of developing mental health problems in ethnic minorities (McKenzie, 2008; Khaylis, Waelde, & Bruce, 2007; Vega & Rumbaut, 1991) and show how their ethnic identity is affected, mainly through discrimination. Poor adaptation to the host society among affected ethnic minority groups is an additional risk factor for mental health problems, because a low, weak, or diffuse ethnic identity is related to low self-esteem and psychological well-being (Phinney, 1991; Phinney, Horenczyk, Liebkind, & Vedder, 2001). Our study indicates that the initial conditions for participation in the host society, communication abilities and feelings of being understood, are very poor. Therefore, the results of this study underscore the need to study ethnic identity and acculturation, for ethnic minorities in the host country and/or ethnic minorities among immigrants from the same country of origin (Persky & Birman, 2005; Tsai, Chentsova-Dutton, & Wong, 2002).

Interaction of social identity with stress and acculturation

Since social support from relations within and outside the family, social position, and social status are crucial for refugee patients from interdependent societies, which most (post)conflict areas are, social identity ought to be distinguished as a domain of cultural identity. The variety and frequency of items in this domain point out how important social identity is to the respondents and how changes as a consequence of stress and acculturation affect their lives as social beings. Social identity may be crucial for self-esteem, and, it is postulated, maybe even more than personal identity (Taylor & Usborne, 2010). The consequences of loss, grief, and bereavement for social functioning in the host society are numerous. The findings in this study underline that the transition to a new society has effected in a dramatic fall of the social functioning of respondents who socialized in interdependent societies, although individuals may be idiocentric or allocentric (Bhugra, 2005). Their social embeddedness in the past and stress caused by social loss, grief and bereavement seem to deflate their social self in the present, causing a socio-cultural void. Social bereavement adds to lack of trust in others and avoiding social contacts that are symptoms of PTSD alone, and hamper participation in society. Acculturation problems in social interaction intensify a downturn in social and individual functioning, causing loneliness, homesickness and feelings of being lost in society.

Implications for cultural competency

Elaborating on the suggestion that the concept of cultural identity in DSM-IV needs further development, the framework offers three domains: start from the perspective of the individual (personal identity), amplify it to the potentially most direct meaningful social environment (ethnic identity) and contextualise within the wider social environment (social identity). For mental health professionals this elaboration may help to increase cultural competency. Noteworthy, the health care provider ought to be open-minded, willing to learn about cultural differences, and treat each patient as an individual (Jenks, 2011). Open-mindedness towards cultural identity might enhance understanding of the change refugee patients have undergone and lead to what is really at stake for these patients (Kleinman & Benson, 2006). Most respondents in this study feel they are bereft of their 'old' cultural identity while a 'new' cultural identity has not been established yet, partly due to mental health problems and partly due to acculturation problems. Eisenbruch's definition of cultural bereavement as "... the experience of the uprooted person ... resulting from loss of social structures, cultural values, and self-identity" (1991:674) addresses representations of the self and loss in our study results.

For mental health professionals, we reach the following recommendations to explore cultural identity of culturally diverse patients in their diagnosis and treatment:

• discuss the meaning of personal identity items, such as age, gender, education and work, in the light of their socio-historical context in order to understand the changes PTEs have made to these personal characteristics of the individual;

- discuss the patient's experiences with one's ethnic group, with members of another ethnic group, what these experiences mean to him or her, in the past and in the present, and how these are related to causes of mental health problems;
- discuss changes in the social environment, in the family or in socio-economic perspective (decline of social status) and how these changes are related to coping with mental health problems;
- apart from the stress factors from the past, discuss social changes after migration that are often more, or more intense, or more complex than expected at first, and how these changes intensify or influence coping with mental health problems.

Information concerning cultural identity offers clinicians opportunities to a holistic perspective in transcultural psychiatry, from disease to patient to person, on mental health problems in person-centered care (Mezzich, Snaedal, Van Weel, & Heath, 2010). However, they should realize that the provided framework is a simplification of the complexity of cultural identity in daily practice. We recommend mental health care professionals to take the broad range of aspects in the framework as a starting point, but should not limit themselves to them. Above all, they should be aware of the risk of stereotyping (Kleinman & Benson, 2006). They should preferably use their patients as their primary source in meaningful dialogue. The focus may even lead to a reshuffling of identity components, but the framework of personal, ethnic, and social identity will presumably not alter.

Limitations

The results of this study have to be interpreted with some caution. First, the selection of patients from the two largest refugee populations in the Netherlands at the time limits generalization for the entire refugee population. We felt that this multi-ethnic sample is helpful, because from a clinical perspective, clinicians would have more opportunities to practice cultural competency in treatment of patients from various cultural backgrounds then in the case we selected only one country of origin, or one ethnic or religious group. Second, the data are gathered in one transcultural mental health institute in the Netherlands. Comparison with other mental health institutes might have enhanced the findings. Third, we did not distinguish strongly between refugees and asylum seekers in our research because our focus was on cultural identity in all variations, not depending on juridical status. Uncertainty about stay may have had consequences for the acculturation style and language abilities depending on the length of stay in the Netherlands. We will elaborate on differences between asylum seekers and refugees in further research. Fourth, the qualitative analyses have been carried out by the researcher who also conducted the interviews, which may have led to a bias. This was for practical reasons and there has been no other interest than to explore the relevance of cultural identity for clinicians. We acknowledge that theoretical pre-occupations of the researchers which were referred to in the

introduction may have driven the results. Finally, the questions concerning cultural identity were leading questions to enhance patient-interviewer interaction, but may have had a steering influence on the outcomes.

Conclusion

In this article we suggest, based on qualitative research of interview reports collected among traumatized refugees from Afghanistan and Iraq, a framework for cultural identity that can be potentially useful for clinicians in transcultural psychiatry settings. While in dialogue with patients, the complexity of cultural identity may be more appropriately addressed when the clinician takes the division into personal, ethnic, and social identity into account. When clinicians succeed in clarifying changes in these domains as a consequence of stress and acculturation problems, they will have better treatment perspectives, because they could better connect to the culturally diverse patients' needs, to what is really at stake for these patients.

Chapter 6

Cultural identity confusion and psychopathology: A mixed-methods study among refugees and asylum seekers in the Netherlands

Abstract

While there is ample empirical evidence that traumatic events, post-migration stress and acculturation problems have a great impact on the mental health of refugees, so far no studies have included cultural identity after migration in the equation. This mixed-methods study conducted among Afghan and Iraqi refugee and asylum seeker psychiatric patients aims to fill this gap. Associations between post-migration stress, symptoms of anxiety and depression disorders and of post-traumatic stress disorder were significant. When differentiated for the two groups, associations with post-migration stress were no longer significant for Afghan patients, who were predominantly younger and more often single, lower educated and without resident status compared to Iraqi patients. Qualitative results indicate that in addition to psychopathology and post-migration stress, acculturation problems contribute to confusion of cultural identity. The findings indicate that reduction of post-migration stress and acculturation problems may clarify cultural identity and as such may contribute to post-traumatic recovery.

Introduction

It is well-known that refugees and asylum seekers often have prolonged mental health problems. Several studies have shown that anxiety, depression and post-traumatic stress disorder (PTSD) tend to be highly prevalent among these groups, even years after resettlement in the host country (Bogic, Njoku, & Priebe, 2015). Earlier studies have focused on the relationship between experienced potentially traumatic events (PTEs) and psychopathology, while more recent studies have shown that post-migration living problems (PMLPs) among resettled refugees and asylum seekers have a significant impact on psychopathology as well (Carswell et al., 2011; Porter & Haslam, 2005; Laban et al., 2005).

Like all migrants, refugees and asylum seekers have to relate to norms and values in the host country that may be (partly) different from those in the home country. This process is referred to as acculturation, defined by Berry (2005:698) as "… the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members". When this acculturation process is perceived as problematic, it is to be considered as a risk factor for mental illness of the respective migrant, along with biological and other psychological and social factors (Bhugra & Becker, 2005). More than other migrants, refugees and asylum seekers may be confronted with PTEs, PMLPs and problematic acculturation as risk factors for mental health problems. These risk factors may have a troubling impact on cultural identity. Confusion regarding one's cultural identity, in its turn, may have negative consequences for mental health.

In a previous article, we defined cultural identity as the identity shaped by incorporated norms and values that constitute an image that an individual holds of him- or herself, which urges the individual to decide what is to be considered as right or wrong and what kind of behavior is appropriate or not, while these norms and values are negotiated within the (ethnic or ethno-religious) group to which the individual belongs (Groen, Richters, Laban, & Devillé, 2018). In a study by Mezzich et al. (2009b), cultural identity was found to be relevant or even central for understanding mental health problems and levels of individual and social functioning in a culturally diverse patient population. Bhugra (2005) in a literature review on the relationship between migration, cultural identity and mental health had already observed that "when individuals migrate from one type of culture to another it is likely that [they], depending upon their own personality traits, … may develop psychiatric disorders (2005:84)."

We postulate that experiencing PTEs may have far-reaching consequences for an individual's inner core cultural values that shape thought and action; in other words, his or her cultural identity. The way in which PTEs and/or PMLPs may affect cultural identity has, however, so far

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remained unclear. To the best of our knowledge, this issue has not been studied until now. Given the complexity of the interrelationship between various risk factors for psychopathology in the population of our study and cultural identity, a qualitative approach may contribute towards gaining a deeper insight. In our previous publication, cultural identity – subdivided into personal, ethnic and social identity – was analyzed among 85 Afghan and Iraqi patients (Groen et al., 2018). Their personal life stories, their sense of belonging to an ethnic (minority) group and their social embeddedness in the host society appeared to be strongly connected to both trauma-related stress and acculturation problems.

The aim of this study, conducted among newly referred Afghan and Iraqi patients, is to investigate interrelationships between cultural identity, aforementioned risk factors, and psychopathology. Associations between experienced PTEs, post-migration stress, and acculturation preferences are explored. Qualitative data were used to describe the process of the way these factors cohere with (changes in) cultural identity in the trauma-affected study population. Finally, by linking the results of both parts of the study, the implications of the study findings for mental health professionals in their clinical practice are addressed.

Methods

A concurrent design of quantitative and qualitative methods was applied in this study (Creswell & Zhang, 2009). Quantitative measures were used to explore patterns of associations between PTEs, PMLPs, acculturation and psychopathology. In the same group of participants qualitative data were collected and analyzed to gain an in-depth understanding of how these relationships may lead to mental health problems and may change cultural identity after migration. Results were disaggregated between Afghan and Iraqi participants to enhance insight in potential differences in outcomes between both groups.

Participants

A consecutive sample of an eligible group of 100 Afghan and Iraqi patients was recruited from a Dutch center for transcultural psychiatry, between August 2012 and February 2015. The group of patients was part of a bigger case-control study aiming at including in total 100 patient and controls of both countries of origin together. The required size of the total sample aimed at studying an effect size (Cohen's f^2) of 0.15 (power=0.8; α=0.05) in a multiple linear regression analysis with three predictors and three confounding variables (Soper, 2018; Cicchetti, 2008; Cohen, Cohen, West, & Aiken, 2003). Invitation letters for the clinical assessment including an

invitation for participation in the study were sent to all referred patients who were originally from Afghanistan or Iraq. Participants were selected from patients from these countries of origin, because they were the largest groups of refugees in the Netherlands and also the largest groups of patients in the center at the moment of inclusion. A second reason was to make the study population not too culturally heterogeneous while in the meantime avoid relying on results on one group only. Inclusion criteria were a minimum age of 17 years, at least resident in their home country until the age of 12, and speaking Dari, Arabic, Dutch or English. Patients with florid psychosis or substance-related disorders, or those with cognitive disabilities, were excluded. Furthermore, patients who were fluent only in Pashto or any Kurdish language (Badini, Kurmanji, Sorani) were excluded, because translations of the questionnaires in these languages were not available. Two patients refused to participate because they expected the questionnaires to be too intrusive. Two were excluded because they had been referred to the center for a second opinion regarding diagnosis without the aim of being included in treatment; in this case, completion of the questionnaires would have been complicated. Four were excluded due to illiteracy and the unavailability of assistance in filling in the questionnaires. In one case there was no Arabic interpreter available. The 91 potential remaining participants were informed about the study in the invitation letter that they received for their psychiatric assessment. Following psychiatric assessment, they were given written and oral information about the purpose of the research, the guarantee of confidentiality, the procedures, the fact that participation was voluntary, and the right to withdraw without negative consequences for their treatment. Not all questionnaires were completed or returned after several attempts to stimulate completion. Eventually, 57 patients (response rate 62.6%) were included in the study: 28 Afghan patients (response: 57.1%) and 29 Iraqi patients (response: 69.0%). The final sample of patients allowed us to study an effect size of 0.30 in a multiple linear regression analysis with three predictors and three confounding variables (Soper, 2018; Cicchetti, 2008; Cohen et al., 2003). Approval for the research study was granted by the University Medical Centre of the University of Groningen (Protocol ID 2012.404).

Instruments

A structured questionnaire on sociodemographic characteristics covered the following items: gender, age, education, work, family situation, ethnic group, languages, importance of religion and politics, region of origin, juridical status, and length of stay in the Netherlands.

The Harvard Trauma Questionnaire (HTQ) was used to assess the number of PTEs (Part 1) and the severity of trauma symptoms (Part 2) and the Hopkins Symptoms Checklist-25 (HSCL-25) was used to assess the severity of anxiety and depression symptoms and are both culturally validated (Mollica et al., 1992; Mollica, Wyshak, De Marneffe, Khuon, Lavelle, 1987). The first

part of the HTQ contains 20 items related to PTEs that participants may have experienced, witnessed or heard about. Cronbach's α was 0.932 (Cronbach, 1951). The second part contains 30 items related to any trauma symptoms experienced one week prior to administration on a 4-point Likert Scale (1=not at all, 4=extremely). The score is calculated by dividing the sum of the results (from x times 1 to x times 4) by the number of questions (Cronbach's α=0.969). The HSCL-25 contains 10 anxiety symptoms and 15 depression symptoms and was administered following the same procedure (Cronbach's α=0.969).

Post-migration stress factors were gathered using the Post-Migration Living Problems Checklist (PMLP-CL), which was adapted from Silove et al. (1997). This list includes 23 items and 2 open items on a 4-point Likert Scale (1=no, 4=very much), which could be identified by participants in the 12 months prior to administration (Cronbach's α=0.875). In addition, participants were asked which 3 items worried them the most.

The Cortes Rogler Malgady Bicultural Scale (CRM-BS) was used to measure acculturation preferences. The CRM-BS was found feasible by Latino, Korean, and Chinese psychiatric patients in a New York City hospital: 64.5% perceived the questionnaire to be very easy to somewhat easy. Test-retest reliability showed Pearson's r of 0.82 for the total scale. Ratios in a discriminant validity test of the first 10 and second 20 items were 1.70 (SD = 1.75) for the multiethnic sample (validated in Mezzich et al., 2009b). In accordance with CRM-BS instructions, participants were asked to refer to their experiences up to 12 months prior to administration on a 4-point Likert Scale (0=not at all, 4=very much). For our purposes, the name of the host country (United States) and language (English) were changed to "the Netherlands" and "Dutch" respectively. The CRM-BS contains 20 items, the first 10 for ethnic group ("origin"), and the remaining 10 for Dutch culture ("host"); the former correspond to the latter. Before responding to the items, they could indicate their ethnic group to ensure that they would refer to, for example, being Kurdish or Iraqi, Hazara or Afghan. Results were analyzed by dividing the scale of "origin" by the scale of "host" (range=0-60) for the total research population (Cronbach's α=0.850), and for Afghans and Iraqis separately. To calculate cut-off scores, subscales of the CRM-BS were made for "origin" (Cronbach's α=0.892) and "host" (Cronbach's α=0.824) and scores of origin divided by host of < 1.00 were considered to display a preference for norms and values of the host society.

All questionnaires were translated into Arabic, Dari and Dutch by official native language interpreters and were controlled by co-interpreters of the Free University Language Centre in Amsterdam. Separate sets of questionnaires were composited for Afghan and Iraqi participants, including Dutch and Dari or Dutch and Arabic versions.

Qualitative data were collected using the Brief Cultural Interview (BCI) (Groen et al., 2017) from all participants who agreed to participate and who had received the abovementioned questionnaires. The BCI is an operationalization of the Outline for Cultural Formulation in the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV, American Psychiatric Association, 1994) and covers the following components: cultural identity of the individual; cultural explanations of the individual's illness; cultural factors related to the psychosocial environment and levels of functioning; and cultural elements in the relationship between the individual and the clinician (cf. Lewis-Fernández, 1996). Twenty-three of the interviews were conducted in Dutch, 16 in Dari, 1 in Pashto, 12 in Arabic, 2 in Turkmen, 1 in Assyrian, 1 in Sorani, and 1 in English; an interpreter by phone was arranged when necessary. There were no differences between Afghan and Iraqi participants regarding the need to use an interpreter: 17 out of 28 (60.7%) and 17 out of 29 (58.6%) respectively.

Data analysis

Data from the pre-structured questionnaires were analyzed using the Statistical Package for Social Science for Windows, version 23. Descriptive analyses were used to describe the characteristics of the sample, with χ^2 and Independent Samples T-tests to test differences between Afghan and Iraqi participants. Participants were divided into younger and older groups according to the median age of 30 years. Associations between the various instruments in the total sample were studied by Pearson correlation. Linear regression analysis was performed to explore the relationship between anxiety/depression and PTSD symptoms with PTEs, acculturation and PMLPs. This analysis was first done for the whole group controlled for age, gender and juridical status. To gain insight into differences in the associations between the two groups, the analyses were also done for Afghan and Iraqi participants separately. Imputation of the mean was performed for missing values (maximum=2 per scale).

Ad hoc reconstructed interview reports of the BCIs were analyzed using ATLAS.ti, version 7.0 (ATLAS.ti Scientific Software Development GmbH, Berlin), which is based on a grounded theory approach (Glaser & Strauss, 1967). Narrative reconstructions from the BCI reports were first open coded, to identify the same parameters as in the quantitative analysis. When fragments from the reports were recognized as conforming to a previously identified code, this particular text was assigned to the existing code. Codes were accumulated in a code list until the point of saturation was reached.

Results

Socio-demographic characteristics

The study group of 28 Afghan and 29 Iraqi participants (see Table 6.1) consisted of more men than women (65% vs. 35%), with a larger sex difference among the Afghans (71% vs. 29%) compared to the Iraqis (59% vs. 41%). There was a significant difference between both groups in terms of age, marital and juridical status, and length of stay in the Netherlands: the Afghan participants were much younger, more often single, and more often asylum seekers than the Iraqis, and their duration of residence in the Netherlands was less than half that of the Iraqis. Ethnic variety among both groups was extensive, with ethnic minorities dominating. The level of education received in the country of origin and current employment status in the host country varied significantly between the two groups: Afghan participants were more often uneducated or lowly educated and unemployed than Iraqi participants.

Satisfaction with the employment situation among those employed was low in both groups (only 15% was satisfied).

Psychopathology, PTEs, PMLPs and acculturation: Descriptions and associations

Levels of PTSD and anxiety/depression were relatively high in the total study population, and were higher among the Afghan than Iraqi participants (see Table 6.2). The study population had experienced a mean of almost ten PTEs per person, Afghans significantly more than Iraqis.

The most frequently mentioned experienced PTEs were: *ill health without medical care*, *imprisonment*, *lack of food and water*, *being close to death*, and *having been threatened with physical torture*. The most frequently mentioned PMLPs were: *missing the family*, *insecurity about the future*, *loneliness*, *health problems*, and *fear of being sent back*. Acculturation scores were a little lower than 1, meaning that all of the participants attached almost equal appreciation of Dutch items and items of their ethnic group, as included in the CRM-BS, with a slight preference for Dutch items. There was no significant difference between Afghans and Iraqis.

For PTSD and anxiety/depression, no differences were found between men and women, or between participants who were 30 years or younger and those older than 30 years. Results show a significant difference between men and women and between younger and older participants with regard to the number of PTEs. Men had experienced more PTEs than women (10.73, SD=5.51 vs. 6.70, SD=4.57; t(55)=2.79, p=0.007), and younger participants had experienced more PTEs than older participants (12.43, SD=4.56 versus 7.21, SD=5.13; t(55)=3.95, p=0.000). No such differences were found for PMLPs and acculturation preferences.

Table 6.1. Sociodemographic characteristics of the study population of Afghan and Iraqi participants (n=57)

Variables		Afghans (n=28)[1]	Iraqis (n=29)[1]	Total (n=57)[1]	χ^2 and p[2]
		n (%)	n (%)	n (%)	
Gender					$\chi^2(1)$ = 1.03, p = 0.311
	Male	20 (71.4)	17 (58.6)	37 (64.9)	
	Female	8 (28.6)	12 (41.4)	20 (35.1)	
Juridical status					$\chi^2(1)$ = 24.43, p < 0.001
	Asylum seeker	21 (75.0)	3 (10.3)	24 (42.1)	
	Refugee	7 (25.0)	26 (89.7)	33 (57.9)	
Marital status					$\chi^2(1)$ = 6.63, p = 0.010[3]
	Married/cohabiting	7 (25.0)	16 (59.3)	23 (41.8)	
	Married/partner abroad	1 (3.6)	2 (7.4)	3 (5.5)	
	Divorced/not cohabiting	0 (0.0)	4 (14.8)	4 (7.2)	
	Widowed	2 (7.1)	2 (7.4)	4 (7.2)	
	Single	18 (64.3)	3 (11.1)	21 (38.2)	
Children					$\chi^2(1)$ = 10.68, p = 0.001[4]
	No children	19 (70.4)	7 (25.9)	26 (48.1)	
	Children in NL/abroad	8 (29.6)	20 (74.1)	28 (51.9)	
Education					$\chi^2(2)$ = 9.52, p = 0.009
	None	12 (42.9)	7 (26.9)	19 (35.2)	
	Primary (religious)	11 (39.3)	4 (15.4)	15 (27.8)	
	More than primary	5 (17.9)	15 (40.7)	20 (29.1)	
Social position abroad					$\chi^2(1)$ = 3.97, p = 0.046
	Low	15 (53.6)	7 (26.9)	22 (40.7)	
	Middle/high	13 (46.4)	19 (73.1)	32 (59.3)	
Employment NL					$\chi^2(1)$ = 4.19, p = 0.041
	Yes	4 (14.8)	10 (40.0)	14 (26.9)	
	No	23 (85.2)	15 (60.0)	38 (73.1)	
					t and p
Age					$t(55)$ = -6.93, p < 0.001
	Mean (SD)	27 (8.2)	44 (9.8)	36 (12.3)	
	Range	17- 43	19- 59	17- 59	
Length of stay in years					$t(46,24)$ = -3.85, p < 0.001
	Mean (SD)	4.08 (3.6)	9.06 (5.9)	6.61 (5.5)	
	Range	1.25-16.83	0.83-19.25	0.83-19.25	

[1] Totals may differ because of missing values per variable.
[2] Significant at p < 0.050.
[3] Difference between married/cohabiting and otherwise.
[4] Children abroad is accounted similar to living with children in the Netherlands.

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Table 6.2. Posttraumatic stress disorder, anxiety/depression disorder, number of experienced traumatic events, post-migration living problems, and acculturation in Afghan and Iraqi participants (*n*=57)

	Afghan patients (*n*=28)	Iraqi patients (*n*=29)	Total patients (*n*=57)	*t, p* Value
Posttraumatic stress symptoms (mean, SD)[1]	3.07 (0.46)	2.79 (0.61)	2.93 (0.55)	*t*(53) = 1.92, *p* =0 .060
Anxiety/depression (mean, SD)[2]	3.12 (0.45)	2.90 (0.63)	3.01 (0.55)	*t*(52) = 1.44, *p* = 0.155
Total experienced traumatic events (*n*, SD)[3]	10.93 (5.57)	8.66 (4.78)	9.77 (5.26)	*t*(55) = 1.66, *p* = 0.029
Post-migration living problems (mean, SD)[4]	2.50 (0.48)	2.39 (0.56)	2.44 (0.52)	*t*(54) = 0.84, *p* = 0.407
Acculturation (mean, SD)[5]	0.87 (0.38)	0.99 (0.70)	0.93 (0.31)	*t*(54) = -0.785, *p* = 0.436

[1] Measured by Harvard Trauma Questionnaire-part 2
[2] Measured by Hopkins Symptoms Checklist-25
[3] Measured by Harvard Trauma Questionnaire-part 1
[4] Measured by Post-Migratory Living Problem Checklist (PMLP-CL)
[5] Measured by Cortes, Rogler and Malgady Bicultural Scale (CRM-BS)

For the whole study sample, a significant correlation was found between all three measures: anxiety/depression, PTSD symptoms and PMLPs (Table 6.3). For Afghan participants, PMLPs were no longer significantly associated, but anxiety/depression symptoms remained significantly associated with PTSD symptoms. For Iraqi participants, however, PMLPs remained significantly correlated to both anxiety/depression and PTSD symptoms. There was no significant correlation between acculturation or PTEs and any other measure.

Table 6.3. Correlations between Posttraumatic stress disorder (PTSD) symptoms, anxiety/depression symptoms, experienced potentially traumatic events (PTE), post-migration living problems (PMLP), and acculturation in Afghan and Iraqi participants (*n*=57)[1]

		PTSD	Anxiety/ depression	Experienced PTE	PMLP	Acculturation
PTSD	Pearson Correlation	1				
	Sig. (2-tailed)					
	n	55				
Anxiety/depression	Pearson Correlation	0.875	1			
	Sig. (2-tailed)	<0.001				
	n	54	54			
Experienced PTE	Pearson Correlation	0.234	0.225	1		
	Sig. (2-tailed)	0.086	0.102			
	n	55	54	57		
PMLP	Pearson Correlation	0.475	0.480	0.130	1	
	Sig. (2-tailed)	< 0.001	< 0.001	0.341		
	n	54	53	56	56	
Acculturation	Pearson Correlation	-0.199	-0.244	-0.102	-0.032	1
	Sig. (2-tailed)	0.150	0.078	0.456	0.814	
	n	54	53	56	56	56

[1]Pairwise deletion of missing cases.

Multivariate regression analyses for PTSD and for anxiety/depression were carried out. Stepwise regression, both backward and forward, resulted in the exclusion of all variables except for PMLPs. The number of PTEs and PMLPs, acculturation, age, gender and juridical status were entered into a forced model. Only PMLPs remained significant both for PTSD and anxiety/depression. For both models the Cohen's effect sizes were of a medium level, respectively 0.41 and 0.40 (Cicchetti, 2008) (Table 6.4). When both groups were analyzed separately, neither PMLPs nor any other variables remained significant for Afghans.

Table 6.4. Multivariate linear regression of PTSD and anxiety/depression symptoms

	PTSD[a]			Anxiety/Depression[b]		
	$F_{(6,47)} = 3.24$; $R^2 = 0.293$; $p < 0.010$			$F_{(6,48)} = 3.20$; $R^2 = 0.286$; $p < 0.010$		
	Standardized Coefficients			Standardized Coefficients		
	β		95% CI	β		95% CI
		Sig.			Sig.	
Constant		0.001	0.816-2.906		0.000	0.880-2.855
No. experienced traumas	0.045	0.769	-0.029-0.038	0.070	0.649	-0.025-0.040
PMLP	0.396	0.004	0.140-0.713	0.428	0.002	0.170-0.710
Acculturation	-0.112	0.376	-0.642-0.247	-0.113	0.373	-0.625-.0239
Age	0.030	0.857	-0.014-0.016	0.049	0.771	-0.012-0.017
Gender (female/male)	0.038	0.784	-0.276-0.364	0.084	0.549	-0.218-0.406
Juridical status (asylum/ refugee)	0.241	0.146	-0.096-0.628	0.193	0.239	-0.143-0.560

[a] Cohen's f^2 medium effect size is 0.41.
[b] Cohen's f^2 medium effect size is 0.40.

Findings from the interviews

Trauma and ethnicity-related vulnerability

In the interviews, belonging to an ethnic or ethno-religious minority appeared to be a high risk factor for experiencing PTEs. When participants did not belong to such a minority, other socio-demographic characteristics distinguished them from mainstream groups in their country of origin, such as growing up in a communist family, working for the government, or working for a United States company or the US army. PTEs, as experienced by participants in both groups, were culturally specific, particularly among those belonging to ethnic minorities. Among Afghans, this included violence against Shiites in Herat, a Hazara being used as a slave by the Taliban, a man being kidnapped because his wife worked for a foreign company, mothers being threatened by force to give away a daughter for marriage, and so on. The following quote reveals the living conditions of a single 21-year-old Hazara participant from Afghanistan, who

had been used as a slave by the Taliban at the age of twelve after both of his parents died shortly one after the other:

> … there were a lot of Taliban over there. The young boys of twelve and thirteen years old, they just took them, and then just raped them. Those people [from the village where he lived, SG] just had to give them money or food. They had nothing to eat, but they had to give them, for example, a sheep (Interview in Dutch).

Post-migration stress

Post-migration stress factors did not fully correspond with factors items of the PMLPs checklist used in the quantitative part of the study but there is a considerable overlap. Codes for post-migration stress were grouped into the following: being without family; disappointments; fear; and language problems. The most recurrent item was being without family, both in the home country and in the country of residence, and encompassed the following codes: *living without family*; *being away from family*; *no contact with children in the home country*; *missing the family*; *worries about the family in the home country*; *mental health problems within the family*; *responsibility for the family*; *marriage problems*; and *acculturation differences within the family*. Participants often mentioned homesickness and loneliness as a means to express their strong wish to be with their family, and a lack of social contacts as a means to express being unable to discuss problems within the family. Indirectly, the urge to follow news about their country of origin could be linked to concerns about their family, but not in all cases.

Disappointments concerned the way of living, education and work in the host society. Relevant interview fragments were coded as: *living in the Netherlands*; *afraid of expectations in the Netherlands*; *imprisonment episodes*; *homelessness*; *adaptation problems*; *problems at work*; *socio-economic status*; *lack of work*; *lack of education*; *lack of activities*; *financial problems*; *problems with institution*s; *problems with law and/or police*; *failing legal obligations*; and *travel difficulties*. *Failing legal obligations* referred to problems experienced in the obligatory civic integration course that follows the obtaining of legal status in the Netherlands or problems obtaining a Dutch passport. Apart from being arrested and placed in custody as a foreigner, *problems with the law and/or police* also concerned disappointments over the Dutch legal system; some of the participants had difficulties accepting lower punishments for crimes committed against them in the Netherlands when compared to punishments in their home country.

Participants expressed fear in terms of *being found crazy*, *being sent back*, *in relation to the asylum procedure*, and *threats from or in the home country*. *Fear of being found crazy* often recurred in interviews as the fear that the mental condition would further deteriorate to a point that would be shameful, taboo and stigmatizing. *Fear of threats from or in the home country* referred to harm that could come to relatives who had been left behind, and this was found

among those who were on a black list in their country of origin; they still feared that they could be discovered and caught.

Language problems referred to *misunderstandings*, *difficulties reading letters*, *being dependent upon others for translation*, *limited abilities to communicate with Dutch people*, and *not being able to travel autonomously*. Constrained Dutch language capabilities led to situations of not understanding or misunderstandings. Many participants complained about not being able to acquire the Dutch language despite their desire to speak it, which was expressed in terms of a structural living problem.

Post-migration stress was different for Afghan compared to Iraqi participants. Problems related to the asylum procedure were predominant in interviews with Afghans. *Fear of being sent back* only appeared in interviews with Iraqis who experienced problems in the asylum procedure. Afghans mentioned loneliness more often than Iraqis. *Lack of social support* was dominant among Afghans, as a married 22-year-old Hazara male participant from Afghanistan stated:

> … I do not know anyone there [in the Dutch village where he lived, SG]. Yeah, for example, a friend, or anyone who helps me, let us say. I know two or three friends, let us say, in school, but they are in Assen [a city some twelve kilometers away from the village where he lived, SG]. There, where I live, … there is nothing over there. It is a small village, I think for an old man (Interview in Dutch).

Marriage problems were dominant in interviews with Iraqi participants. *Missing family members* and *problems of not being with family members* who were left behind in the home country were themes among Iraqi participants exclusively, as well as *acculturation differences with family members* and *adaptation problems*. *Worrying and news about (family in) the home country*, *failing legal obligations*, *problems with institutions,* and *problems with the law and/or police* were dominant among Iraqi participants.

Among participants in this study, post-migration stress factors appear to raise doubts about the questions "Who am I?" and "Whom do I belong to". Being physically without family provoked such a strong feeling of psychological connectedness to the family in the home country that participants seem to be left with the perception that part of them has been bereft. Disappointments about their way of living in the host country refer to dissatisfaction with participants' current sense of self and their meaning in society. Fear as experienced by participants designates insecurity about the self and as problematic experienced emotional distance to the other. Language problems limit ways of communication, expressing oneself, and perspectives on exchanging norms and values.

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Acculturation

Interview questions concerning acculturation generated the following codes: *feeling understood* and *perceived cultural differences*. Participants often declared that they did not feel well or only sometimes felt understood, both in general and by clinicians in particular. Many Afghans were more negative than positive about feeling understood, or they had mixed feelings. Iraqis were slightly more positive, although a majority still held mixed feelings. In both groups, residential status did not influence the level of feeling understood. Cultural differences were mostly conceived as being large. Some outspoken participants described them as "differences between heaven and hell" in favor of the host society. *Feeling safe*, *freedom* and *respect* were the most frequently mentioned positive aspects. Some participants specifically declared that they were no longer afraid to go out on the streets, in comparison to in their home country. This was the case in particular for threatened ethnic minorities such as Afghan Hazara and Iraqi Christians.

The most troublesome cultural difference compared to the Dutch was *being far away from family*. This is similar to the PMLP code *not being with family*, but here participants distinguished themselves from Dutch people who were close to their family. The absence of "warm" social contacts in combination with the self-directedness of people in the host country was another frequent acculturation issue. Participants' personal situation in the present and their experiences in the past had a strong influence on the perception of cultural differences. One 25-year-old participant who had experienced problems in Afghanistan because he is a Shiite Hazara and his wife had worked for a foreign company stated:

> What strikes me here is the tranquility. That people do not interfere with one another. That someone is free. Those are the things that are not there in Afghanistan … Here, no one interferes with your religion. It is not like Muslims who interfere with everything. Now I am here, my wife knows I am here. She easily goes to a doctor alone. I am not afraid that something will happen to her. The freedom, the freedom, that people allow each other their freedom (Interview with a Dari interpreter).

The main dilemmas that most participants faced, from an acculturation point of view, was of finding themselves in a much safer place than in their home society, yet experiencing social losses and having to struggle to participate in society. The gain of more freedom to speak and act was challenged by the absence of family members and worries about them. Acculturation difficulties seem to confuse confidence related to participation in the host society, a sense of belonging, and levels of functioning. Mixed feelings about whether or not being understood in the host society threaten participants' feelings of belonging and create feelings of alienation. Perceived cultural differences point in the same direction, but in this case in comparison to people in the host society who live in a family setting and to warm social contacts in the past compared to the present.

Cultural identity

Effects on cultural identity of having experienced PTEs, suffering from post-migration stress, and acculturation difficulties could be identified on a personal, ethnic and social level. Personal identity characteristics such as *age*, *gender*, *marital status*, *education*, *work* and *social class* or *position* appeared to influence the likelihood of experiencing traumas and acculturation problems, or of suffering from post-migration stress. For example, in Afghanistan under Taliban rule, it is considered culturally unacceptable for young women to engage in premarital relationships, receive education in English or work for a state company. Such gender restrictions could lead to personal identification and acculturation problems in the Netherlands when their Dutch counterparts fail to understand these norms and values. In Iraq, women (especially married women) who experienced sexual abuse could suffer from culture-related shame due to the loss of family honor. Post-migration stress related to family issues could permeate personal identity, in the sense of feeling lonely or worthless: "being without family is having no life at all" or "I am safe, but without family." Difficulties in identifying with Dutch peers due to cultural differences equally interfered with feelings of worthlessness, powerlessness and being unappreciated on a personal level.

Ethnicity played a major role in the risk of exposure to trauma, and to a lesser degree, post-migration stress and acculturation problems. Violence against ethnic and other minority groups intervened at the ethnic identity level, especially for Hazara in Afghanistan, and Kurds and Christian minorities in Iraq. Participants often referred to the history of ethnic violence in their country of origin to give meaning to the traumatic events they had experienced. The most frequently mentioned post-migration stress was *being an ethnic minority*, *fear for the safety of their family*, as well as *loneliness* and *lack of social contacts* due to living in an area where members of one's ethnic group are few. The acculturation process was complicated by ethnicity through the avoidance of social contacts with people not of their own ethnic group, and feelings of constrained acceptance and integration.

Social identity aspects such as *family in the host or home country*, *social role or position in the family*, *social status*, *social relations*, *partner relationships*, and *social contacts* were expressed in the context of post-migration stress and acculturation problems more than for experienced traumas. Participants mostly referred to post-migration stress in terms of *feeling socially detached*, *worries about the family*, or *feeling guilty towards the family*. Acculturation problems often denoted cultural differences in social interactions between the "cold" (host) and "warm" (home) society, *acculturation problems among family members*, *intergenerational acculturation differences*, or *the accusation of westernizing too much* made by other Afghans or Iraqis. Participants explained that in both Afghanistan and Iraq, cultural demands require that the eldest son or daughter in a family where the father or mother has been killed should leave school and find work; however, this caused a higher risk for exposure to traumatic events because of the lack of parental protection.

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In conclusion, the many socio-cultural changes following traumatic experiences and post-migration stress result in far-reaching changes in cultural identity on all three levels – personal, ethnic and social – as the two following vignettes show.

Vignette #1

Twenty-year-old Afghan Sahar (a pseudonym) was diagnosed with PTSD, depression and suicidal ideations. Sahar had experienced traumatic events following her refusal to accept a forced marriage to a Sunni man, being Shiite herself and secretly having a Shiite boyfriend. Members of the Sunni family of the man whom Sahar was supposed to marry murdered her boyfriend and raped her in front of her family. Afterwards they also threatened to kill her father, so Sahar and her family fled. In the Netherlands, she attempted suicide by cutting her wrists. At the time of the research, none of the family members held residency status, and all lived in a center for asylum seekers. The conclusion from the interview was that the traumatic events were deeply rooted in a local culture where a girl is not supposed to refuse a proposed marriage. Sahar's refusal violated the honor of the Sunni family, who in turn sought revenge by killing the man she wanted to marry and brutally violating her and thus her family's honor. This led to such a degree of shame that, according to the cultural code, the raped girl would have to take her own life to restore the violated honor of the family, something that Sahar attempted. Fear in her case was deeply rooted in the risk of being kidnapped and forced into marriage, which was anchored in her cultural identity as the eldest daughter (social identity) of a Shiite minority (ethnic identity) who displayed culturally inappropriate behavior related to gender, age and premarital status (personal identity). As a consequence, Sahar felt worthless and guilty in relation to her family, in particular towards her father who suffered from heart problems. She experienced difficulties acquiring the Dutch language, being partly illiterate and uneducated (post-migration stress). And she felt too much shame to enter into social contact with other Afghans, let alone with Dutch peers (acculturation problems).

In this example, Sahar's personal identity as a young woman in Afghanistan who was supposed to marry – and indeed should not refuse a forced marriage – was conceived as problematic and unclear, and was especially troubled by her Shiite ethnic identity and complicated by her social identity as the eldest daughter who is supposed to be a role model.

Vignette #2

A 50-year-old man from Iraq, Salam (a pseudonym), was diagnosed with PTSD after being kidnapped in Syria, where he was visiting an ill sister, three years after his initial arrival in the Netherlands. He had been imprisoned for four or five months in Syria, where he had been mistreated. With the help of another sister, Salam had managed to return to the Netherlands. However, because he had been absent for a long time, his social welfare allowance had been stopped. A neighboring young man frequently started fires in his garden, causing Salam fear. During the interview, Salam revealed that he was Sabi Mendaean, a discriminated and suppressed Christian-related minority that holds John

the Baptist as its prophet. He used to have an active social life during the good times back in Iraq, but in the Netherlands language barriers hampered his social contacts with the Dutch. Furthermore, in the city where he lived peers from his ethno-religious group were rare, therefore he desired to move to another city where other Sabi Mendaeans lived. He felt lonely and useless because he had not been able to work for five years, and acquiring the Dutch language was difficult. His current mental health problems were found to have an impact on his pre-traumatic cultural identity as a middle-aged socially active and economically successful father (personal and social identity) from a Christian-related minority (ethnic identity). The consequences of migration were a lack of social contacts with ethnic peers, loneliness, financial problems and language barriers (post-migration stress), and feeling useless, powerless and unable to participate in Dutch society (acculturation problems).

In this second example, expectations of personal identity – what a middle-aged man from Iraq is supposed to do – and social identity – being economically successful and socially active – as well as ethnic identity – as a Sabi Mendaean – were troubled in the post-migration process of a man who was unable to work, had financial problems, and who lacked social contacts, especially with his ethno-religious peers.

Discussion

The quantitative findings of this study clearly point to a persistent association of post-migration problems with trauma-related psychopathology among 57 Afghan and Iraqi participants, while the number of experienced traumas is not significantly associated with psychopathology. Studies of PMLPs among refugee and asylum seeker populations not in treatment have already shown their impact on psychopathology (Laban et al., 2005; Porter & Haslam, 2005); this study concerns *psychiatric patients* with PTSD and/or anxiety/depression who have been referred to a mental health institute. Even in this group, which experienced a mean of almost ten PTEs, current post-migration stress seems more important for psychopathology than experienced traumas. Apparently, resources for coping with stress fall short after resettlement. The participants in this study seem unable to regain material, psychosocial, financial and other resources after experiencing adversities. In the conservation of resources theory, the loss of valuable resources enhances stress, whereas striving to retain, protect and build these and new resources stimulates stress recovery (Hobfoll, 1989). The findings of this study among traumatized refugees and asylum seekers support this theory.

When differentiating between both groups of patients, the association of PMLPs with psychopathology becomes insignificant for Afghan participants, while it remains significant for Iraqis. Given the socio-demographic characteristics of both groups, this is a remarkable finding.

It could be expected that mostly young, single and low-educated Afghans who are mainly asylum seekers would be more vulnerable to PMLPs than married and middle to highly educated Iraqis with residency security. However, in this study this is not the case. Length of stay in the host country and escalating violence in the country of origin appear to reinforce the association of PMLPs with psychopathology among Iraqi participants. The mean duration of residency of Iraqis in this study is more than twice that of the Afghan participants. The former are unemployed or working below their education level and are more often dissatisfied with their current employment than Afghans, although the employment rate of the latter group is even lower. While it has been shown that length of stay among asylum seekers may lead to an increase in mental health problems (Uribe Guajardo, Slewa-Younan, Smith, Eagar, & Stone, 2016; Laban et al., 2005), dissatisfaction about one's current socio-economic situation, resulting in feelings of uselessness, powerlessness and increased worthlessness, may contribute to mental health problems among refugees as well. During the research period, the threat of the Islamic State in some parts of Iraq was tremendous and dominated the world news. Fears about the fate of family members left in the home country have been found to be a high risk factor for psychopathology (Nickerson, Bryant, Steel, Silove, & Brooks, 2010), and indeed it is one of the most prevalent PMLPs among both groups in this study.

The findings of this study show that acculturation preferences have no significant association with psychopathology. Mean scores for both groups indicate that they have a slight preference for host (Dutch) norms and values over those of their home country, and the interview data reveal a more or less balanced representation of values attached to cultural differences between host country and country of origin. In the interviews, the acculturation process appears to lead to acculturation problems, which in turn influence coping with stress. Uncertainty over being understood and the cultural dilemmas that trouble participants appear to be in line with other, quantitative, studies that conclude that acculturation problems may lead to an increase in mental health problems (Ince et al., 2014). People may find comfort in more freedom of choice and speech compared to their home country, but experience discomfort related to a lack of warmth in social contacts and embeddedness in the host country. In this study, participants experience some level of discomfort in a setting in which they have mixed feelings over being (mis)understood, which lead to questions about who they had been in the past, who they are now, and who they will be in the future. Moreover, most acculturation studies focus on migrants who potentially have sufficient abilities for successful participation in society and the maintenance of their cultural heritage and identity (Fassaert et al., 2011), whereas the participants in this study are constrained by their mental health problems that undermine these abilities. This finding implies that in conjunction with trauma treatment, the resilience of refugee patients should be strengthened through guidance in the acculturation process.

According to the interviews, traumatic experiences, trauma-related psychopathology, post-migration stress and acculturation problems appear to confuse cultural identity among this study group. Trauma seems to be deeply interwoven into the personal, ethnic and social self. Norms and values that constitute an image of the self, and deciding between right and wrong, all of which give direction to every thought and action, touch a deeper level of the self than post-migration stress. In this study, it was found that the context of one's personal life story, including socio-demographic variability, could inform clinicians in terms of how the experience of traumatic events or post-migration stress in particular may have caused the patient to question his or her cultural orientation, which originally would have been self-evident. The relevance of cultural differences in personal identity for PTSD is not limited to Afghanistan or Iraq (e.g., Jobson & O'Kearney, 2008). A focus on ethnic identity offers the opportunity to differentiate within a culture and to increase awareness of the vulnerability of certain ethnic minorities in countries such as Afghanistan and Iraq in terms of experiencing traumatic events. Ethnic minorities from other countries often are more vulnerable than mainstream ethnic groups for these experiences as well, as has been shown in a Somalian case study (Groen, 2009). The disproportionate representation of ethnic and ethno-religious minorities in the study population and deviation otherwise from the majority of the population in the home country is an indication in that direction. When clinicians include the sociocultural context into their treatment sessions, opportunities will arise for a better understanding of role responsibilities within the family that may change after experiencing traumatic events, and even more of consequences of the transition from an interdependent to an independent society (Taylor & Usborne, 2010; Bhugra, 2005).

Forced migration additionally includes cultural bereavement (Bhugra & Becker, 2005), in terms of losses such as being detached from family ties, a lack of meaningfulness in society (work, social status), and being unable to manifest oneself in society (language, education). Post-migration stress intensifies these losses, as the study population is confronted with loneliness, worries about family members in the home country, and experiences of disappointment in the host society. When a clinician succeeds in improving the patient's coping with post-migration stress, then cultural identity may become clearer than before and a more positive condition for trauma treatment may be created.

This study suggests further research including a control group of participants from the same countries of origin who do not receive treatment in a mental health institute. They would most probably have less post-migration stress, fewer acculturation problems and, therefore, a clearer cultural identity. Whether the mental health problems of refugee patients, which disturb their sense of self to some degree already, reinforce acculturation problems remains to be studied further through comparison with such a "healthy" control study group. The findings of this study indicate that cultural identity confusion might be a barrier to recovery from mental health

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problems and coping well with PMLPs. Therefore a controlled study is recommended, focusing on the effects of offering a meaningful life fulfillment, such as (voluntary) work or project activities, in terms of helping refugee patients to recover from trauma-related disorders.
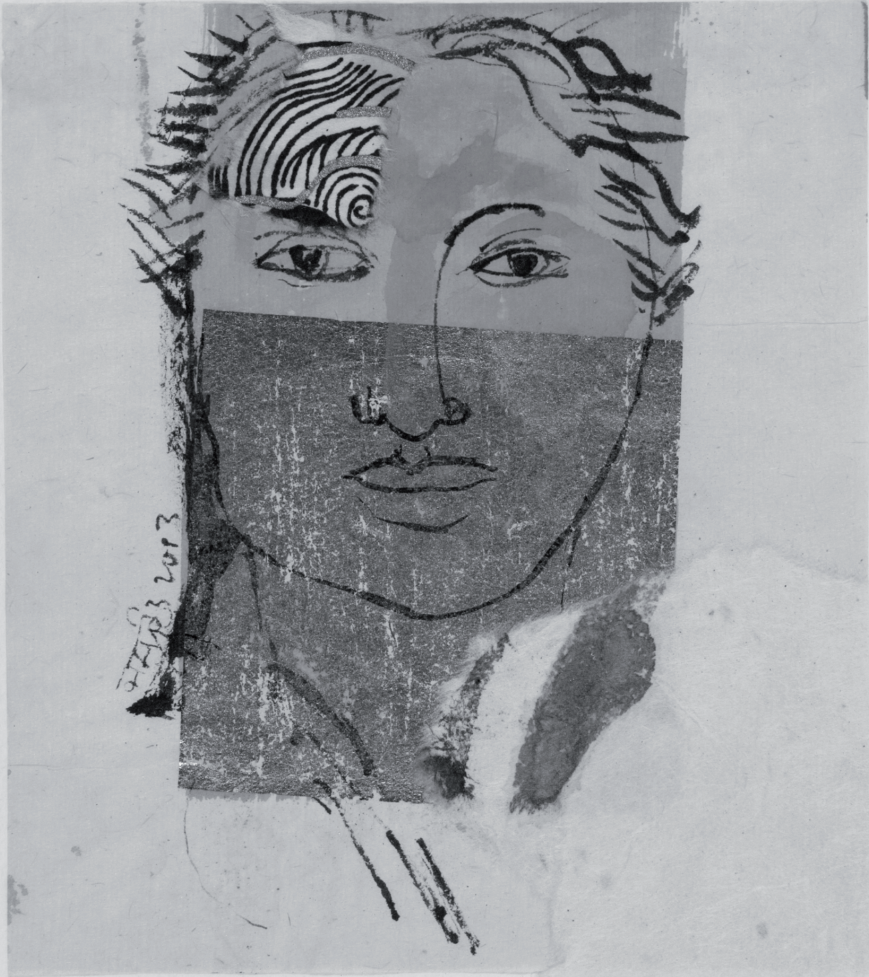
The findings of this study have to be interpreted with some caution. First, the relatively low number of participants limits the generalizability of the outcomes of the quantitative analysis. Taking the scores in some of the analyses into account, associations between acculturation preferences and psychopathology might have become significant if more participants had been included. Second, the sampling of the research population within the restricted research period led to a certain socio-demographic imbalance between Afghan and Iraqi patients, especially in terms of age, marital status, education and juridical position. Reasons for a higher non-response rate among Afghan patients were hard to track down. Often those not wanting to participate refused to give a reason for not participating. We suspect that a high level of shame towards having mental health problems played a role. Further, because most Afghan patients were asylum seekers, they may have been reluctant to participate because of not wanting to endanger their asylum procedure. Although differences in socio-demographic characteristics did not influence PMLPs or acculturation outcomes, if the composition of both groups had been more similar, the quantitative findings might have been easier to interpret. Third, there might be methodological shortcomings in the quantitative analyses, because all participants reported high scores on the HSCL-25 and the HTQ, which may have led to a "restriction of range."

Conclusion and recommendations

The increasing influx of refugee and asylum seeker patients will have an effect on mental health care, due to psychopathology resulting from pre-migration and post-migration stress among these patients. This study indicates that post-migration stress among refugees and asylum seekers not only remains significantly associated with psychopathology after controlling for socio-demographic variables and acculturation, but also suggests a far-reaching effect on cultural identity as the carrier of deep-rooted norms and values. Getting a solid, secure position in the host society as a firm basis for recovery from mental health problems is complicated by being torn between safety and freedom on the one hand, and facing difficulties in adapting to a different socio-cultural order of norms and values on the other. Equally, being released from life threatening stress, but remaining strongly attached to – yet separated from – a sense of deeply rooted meaningfulness (through family, work), is another complication. The findings of this study imply that giving attention by health professionals to (changes in) cultural identity may lead to a better understanding of trauma-related psychopathology and so enhances opportunities for adequate treatment. This implication applies also to refugees from other countries of origin than Afghanistan and Iraq.

Based on our study findings, we recommend that:

- both researchers and clinicians take into consideration that post migration stress and acculturation problems may confuse cultural identity
- both researchers and clinicians bear in mind that fears about the fate of one's family in the home country (e.g., due to war and IS actions) is an important post-migration stressor
- clinicians take into consideration that cultural identity confusion might be a barrier to recovery from mental health problems and adequate coping with post migration stress
- the exploration of changes and confusion in cultural identity will become common use in the clinical assessment and practice with refugees and asylum seekers
- to use the Cultural Formulation as this is helpful in assessing cultural factors affecting the clinical encounter, such as cultural identity, and enhances culturally sensitive diagnosis and care
- clinicians, including psychotherapists, strengthen, in conjunction with trauma treatment, the resilience of refugee patients through guidance in the acculturation process
- research will be conducted among non-patient groups to explore differences in cultural identity confusion between patients and non-patients
- an increased recognition of the value of mix-methods research and an increased implementation of this kind of research, because the combination of qualitative and quantitative methods enhances insight in complicated processes such as the one addressed in this article.

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Chapter 7

Resilience grounded in cultural identity: A comparison between refugee psychiatric patients and non-patients in the Netherlands

Abstract

Experiencing potentially traumatic events (PTEs), post-migration stress and acculturation problems have been identified as risk factors for psychiatric problems among refugees. When the memory of PTEs becomes a central point in daily life and identity, so-called event-centrality, this can be an additional risk factor for psychopathology. After migration and when adapting to another culture and society, these risk factors and psychopathology itself may confuse refugees' cultural identity, defined as incorporated norms and values that are decisive for every thought and action. Some refugees, however, are found to be resilient to developing mental disorders, despite adversity. For this latter group, event-centrality apparently does not play a major role in their lives and they experience no confusion of cultural identity.

This mixed-methods study among 57 patients and 49 non-patients from Afghanistan and Iraq aims to find deeper layers of meaning concerning resilience in the norms and values of cultural identity. The questions addressed are: 1. Which risk factors make the difference among refugees in terms of being a psychiatric patient or not? 2. Is cultural identity confusion different between refugee psychiatric patients and non-patients, and why? 3. How is resilience grounded in cultural identity?

Quantitative results show that non-patients reported significantly fewer PTEs, and less post-migration stress, event-centrality and psychopathology. Post-migration stress was found to be the strongest predictor of psychopathology. Qualitative analysis resulted in four resilience factors: positive cognitive appraisals of the situation; social and religious support; active lifestyle; and orientation towards the future. These resilience factors were found to be grounded in norms and values that constituted non-patients' cultural identity. However, notwithstanding the differences in outcomes, the line between being a patient or not may be thin. Exploration of cultural identity among refugee patients could offer opportunities for mental health professionals to better assist them to increase their resilience.

Introduction

Experiencing potentially traumatic events (PTEs) and post-migration stress have been identified as risk factors for the development of psychopathology among refugees (Bogic et al., 2015). Although there is substantial heterogeneity in prevalence rates across studies, in a meta-analysis comprising over 80,000 refugees from 40 different countries, Steel and colleagues (2009) found prevalence rates up to 31% for both posttraumatic stress disorder (PTSD) and depression disorder. Recent studies have shown that post-migration stress factors, such as a long asylum procedure (Laban et al., 2005), accumulating problems related to length of stay (Uribe Guajardo et al., 2016), and fear for the safety and fate of family left behind (Nickerson et al., 2010) have a significant influence on mental health, more so than PTEs. Problems during the acculturation process, defined as "… the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005:698), may also be a risk factor for psychopathology among minority populations such as refugees (Fox et al, 2017). A growing body of literature indicates that event-centrality is another predictor of trauma-related symptoms (Bishop, Ameral, & Palm Reed, 2018; Ionio, Mascheroni, & Di Blasio, 2018; Wright, 2015). Event-centrality refers to the extent to which traumatic memory forms a central component of a person's identity, a turning point in his/her life story and an everyday reference point (Berntsen & Rubin, 2007). To the best of our knowledge, the association between event-centrality and psychopathology has not specifically been studied among refugees.

Despite all adversities, some refugees are resilient to developing mental disorders. In general populations, "… resilience to loss and trauma … pertains to the ability of adults in otherwise normal circumstances … to maintain relatively stable, healthy levels of psychological and physical functioning" (Bonanno, 2004:20). In the case of refugees, in contrast to general populations, post-migration stressors may be conceived as abnormal yet frequent circumstances. From this perspective, Laban (2015) describes resilience as "… the capacity to maintain or regain health and function ability despite past experiences … and all daily life hassles (post-migration living problems)" (2015:192). Resilience has been found to be a protective factor against the development of psychopathology among refugees (Arnetz et al., 2013), although it does not guarantee enduring psychosocial stability.

Risk factors for psychopathology in refugees may confuse cultural identity in the country of resettlement (Groen, Richters, Laban, Van Busschbach, & Devillé, 2019). Identity is considered to be cultural in situations where cultural differences are potentially relevant. Cultural identity can be described as incorporated "… norms and values that constitute an image that an individual holds of him- or herself, which urges the individual to decide what is right or wrong, what kind of behavior is appropriate or not, [while these] … norms and values are negotiated within the ethnic

or ethnoreligious group(s) to which the individual belongs" (Groen et al., 2018:70). Cultural identity has been found to be associated with acculturation problems and mental health issues in migrants in a literature review by Bhugra (2005). This may be particularly the case for refugees who, per definition, were forced to migrate. Culturally- and contextually-specific aspects of resilience when faced with adversity have been studied among youth (Ungar, 2008), but, to the best of our knowledge, not in relation to the dynamics of change and stability in cultural identity. The main aim of this study is to determine whether a deeper meaning of resilience may be found in cultural identity.

In this mixed-methods study among Afghan and Iraqi refugees and asylum seekers, the following questions are addressed: 1. Which risk factors make the difference among refugees in terms of being a psychiatric patient or not? 2. Is cultural identity confusion different between refugee psychiatric patients and non-patients, and why? 3. How is resilience grounded in cultural identity?

Methods

An exploratory sequential mixed-methods design of quantitative and qualitative methods was applied (Creswell & Zhang, 2009). Quantitative multivariate analyses were carried out to analyze the impact of known risk factors for PTSD and anxiety/depression in a refugee patient group and non-patient group. Qualitative content analysis of semi-structured interviews was conducted to retrieve resilience factors and components of cultural identity. In a comparative analysis of both groups, the grounding of resilience in cultural identity or lack thereof was traced. Ethical approval for the study was granted by the University Medical Centre of the University of Groningen (Protocol ID NL2012.404).

Sample
Study participants included 57 patients referred for treatment for trauma-related mental health problems and 49 non-patients, who were born and raised in Afghanistan or Iraq. Inclusion criteria for the patient group were a diagnosis of trauma-related disorder, born and resident in Afghanistan or Iraq until the age of at least 12, a minimum age of 18 years, and language abilities in Dari, Arabic, Dutch or English. The age of 12 was included to guarantee a certain level of identity understanding and memory of life in one's home country. The same criteria applied for the non-patient group, with the exception that participants in this group were not in mental health treatment during the research period. Exclusion criteria for both groups were substance dependency, florid psychosis and cognitive disabilities. Eventually, 28 Afghan and 29 Iraqi patients, and 23 Afghan and 26 Iraqi non-patients, participated in the study.

Procedure

Patients were recruited during the clinical assessment procedure of the North Netherlands center for transcultural psychiatry De Evenaar between August 2012 and February 2015. An eligible group of 100 patients was invited to participate. After exclusion due to illiteracy, demotivation, unavailability of an interpreter or clinical assessments without the need for further contact (such as when providing second opinions), 91 eligible participants remained. Non-patients were recruited by research assistants between July 2014 and August 2016 through (meetings of) refugee organizations, self-help and educational organizations, posters in Dari, Arabic and Dutch distributed within these organizations, and news posts on relevant websites. An eligible group of 59 non-patients was invited to participate. After receiving informed consent forms addressing the purpose of the study, confidentiality, procedures and participants' rights to withdraw, 62.6% (57/91) of the patients and 83.1% (49/59) of the non-patients agreed to participate. For both groups, the aim was to include an equal proportion of Afghan and Iraqi participants. The required size of the total sample aimed at an effect size (Cohen's f2) of 0.15 (power=0.8; α=0.05) in a multiple linear regression analysis with three predictors and three confounding variables (Cohen, 1988).

All participants were interviewed, psychopathology questionnaires were administered, and subsequently a set of four self-completion questionnaires was handed out with a franked return envelope. The focus of the interview was to elicit cultural factors that could be relevant for consideration in appropriate diagnosis and mental health care, resulting in the composition of a cultural formulation of diagnosis (Lewis-Fernández, 1996).

Instruments

Psychopathology was measured using the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptoms Checklist (HSCL-25). The HTQ assesses the number of experienced PTEs (Cronbach's α was 0.932 in this study) and (30) trauma symptoms (α=0.969). The HSCL-25 contains ten anxiety symptoms and fifteen depression symptoms (α=0.969). In both questionnaires, symptoms are assessed on a 4-point scale (1=not at all, 4=extremely). The cut off score for the HTQ is 2.50 and for the HSLC-25 1.75. Both instruments are culturally validated (Mollica et al., 1992; Mollica et al., 1987).

A fifteen-item socio-demographic questionnaire elicited gender, age, ethnic group, languages, marital status, education, social position, professional occupation, religion and length of stay in the Netherlands. The Post-Migration Living Problems Checklist (PMLP-CL), adapted from Silove and colleagues (1997), contains 20 items assessing the severity of post-migration stress factors, e.g. uncertainty about stay or fear of being sent away, lack of work, money and proper housing, missing and worrying about children and family in country of origin, and discrimination (4-point scale, 1=no, 4=very much; α=0.875).

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Acculturation preferences were assessed using the Cortes Rogler Malgady-Bicultural Scale (CRM-BS), a psychometrically adequate measure (Mezzich et al., 2009b; Groen et al., 2019) that includes 20 items: ten cultural descriptors related to ethnic group (α=0.892) and the same ten descriptors for the host society (α=0.824). A 4-point scale was used (1=not at all, 4=very much). In the analyses, acculturation was operationalized by 1 a ratio score of 'origin' divided by 'host' (α=0.850).

Event-centrality was assessed using the 20-item Centrality of Event Scale (CES), that aims to "… measure the extent to which a memory for a stressful event forms a reference point for personal identity and for the attribution of meaning to other experiences in a person's life" (Berntsen & Rubin, 2006:220). Example questions are: "This event has become a reference point for the way I understand new experiences" and "This event tells a lot about who I am." A 5-point scale was used (1=totally disagree, 5=totally agree). Cronbach's α was 0.967. Psychometric properties of the CES were considered adequate in earlier studies and positively related to PTSD and depression (Berntsen & Rubin, 2007). Since the CES has not been used for homogeneous samples of refugees and asylum seekers, a small-scale pilot among the first seven participants was done, showing good feasibility.

All questionnaires, with specific adaptations for country of origin, ethnic groups, languages and religions, were translated into Arabic, Dari and Dutch by official native language interpreters and controlled by co-interpreters of the Free University Language Center in Amsterdam.

Qualitative data were collected using the Brief Cultural Interview (BCI) (Groen et al., 2017), a semi-structured interview based on the DSM-IV Outline for Cultural Formulation, which includes the following items: cultural identity, cultural explanations of illness, cultural factors in the psychosocial environment and levels of functioning, and cultural elements in the relationship between the individual and clinician (cf. Lewis-Fernández, 1996). With the BCI, the participant's narrative on a range of topics, such as cultural background, language, ethnic group- and ethnicity-related problems, post-migration stress, and acculturation problems, was obtained. An interpreter by phone was arranged when necessary. All interviews were audio-recorded.

Data analysis
Quantitative analyses were conducted using SPSS 23 (IBM Corp, 2015), under supervision of a data analyst (JTVB). Socio-demographic characteristics of the patient and non-patient groups were analyzed with $\chi 2$, Mann-Whitney U test and Independent Sample T-tests. Because of small cell sizes, marital status (with a partner in the Netherlands or not) and educational level (low = primary education, including Quran school, high = > primary education) were dichotomized. Univariate associations were studied using Pearson correlation. Two linear regression analyses

were performed to explore the relationship between both PTSD and anxiety/depression symptoms respectively with the number of experienced PTEs, post-migration living problems (PMLPs), event-centrality and acculturation preferences. In these regressions, a variable identifying patients and non-patients (dummy 1-0) was included and socio-demographic variables that significantly differed between groups were entered as possible confounders. Imputation of the mean was performed for missing values (maximum 2 per scale). To test for the robustness of the models, two stepwise backward linear regressions were done to exclude variables that were not or to a lesser extent associated with psychopathology. Adjusted R squares (ΔR2) and Betas (β) for each predictor variable were estimated. The ΔR2 show the proportion of explained variance of the outcome variable by all analyzed predictors. The β shows the relative contribution in explained variance of the outcome variable for each predictor.

Analysis of results of the BCIs was performed using the qualitative data analysis and research software Atlas.ti 7.5 (Atlas.ti Scientific Software Development, 2014), based on a grounded theory approach (Glaser & Strauss, 1967). Narrative reconstructions were first open coded for cultural identity components and resilience factors. Distinguished components were personal, ethnic and social identity (Groen et al., 2018). Coding of the interviews was performed by the first author (SG) and a research assistant. Sub-codes were used to specify particular fragments (e.g. *RF_flexibility* means resilience factor flexibility) and codes were accumulated in a code list until no further codes were found and saturation was reached. Codes mentioned only once were merged into comparable codes (e.g. *RF_taking on new challenges* was merged into *RF_personality traits*). Upon analysis, the codes were grouped into categories (e.g. *support partner*, *support family*, *support by others*, *religion* and *social contacts* were grouped into *RF_social and religious support*).

Results

The non-patient group differed significantly from the patient group with respect to juridical status, marital status, education, social position in the country of origin, age and length of stay in the host country (Table 7.1). There was no difference with respect to gender or current employment. In the patient group, 42% of participants were asylum seekers (refugees without residence permit) compared to 6% of the non-patient group. Significantly more patients were single and had higher rates of being divorced, widowed or having partners living abroad than non-patients. Non-patients appeared to be higher educated, particularly Afghans (82.6% of Afghan non-patients received more than primary education versus 17.9% of Afghan patients), and had a higher social position in their country of origin than patients. Afghan non-patients were older than Afghan patients, Iraqi non-patients were slightly younger than Iraqi patients.

Overall, the non-patient group was significantly older than the patient group. Both Afghan and Iraqi non-patients had a significantly longer length of stay in the Netherlands than patients.

Table 7.1. Socio-demographic characteristics of the study population of Afghan and Iraqi patients (n=57) and non-patients (n=49)

Variables		Patients Total (n=57)[1] n (%)	Non-patients Total (n=49)[1] n (%)	χ² Value and p Value[2]
Country of origin				χ² (1) = 0.05, p = 0.822
	Afghanistan	28 (49.1)	23 (46.9)	
	Iraq	29 (50.9)	26 (53.1)	
Gender				χ² (1) = 0.31, p = 0.860
	Male	37 (64.9)	31 (63.3)	
	Female	20 (35.1)	18 (36.7)	
Juridical status				χ² (1) = 17.97, p < 0.001
	Asylum seeking	24 (42.1)	3 (6.1)	
	Refugee status	33 (57.9)	46 (93.9)	
Marital status				χ² (1) = 4.78, p = 0.029[3]
	Single	21 (38.2)	17 (36.2)	
	Married/cohabiting	23 (41.8)	31 (61.7)	
	Married/partner abroad	3 (5.5)	0 (0.0)	
	Divorced/not cohabiting	4 (7.2)	1 (2.1)	
	Widowed	4 (7.2)	0 (0.0)	
Children				χ² (1) = 1.91, p = 0.167[4]
	No children	26 (48.1)	17 (34.7)	
	Children in NL/abroad	28 (51.9)	32 (65.3)	
Education				χ² (2) = 13.32, p = 0.001
	None	19 (34.5)	6 (12.2)	
	Primary (and/or religious)	15 (27.3)	7 (14.3)	
	More than primary	21 (38.2)	36 (73.5)	
Social position abroad				χ² (1) = 8.89, p = 0.003
	Low	22 (40.7)	7 (14.3)	
	Middle/high	32 (59.3)	42 (85.7)	
Employment NL				χ² (1) = 3.09, p = 0.079
	Yes	15 (28.8)	22 (45.8)	
	No	37 (71.2)	26 (54.2)	
				t Value and *p* Value[2]
Age				t(104) = -2.16, p = 0.033
	Mean (SD)	36 (12.3)	41 (12.5)	
	Range	17- 59	19- 64	
Length of stay in years				t(87.83) = -4.29, p < 0.001
	Mean (SD)	6.63 (5.5)	12.01 (7.1)	
	Range	0.83-19.25	0.67-25.00	

[1] Totals might differ because of missing values per variable.
[2] Significant at p < 0.05.
[3] Difference between having a partner in the Netherlands and otherwise.
[4] Having children and living with children in the Netherlands are not counted separately.

Risk factors for psychopathology

PTSD and anxiety/depression symptoms, the number of experienced PTEs (median 11 for patients, 3 for non-patients), PMLPs, and event-centrality were significantly lower in the non-patient group. Non-patients showed an average score just below the cut-off point for anxiety/depression (1.74, SD=0.63). However, more than a third (36.84%) of the non-patient group scored higher than the cut-off point (Table 7.2). For PTSD, non-patients scored on average 1.81 (SD=0.67), lower than the cut-off score of 2.50. Between both groups, acculturation preferences were not significantly different.

Table 7.2. Posttraumatic stress disorder (PTSD), anxiety/depression disorder, number of experienced potentially traumatic events (PTEs), post-migration living problems (PMLPs), event-centrality, and acculturation preferences among Afghan and Iraqi patients (*n*=57) and non-patients (*n*=49)

	Patients (*n*=57) (mean, SD)	Non-patients (*n*=49) (mean, SD)	*t, p* Value
PTSD[1]	2.93 (0.55)	1.81 (0.67)	$t(91.79) = 9.16, p < 0.001$
Anxiety/depression[2]	3.02 (0.55)	1.74 (0.63)	$t(93.53) = 10.90, p < 0.001$
Experienced PTEs[3]	9.77 (5.26)	4.55 (4.69)	*MW U, p* < 0.001
PMLPs[4]	2.44 (0.51)	1.93 (0.51)	$t(100) = 4.98, p < 0.001$
Event-centrality[5]	4.11 (0.80)	3.20 (1.02)	$t(84.29) = 4.89, p < 0.001$
Acculturation preferences[6]	0.93 (0.31)	0.90 (0.31)	$t(102) = 0.44, p = 0.663$

[1]Measured by the Harvard Trauma Questionnaire-part 2, Likert scale 1=not at all, 4=extremely
[2]Measured by the Hopkins Symptoms Checklist-25, Likert scale 1=not at all, 4=extremely
[3]Measured by the Harvard Trauma Questionnaire-part 1, *n* events
[4]Measured by the Post-Migratory Living Problems Checklist, Likert scale 1=no, 4=very much
[5]Measured by the Centrality of Event Scale, Likert scale 1=totally disagree, 5=totally agree
[6]Measured by the Cortes Rogler Malgady Bicultural Scale, Likert scale 1=not at all, 4=very much

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Correlations were found between PTEs, PMLPs, event-centrality, PTSD and anxiety/depression, but not for acculturation preferences. PMLPs were more strongly related to PTSD and anxiety/depression, and mildly to moderately related to event-centrality and experienced PTEs.

Table 7.3. Correlations between posttraumatic stress disorder (PTSD) symptoms, anxiety/depression symptoms, experienced potentially traumatic events (PTEs), post-migration living problems (PMLPs), event-centrality, and acculturation preferences among Afghan and Iraqi patients and non-patients (*n*=106)[1]

	PTSD	Anxiety/ depression	Experienced PTEs	PMLPs	Event-centrality
Anxiety/Depression	0.927[2]				
Experienced PTEs	0.449[2]	0.486[2]			
PMLPs	0.635[2]	0.657[2]	0.380[2]		
Event-centrality	0.624[2]	0.618[2]	0.359[2]	0.457[2]	
Acculturation preferences	0.071	0.046	-0.062	0.191	0.176

[1] Pairwise deletion of missing cases.
[2] *p* < 0.001

Event-centrality and post-migration stress were independently associated with PTSD and anxiety/depression. Post-migration stress was the strongest predictor for psychopathology. The number of experienced PTEs and acculturation preferences were not significantly related to psychopathology, nor were age, education, marital status or length of stay. In all analyses, when post-migration stress and event-centrality were controlled for, patients remained significantly more at risk for psychopathology compared to non-patients, but there was no indication for an interaction effect between patients or non-patients and number of PTEs, PMLPs or event-centrality.

Table 7.4. Multivariate linear regression of risk factors for posttraumatic stress disorder (PTSD) (n=95) and anxiety/depression (n=96) in patients and non-patients

	PTSD			Anxiety/depression		
	$F_{(9,86)} = 24.829; R^2 = 0.693, p < 0.01$			$F_{(9,87)} = 30.860; R^2 = 0.737, p < 0.01$		
	Standardized coefficients			Standardized coefficients		
	β	Sig.	95% CI	β	Sig.	95% CI
Constant		0.002	0.374-1.662		0.001	0.481-1.717
Patients	0.390	0.000	0.396-0.884	0.476	0.000	0.586-1.062
Experienced PTEs	0.036	0.600	0.015-0.025	0.024	0.702	-0.016-0.023
PMLPs	0.365	0.000	0.316-0.744	0.348	0.000	0.320-0.724
Event-centrality	0.257	0.001	0.092-0.330	0.259	0.000	0.110-0.339
Acculturation preferences	-0.052	0.384	-0.452-0.176	-0.083	0.132	-0.539-0.072
Age	-0.060	0.471	-0.015-0.007	-0.058	0.455	-0.014-0.006
Education (primary/more)[1]	-0.075	0.267	-0.342-0.096	-0.054	0.384	-0.303-0.118
Marital status (partner/not)[2]	0.055	0.444	-0.141-0.320	0.078	0.233	-0.088-0.358
Length of stay (years)	-0.012	0.883	-0.021-0.018	0.036	0.621	-0.014-0.023

[1] Primary education including Quran school and more
[2] Having a partner in the Netherlands or not

Qualitative analysis of resilience factors

Qualitative analysis of the interviews showed a number of potential reasons why participants in the non-patient group experienced fewer mental health problems. Although these participants had no contact with a mental health professional during the study period, a considerable part of this group had been in touch with a psychologist in the past, and some were thinking of seeking contact with a psychologist in the future. Retrieved resilience factors were grouped into: 1. positive cognitive appraisals of the situation; 2. social and religious support; 3. active lifestyle; and 4. orientation towards the future.

Positive cognitive appraisals of the situation

In the interviews, non-patients argued that their flexibility, strong mentality and open mindedness, all coded as *cognitive appraisals of the situation*, helped them to cope with their problems. *Flexibility* refers to an adaptive attitude towards the host culture. The majority (32/49) appeared to be flexible regarding other religions, the strict rules of their own religion, and social contacts with their own versus other ethnic groups. They reported being able to put their problems in perspective, as well as flexibility regarding adapting to the norms and values of the host society while maintaining those of their home society. The latter can be understood as, for instance, encouraging one's children to obtain an education in order to be independent and self-determined like their Dutch peers, while maintaining adherence to one's cultural roots, for instance by emphasizing the need for children to pay respect to their parents. In contrast, patients showed fewer positive cognitive appraisals of their situation and were more inflexible regarding adapting their norms and values.

Strong mentality (23 quotations) was labeled when participants referred to themselves as proactive, a strong person who laughs a lot, who takes on new challenges, is disciplined, has a strong motivation to build a beautiful life, and places high demands on him-/herself. A 50-year-old Tadjik woman from Afghanistan chose to adapt to the norms and values of the Netherlands, but she needed to convince her husband, who wanted their children to behave as other Afghans:

> That caused a conflict. It was very bad in the house. My husband wanted to choose for family [to make the children less independent than Dutch children]. He wanted to put pressure. … In the end he saw that this was not possible. Then it [the pressure] became less..... Now it is all good. Because he saw the results. That group of one hundred people [of Afghans in the community], those children have done Vmbo and Mbo [practice-oriented secondary education]. And our children, all of them, they received gymnasium [highest level of secondary education] from CITO [institute that tests children for further education after primary school] … Then you know what the difference is (interview in Dutch).

Open-mindedness refers to openness towards others, regardless of country of origin, ethnicity or religion. Patients were overall much less open-minded than non-patients, and if they were open-minded, this had caused problems in their home country (such as conflicts over educating girls in Afghanistan). More non-patients considered themselves open-minded. Some came from communist or humanistic-oriented families and had been taught norms and values different from those of the majority. For instance, a 27-year-old Yezidi man in the Iraqi non-patient group stated: "Friendship does not depend on one's origin" (interview in Dutch). A 48-year-old Shia man in the same group explained that his parents had told him that all human beings are brothers and sisters, despite religious differences. A 28-year-old female non-patient from Afghanistan with a Pashtun father and a Tajik mother referred to her parents as open-minded and "great in their way

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of thinking" (interview in Dutch). Such parents stimulated their children, especially daughters, to study and become independent.

Social and religious support

Non-patients mentioned the availability of support of any kind, but mostly moral and practical social support, more often than patients. If social support was mentioned by patients, the focus was rather on a feeling of loss, and of not being heard and supported by others. Among non-patients, *social support from the partner* (20 quotations), *from the family* (11 quotations) and *from other people* such as friends (4 quotations) was considered helpful in overcoming psychological distress. Non-patients felt they could share their problems, were motivated to remain strong because of their partner's attitude, received help from friends in juridical procedures, and experienced a strong sense of togetherness with their partner and family. *Religion* was also frequently mentioned as a strong support (34 quotations). Most non-patients were Muslim, some Iraqis were from Christian minorities, and some Afghans had converted to Christianity. Praying to God in times of sadness brought a sense of peace, asking for help through prayer restored feelings of hope, and "being close to God" provided norms and values for being a good person. Patients were much more ambivalent towards religion, because they perceived religion to be the source of their problems, considered their religion to be less important in the Netherlands than in their home country, or they did not acknowledge prayer or going to a religious institution as support for their mental health problems. Having a social network was helpful for starting or maintaining an active lifestyle, such as developing *Dutch language abilities*, finding (voluntary) *work* and "*being among others*." Many non-patients mentioned *social contacts* (14 quotations) obtained through Dutch organizations for refugees, self-help organizations and religious institutions as sources of support.

Active lifestyle

Participation in refugee, self-help and educational organizations and religious institutions, mostly in the form of voluntary work, contributed to a more active lifestyle in non-patients compared to patients. This was seen in quotations that were grouped into *being active* (24 quotations), *personality traits* (8 quotations), and being *busy with work* (4 quotations). Many non-patients described psychological problems, such as feeling dismal and lonely, in the initial period after arriving in the Netherlands, just as patients did. Reasons for these problems were *missing family left behind in the home country*, *worrying about family members*, *a long asylum procedure*, *life changes* (having to start all over again), and (too) *high expectations of the host country*. A 30-year-old Afghan woman in the non-patient group described:

> In the beginning, when you move to a new country, it is always difficult … it certainly was difficult for a couple of weeks, until my school started. After that I was so busy to master the language, to be able to continue studying, that I did not have much time to… then you are just, by yourself… Then you grow up with another culture (interview in Dutch).

Patients in most cases were unable to overcome the initial problems and experienced difficulties in becoming active, mostly because they could not connect sufficiently to Dutch society.

In the patient group, mood was often dominated by memories of traumatic events and mental health problems. Among non-patients, *personality traits* referred to self-descriptions such as "not much of a talking person, but someone who is able to learn hard and is much disciplined," "a liberal person," "a patient man," and "being strict with oneself." A 30-year-old female non-patient from Afghanistan persisted in pursuing a higher level of secondary education, against the advice of her school to move to a lower level because Dutch was not her mother tongue: "I am, uhm … very … then maybe more than now … studious, and, uhm … for me it was the challenge that it had to be difficult, because it is then that you learn the most" (interview in Dutch). These examples indicate that certain personality traits were important for adapting to another mentality. Although for most, the level of work they engaged in in the Netherlands was lower than in their home country, satisfaction with their occupation could be regarded as another mentality aspect. A 46-year-old Kurdish male non-patient from Iraq stated:

> I go to schools, mostly they [students] like the flight story. Sometimes they want [someone to tell about] religion. I like that very much. Our foundation [that organizes lectures in schools] wanted to stop, but I did not want that. I said I am going to save the foundation. Next year I am going to be secretary of that foundation. I also worked for social and juridical services (interview in Dutch).

Orientation towards the future
Orientation towards the future is subdivided into *language acquisition* (24 quotations) and *educational opportunities* (15 quotations). Among patients, plans for the future were mostly absent, while hopelessness when thinking about the future was omnipresent. Non-patients stressed that language and education were important for participation in the Netherlands, and this helped them cope with otherwise stressful memories. Their narratives were more future oriented than those of patients, with terms such as "getting chances," "new challenges," "satisfied with educational opportunities" and "a positive future for our children." Non-patients appeared motivated to learn Dutch as soon as possible and had plans for the future after the language course, such as participating as a volunteer or finding work (this included plans to get their diplomas from their country of origin certified in the Netherlands).

Qualitative analysis of cultural identity components
Cultural identity was subdivided into personal, social and ethnic identity. Regarding personal components of their cultural identity, non-patients were much more light-hearted about changes in their personal situation after migration than patients. They more often presented themselves as "Afghan Dutch," "Dutch" or "neither Iraqi nor Dutch." Some participants declared "having stopped with their country of origin," as if they had pushed a mental button to stop thinking

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about life in Afghanistan or Iraq. This attitude did not confuse their personal identity. With respect to education, non-patients more often took part in or completed academic study than patients. A 48-year-old man from Afghanistan considered it very important that he was already highly educated (as a medical doctor), because "… it would be very difficult for lowly educated Afghans to find a job in the Netherlands" (interview in Dutch). Some non-patients had managed to receive higher education in the Netherlands despite the fact that they had not completed primary education in their country of origin. While most non-patients had occupied a high social position in their country of origin, many nevertheless showed satisfaction with a lower social position in the Netherlands.

Ethnic components of cultural identity were not very different between patients and non-patients. Participants in both groups were often from ethnically or religiously mixed parentage or belonged to an ethnic minority. Among Iraqi participants, ethnic minorities were mainly Kurds, Christians and Yezidis, while Afghan participants were Pashtun, Shiite and Sunni Tajiks, Hazara or members of other small minority groups. There were more Pashtun in the non-patient group than in the patient group. In most cases, (mixed) ethnic origin was a key factor in exposure to PTEs and being forced to leave the country, both of which can result in feelings of confusion related to one's ethnic identity. However, non-patients did not perceive their ethnic identity as being confused. A difference between the patients and non-patients was that participants in the latter group were able to put ethnicity, ethno-religious problems and/or minority political orientation and activity into perspective. Non-patients could be proud of their (for instance, Kurdish or Tajik) identity, but were also liberal towards other ethnic groups, showing a humanistic orientation that considers all humans alike. A 50-year-old Afghan woman was proud of her Tajik identity, because she felt that Tajiks are intelligent. She wished a Tadjik husband for her daughter, because in her experience Pashtun men consider themselves the boss, but she also saw that her daughter did not have as many opportunities in the Netherlands to find one. She wanted her daughter "… not to ask for [a] Pashtun [husband], but ask for [a] Tajik [one]. But she does not know [much] about Tajiks. It is important that his family is a family we are able to deal with" (interview in Dutch). Many non-patients were convinced that the ethno-religious problems they had experienced in their country of origin were political and caused by the government. In daily life, they interacted with other ethno-religious groups or individuals, because "we are all human." Among patients, hostility or anxiety towards other ethnic groups were more prominent.

Regarding social components of cultural identity, social consequences after migration appeared to bother non-patients less than patients, and therefore affected their social identity to a lesser extent. Important themes in the patient group were *worries about the family* in both the home and the host country, *failure to fulfill social tasks* within the family, a negative change in *social status*, problems in *social relations* or *partner relationships*,

and far fewer *social contacts* in the host society. The resilience factors *social support* and *active lifestyle*, as found among non-patients, already indicated that they were socially more involved in the Netherlands than patients. Worries about the family were less prominent in the non-patient group because participants had entered into new social groups which offered some form of replacement for their (extended) family in the home country, and they were focused on social contacts with Dutch people, and thus experienced a stronger hold in the Netherlands. Both groups contained participants with family members who had fled to other safe countries. Contacts with them were restricted to telephone and internet. As was the case in the patient group, a considerable number in the non-patient group missed their family, felt lonely without them, and lacked family members to ask for advice. They turned to their nuclear family and took responsibility for their children, while their spouses offered them strength to carry on, as this 54-year-old Assyrian Iraqi man showed: She [partner] is also very strong … [she] has her weak moments every now and then. She saw me also being strong, and that gave her the strength to add something (interview in Dutch).

Non-patients more than patients were convinced that nuclear family members needed to rely on each other, and most experienced fewer difficulties than patients in maintaining their social tasks within the family and fulfilling their role as a father, mother, son or daughter. One Iraqi non-patient was divorced from her husband, but she had a new relationship. Most non-patients, who had had a clearly higher social position in their home country compared to patients (Table 7.1), managed to establish a more or less satisfying position in the Netherlands. They recognized that their social contacts had decreased since leaving their home country, but this was regretted only by some, while others appreciated the reduced social interference they experienced in the Netherlands. Most participants maintained social contacts with people from their home country or ethnic group living in the Netherlands, and/or with Dutch people or those from a variety of backgrounds. Some wished to have more social contacts with the Dutch, others felt too busy or mentioned difficulties engaging with them. Despite the common experience of decreased social contacts, non-patients showed a higher level of social activity and fewer problems with their social identity than patients.

Discussion

The current study used a mixed-methods design to enhance understanding of resilience as a protective factor against the development of psychopathology among Afghan and Iraqi refugees, and to find deeper layers of meaning concerning resilience in their cultural identity. Questionnaires were used to gather data on risk factors for psychopathology as well as psychopathology itself, and semi-structured interviews were employed to gather data on resilience and cultural identity.

Risk factors that make a difference in being a patient or not

The quantitative analysis shows significant differences in psychopathology between patients and non-patients. Although non-patients scored significantly lower than patients for PTSD and anxiety/depression, their average scores for anxiety/depression were only just below the cut-off point, while more than a third of non-patients (36.84%) scored higher than the cut-off. All risk factors for psychopathology (the number of experienced PTEs, post-migration stress and event-centrality) but one (acculturation preferences), as well as psychopathology itself, were significantly less present in the non-patient group, which was composed mainly of refugees with a residence permit. These results may at least partly explain why some refugees developed psychopathology while others were more resilient (Arnetz et al., 2013). In conclusion, even though the non-patient group was less exposed to the various risk factors for psychopathology, there may nevertheless be a thin line between patients and non-patients in terms of perceived need for mental health care.

In the multivariate regression analysis, the number of experienced PTEs was not associated with psychopathology, leaving event-centrality and post-migration stress as the most important risk factors for psychopathology (see Table 7.4). Neither age, being with a partner or not, being high or low educated, nor length of stay altered these results. Post-migration stress was the strongest factor related to psychopathology. These results are in line with findings from other studies that show that post-migration stress, particularly fear for family remaining in the country of origin, has a great impact on psychopathology among refugees (e.g., Chen et al., 2017; Tinghög et al., 2017; Nickerson et al., 2010; Laban et al., 2005). When controlling for these risk factors, there were still differences in terms of psychopathology between the patient and the non-patient group, so there seems to be a need for more contextual information in order to better understand the complexity of the risk factors for psychopathology. Event-centrality also distinguished patients from non-patients; for non-patients, memories of experienced PTEs were not so central in their daily lives and identity. Although non-patients experienced fewer than half of the number of PTEs as patients, this number did not predict the level of trauma-related problems, while event-centrality did.

Differences in cultural identity between refugee psychiatric patients and non-patients

In a previous study, we found that psychopathology, post-migration stress and acculturation problems contributed to cultural identity confusion among Afghan and Iraqi patients (Groen et al., 2019). Results from this study imply that personal, ethnic and social identity among non-patients was less confused than among patients. Changes in personal identity after experiences of trauma and migration were not perceived as unclear or confused by non-patients, who showed more variability or flexibility in their personal identity; some even discarded their old identity or switched between identities. Though they still had potential worries, such as social-

economic decline, their newly acquired safety and freedom were considered more valuable than socio-economic losses or a diminished social position. Among patients, loss of a meaningful personal identity weighed heavily with respect to mental well-being (cf. Groen et al., 2019). While the process of dealing with changes in personal identity might be similar in both groups of participants, non-patients showed a higher level of introspection, which may have made these changes less problematic.

These introspective abilities may also have contributed to perceived changes in ethnic identity. If self-identification, feelings of belonging and commitment to a group, and a sense of shared values and attitudes towards one's ethnic group are secure and strong, positive outcomes for psychological well-being may be expected (Phinney et al., 2001). Non-patients showed more variety in their sense of ethnic pride and were able to switch, for instance, between Tajik or Kurdish pride and a humanistic attitude. Patients, however, conceived of their ethnic identity as problematic, which is recognized as a potential threat to psychological well-being (Khaylis et al., 2007).

Although differences in social identity between patients and non-patients sometimes appeared negligible, at the group level changes in social identity bothered non-patients less. Missing one's family, loneliness, and lacking advice from family members also weighed heavily on non-patients' emotional well-being, but these problems were resolved in the nuclear family in the host country. Non-patients were more successful in achieving social identity continuity, albeit under different circumstances; this has also been found to predict greater life satisfaction and lower levels of depression in Syrian refugees in Turkey (Smeekes, Verkuyten, Çelebi, Açartürk, & Onkun, 2017).

The grounding of resilience in cultural identity
So far, we have identified that the risk factors for developing psychopathology distinguish patients from non-patients, and that the cultural identities in the latter group are less confused. The final step in reaching the main aim of this study, to gain insight into deeper layers of meaning concerning resilience, is to explore how resilience may be grounded in cultural identity. Participants in the non-patient group showed higher cognitive appraisals of their situation, experienced more social support from their partner, family and friends, maintained a more active lifestyle, and kept more focus on future orientation than patients. These were among the psychosocial factors associated with depression and/or stress resilience in diverse populations, as reviewed by Southwick and colleagues (2005).

In the comparison of cultural identity among patients and non-patients, the greater variability and flexibility in the latter group regarding making adaptations in their personal, ethnic

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and social identity after migration seem to indicate norms and values that constitute resilience. One of the explanations for resilience in the non-patient group may be the level of education (Sleijpen, Boeije, Kleber, & Mooren, 2016): the majority finished higher levels of education (up to university), while only a few participants had received just primary education. While low levels of education may implicitly indicate insufficient cognitive capabilities for overcoming adversity, results from the interviews with some of the patients suggest that being highly educated does not guarantee resilience. Non-patients seem to be resilient because they are flexible in their way of thinking, have the ability to look beyond their current life situation, and consider their success as resulting from their hard-working attitude and mentality. The foundations of this flexibility may be found in the way they were raised and how the incorporation of norms and values were developed in their country of origin. With respect to ethnic identity, patients seemed to be more stuck in 'old' tensions (e.g. regarding being an Afghan Hazara, Iraqi Kurd or Christian). Non-patients were better able than patients to distinguish between the political situation and human interactions in their country of origin resulting in a more humanistic attitude. Their willingness to engage in social interactions in the Netherlands despite cultural differences, and the mobilization of moral support in times of need, helped them to maintain an active lifestyle. Strong social identity supported the conviction that acquiring the Dutch language and educating themselves were important for orienting towards the future. In conclusion, resilience factors seem to be grounded in the norms and values of all components of cultural identity.

Strengths and limitations

One strength of the study is its mixed-methods approach, which allows for in-depth understanding of the quantitative findings. Another strength is the large sample of participants available for the qualitative analysis. However, the study results also have to be interpreted with some caution. Firstly, in the selection of eligible non-patient participants, those in current psychiatric treatment were excluded, but a history of past psychiatric treatment was not an exclusion criterion. Some of the non-patient participants appeared to have received psychiatric treatment and some were considering seeking psychological help. For this reason, boundaries between the patient and non-patient groups may not be that clear. However, this ambiguity also strengthens the quality of the analysis, because the non-patients maintained higher resilience than the patients, despite past psychological needs. Secondly, the recruitment of non-patient participants was executed through self-help and other organizations, which led to a select group of refugees characterized by higher Dutch language capabilities, higher education, and higher levels of social interaction. These differences may already have distinguished patients from non-patients. However, the interviews showed that at an individual level, language abilities in the patient group were such that in some cases an interpreter was unnecessary, while in the non-patient group a family member was sometimes needed for Dutch language assistance in completing the interview. As such, to explain differences between patients and non-patients, personal attitudes were found

to be more important for communication than language abilities. Thirdly, only participants from two countries of origin were included in the study, which limits the generalizability of the results. Studies among other groups are recommended. Fourthly, the results might be influenced by differences in juridical status between the patients and non-patients. Those with residency status were, however, still the majority in the patient group (57.9%), and juridical status made no difference in the multivariate regressions.

Conclusion

Compared to the group of Afghan and Iraqi refugee psychiatric patients, a non-patient group of Afghans and Iraqis showed lower levels of psychopathology and fewer post-migration problems. Although the latter group was also confronted with PTEs, these were lower in number and were not as central in their daily life or cultural identity. Non-patients showed more resilience than patients due to higher cognitive appraisals of their situation, more social and religious support, a more active lifestyle and greater future orientation. These resilience factors were grounded in norms and values that constitute cultural identity. An exploration of cultural identity in refugee psychiatric patients may offer opportunities for mental health professionals to better understand how to increase resilience in their patients by finding ways to enhance cognitive appraisals of their situation, mobilize social and religious support, and offer advice for leading an active lifestyle and setting goals.

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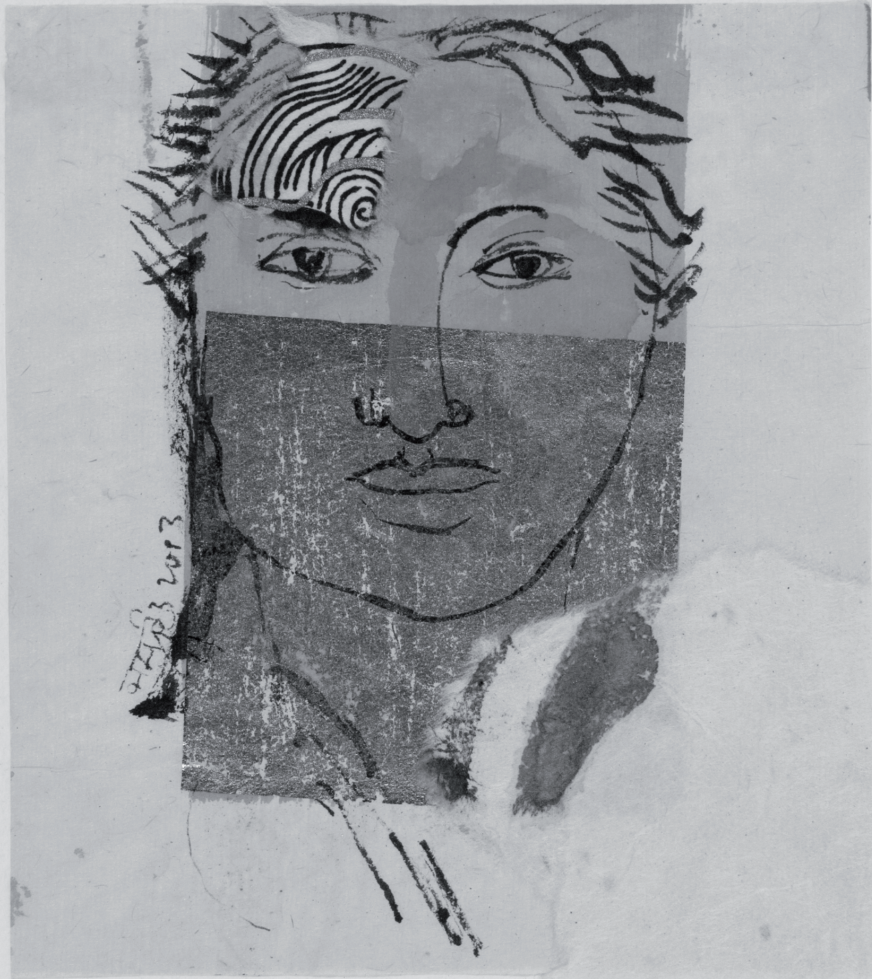
Chapter 8

General discussion

This thesis has explored the relations between cultural identity and psychopathology among refugees. In the case of refugees, experiences of traumatic events, displacement, forced migration, and post-migration stress raise profound questions about the relationship between cultural identity and psychopathology. These questions address current debates on epistemological and methodological issues, as well as practical implications in the field of transcultural psychiatry. Epistemological issues concern clarification of the concept of cultural identity in relation to mental health and the enhancement of our knowledge about how to understand individual perceptions of mental health problems. Eliciting cultural factors that may influence the perception of mental health problems is an ongoing process in the field. Methodological issues concern the search for adequate methods to identify these cultural factors in order to make diagnosis and treatment culturally sensitive. Practical implications include making use of developed knowledge to enhance the cultural competence of mental health professionals.

After the experience of traumatic events that may cause mental health problems, refugees – people who are forced to migrate – often experience post-migration stress, which may reinforce these mental health problems. These traumatic and post-traumatic experiences may lead to questions among refugee psychiatric patients about who they were in the past, who they are now, and who they will be in the future. What these questions may imply for their perception of their mental health problems, and the relevance and role of questions concerning cultural identity and how they may be addressed in culturally sensitive diagnosis and treatment, have, to the best of my knowledge, so far remained unclear. This thesis aims to contribute to a better understanding of these questions.

The main research questions that guided the research project underlying this thesis were:

1. What is the relation between cultural identity and psychopathology?
2. What is the relation between potentially traumatic events and post-migration living problems on the one hand, and cultural identity on the other?
3. What are the implications of the answers to the first two questions for mental health professionals, with respect to person-centered and culturally sensitive diagnosis and treatment?

Brief outline of the study

The exploration of the relation between cultural identity and psychopathology started with a Brief Cultural Interview (BCI) with a male patient from Somalia at De Evenaar, a center for transcultural psychiatry. The exploration revealed that information concerning this man's cultural identity appeared to be crucial for gaining a better understanding of his mental health problems

(**chapter 2**). This case study triggered questions about the role of cultural identity in the emergence and persistence of mental health problems among refugees, and about the process of eliciting cultural factors in clinical assessment.

An evaluation of the BCI was required in order to ensure that this instrument was feasible, acceptable, and clinically useful in psychiatric practice (**chapter 3**). Because cultural identity has been denoted as complex, multilayered, and fluid, a previously developed supplementary module containing themes and questions concerning cultural identity, part of the Cultural Formulation Interview that was included in the DSM-5, is described (**chapter 4**), based on the work of mental health professionals in the field of transcultural psychiatry.

In order to understand how patients themselves perceive their cultural identity, and which elements are relevant to them, interview reports were conducted based on BCIs among 85 Afghan and Iraqi refugee psychiatric patients. These reports were subsequently analyzed. To ascertain whether cultural identity could be relevant for a better understanding of mental health, in particular the cultural aspects of mental health, relations between elements of cultural identity and stress and, in addition, acculturation were analyzed (**chapter 5**).

Relations between cultural identity and mental health among 59 newly included Afghan and Iraqi psychiatric patients were further explored in an analysis of the risk factors for psychopathology: experienced traumatic events, post-migration stress, and acculturation problems (**chapter 6**). Finally, risk factors for psychopathology and cultural identity were compared between the 59 refugee psychiatric patients and 48 Afghan and Iraqi refugees who were not in mental health care. In addition, reasons for being resilient, or not, were evaluated according to the way in which these resilience factors were grounded in cultural identity among non-patients (**chapter 7**).

In this discussion chapter (**chapter 8**), the main findings of each of the previous chapters will be presented, followed by a discussion of these findings according to the three research questions. The chapter will conclude with some methodological reflections, an overview of the strengths and limitations of this study, implications for future studies, and some final remarks.

Main findings

Cultural identity and psychopathology
The origin of this study lays in the exploration of the cultural identity of a Somali man with mental health problems who was not responding to the therapy offered to him, but who showed a

remarkable change of attitude and behavior after he was asked about his cultural identity, and more specifically about the clan in Somalia to which he belonged (**chapter 2**). This specific topic, somewhat serendipitously, opened up the sociocultural context of the mental health problems that had till then remained hidden to the psychiatrist treating him. The exploration started with a question that had probably never been considered relevant in the diagnosis of his mental health problems and subsequent treatment. By relating his meaningful past to his current situation in the Netherlands, the patient began to see new opportunities for recovery that most probably would have otherwise remained hidden.

In **chapter 3**, the Brief Cultural Interview (BCI) was evaluated in order to ascertain whether the questions were feasible, acceptable, and clinically useful. The BCI is a practical tool to gather information about the components of the Outline for Cultural Formulation (OCF) in the DSM-IV (and later the DSM-5): cultural identity, cultural explanations of the individual's illness, cultural factors in the psychosocial environment and levels of functioning, and cultural elements of the relationship between the patient and the clinician. The BCI was found to be feasible, acceptable, and clinically useful. In comparison to the original Cultural Interview (CI), which was introduced in the Netherlands in 2002, conducting the BCI as well as constructing ad hoc reports of the BCI were found to be less time-consuming. Furthermore, patients understood the questions better, and the outcomes for a cultural assessment for the purpose of culturally sensitive diagnosis and treatment were at least comparable to the original CI, in the sense that mental health professionals considered them useful.[1]

Chapter 4 describes themes in the Supplementary Module of the Cultural Formulation Interview (CFI). The CFI addresses cultural identity as one of the components of the OCF in the DSM-5 handbook on the Cultural Formulation Interview (CFI). This Supplementary Module is a semi-structured questionnaire that may be used to further explore cultural identity, after the core CFI has been used. In this questionnaire, cultural identity is related to patients' national, ethnic, and racial background, as well as to language and migration. An anthropological understanding of cultural identity is aimed at addressing its complexity and diversity, so as to provide the clinician an opportunity to explore cultural identity for a better understanding of patients' perspectives on health, illness, and the mental health system in the host country.

The division of cultural identity into different themes in the Supplementary Module was then challenged in **chapter 5** by empirical research based on a grounded theory approach. Interview reports from 85 Afghan and Iraqi refugees and asylum seekers were analyzed in order

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[1] An interview with Andrew Ryder about the evaluation of the BCI, as published in an article in *Transcultural Psychiatry* (included in this thesis as chapter three), can be found in a podcast on the homepage of the journal.

to differentiate cultural identity into domains. In the qualitative analysis of the interviews, I gathered items from the full BCI reports that seemed to be related to cultural identity. I then grouped the items, resulting in the distinction of three domains within cultural identity: personal, ethnic, and social. Interrelationships between these domains on the one hand, and interrelationships of both psychological stress and acculturation with each of these domains on the other, were identified: from the individual perspective (personal identity); amplifying from individual meanings to the most meaningful social environment (ethnic identity); and socially contextualizing within the wider social environment (social identity). Each of these domains proved to be related to both stress and acculturation.

Chapter 6 relates cultural identity to psychopathology and risk factors for psychopathology with a newly included group of 59 Afghan and Iraqi patients. In the part of this chapter addressing the qualitative research findings, experienced traumatic events, post-migration stress, and acculturation problems appeared to contribute to a confusion of cultural identity among the Afghan and Iraqi participants.

In **chapter 7**, the same patient group of 59 Afghan and Iraqi patients was compared to a group of 48 Afghan and Iraqi participants who were not receiving mental health care. Apart from analyzing differences in experienced traumatic events, post-migration stress, acculturation preferences, and psychopathology, both groups were compared with respect to whether experienced traumatic events were central to their cultural identity. Resilience factors identified in the non-patient group were found to be grounded in cultural identity.

Potentially traumatic events, post-migration living problems, and cultural identity
The second research question focused on pre-migration potentially traumatic events (PTEs) and post-migration living problems (PMLPs) as potential life-changing factors in the daily lives of refugees, as well as regarding their cultural identity. PMLPs are the outcome of the Post-Migration Living Problems Checklist, the quantitative equivalent of post-migration stress in the interviews. At this point in the study, in **chapter 6**, mental health differences between Afghan and Iraqi participants were initially quantified in order to obtain more insight into the mental distress that may put pressure on cultural identity, potentially leading to some kind of stress and confusion. In this study, research participants experienced an average number of almost ten PTEs (SD=5). The reported severity of Posttraumatic Stress Disorder (PTSD) among all participants was 2.93 (SD=0.55), and the reported severity of anxiety/depression was 3.01 (SD=0.55), both on a scale of 1 to 4 (1=not at all, 4=extremely). In **chapter 7**, a comparison with Afghan and Iraqi non-patients showed that the differences between non-patients and patients were significant: non-patients reported 1.81 (SD=0.67) for PTSD and 1.74 (SD=0.63) for anxiety/depression. These non-patients reported less than half the number (4.55, SD=4.69) of experienced PTEs than patients

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(9.77, SD=5.26). There was no significant relation between the number of experienced PTEs and psychopathology (see table 4 in **chapter 7**).

In **chapter 6**, the mean PMLP was assessed at 2.44 (SD=0.52) on a 4-point Likert scale (1=no, 4=very much). There were significant correlations with PTSD and anxiety/depression, but not with PTEs or with acculturation preferences. In the multivariate regressions that included the confounders of age, sex, and juridical status, PMLPs remained the only risk factor for psychopathology. In **chapter 7**, PMLPs were compared between a patient group and a non-patient group. The non-patient group had a mean PMLP of 1.93 (SD=0.51), which was significantly lower than in the patient group. In the multivariate regressions with the confounders of age, education, marital status, and length of stay in the Netherlands, PMLPs remained significant for PTSD and anxiety/depression.

In **chapter 7**, the relation between experienced traumatic events and cultural identity was measured in terms of event-centrality. Event-centrality concerns the centrality of traumatic events in terms of cultural identity. In the patient group, event-centrality was 4.11 (SD=0.80) on a 5-point Likert scale (1=totally disagree, 5=totally agree). In the non-patient group, event-centrality was 3.20 (SD=1.02). Traumatic events were more central in the cultural identity of patients than in the cultural identity of non-patients. Together with PMLPs, event-centrality was the only remaining significant factor in the multivariate regressions on PTSD and anxiety/depression.

In **chapter 5**, cultural identity was qualitatively analyzed on the basis of the reports of BCIs with 85 Afghan and Iraqi refugee psychiatric patients. The content analysis led to a distinction in the domains of personal identity, ethnic identity, and social identity. In **chapter 6**, codes that referred to experienced traumatic events, post-migration stress, and acculturation problems were grouped into the three cultural identity domains. The concept of experienced traumatic events, as used in the qualitative analysis, is similar to the concept of PTEs as measured by the Harvard Trauma Questionnaire (HTQ), which was also used in this research. In the qualitative interviews, participants did refer to traumatic events that are not included in the HTQ. The concept of post-migration stress, as used in the qualitative analysis, is similar to the concept of PMLPs as measured by the Post-Migration Living Problems-Checklist (PMLP-CL) which was used in this research. In the qualitative interviews, participants did refer to post-migration stressors that are not included in the PMLP-CL. The concept of acculturation problems, as used in the qualitative analysis, is different from the concept of acculturation preferences as measured in the Cortes Rogler Malgady Bicultural Scale (CRM-BS). In the CRM-BS, participants respond to ten items on a 4-point Likert scale, though these items are not specifically acculturation problems. In the qualitative interviews, participants responded to questions about whether they felt

themselves to be understood in the Netherlands, and about cultural differences between the Netherlands and their country of origin.

In the qualitative analysis, experienced traumatic events, post-migration stress, and acculturation problems appeared to confuse all three domains of cultural identity. Personal identity appeared to influence the likelihood of experiencing traumatic events, post-migration stress, and acculturation problems, resulting in feelings of worthlessness. An overrepresentation of ethnoreligious minorities in the sample resulted in a major role of ethnic identity in the experience of traumatic events, but may also underline the vulnerability of ethnic minority groups in many conflict areas. Feelings of loneliness and fear for the ethnic minority family in the country of origin were identified post-migration stressors, and the avoidance of social contacts was identified as an acculturation problem. Both influenced ethnic identity; examples are provided in **chapter 6**. Post-migration stress and acculturation problems confused social identity more than experienced traumatic events.

In **chapter 7**, in contrast to previous chapters, a non-patient group was included and resilience factors were retrieved from the reports of the BCIs with the participants in this group. These resilience factors included: a positive cognitive appraisal of the current life situation, the availability of social and religious support, an active lifestyle, and an orientation towards the future. Norms and values underlying these resilience factors appeared to be grounded in all three cultural identity domains.

Implications for mental health professionals

The research findings indicate that information about cultural identity contributes to a better understanding of the mental health problems of patients who have a cultural frame of reference different from that of their mental health professionals. In several chapters, recommendations for clinicians are given. In **chapter 2**, the case study of a Somali patient shows that asking about his cultural identity delivered additional information relevant for the clinical assessment with respect to the causes of his mental health problems and lack of improvement from treatment. The psychiatrist treating him was offered a contextualization of these mental health problems, where the cultural identity of the patient played an important role. This information about cultural identity resulted in an understanding of the patient's mental health problems that proved more relevant than information received about cultural explanations of the illness. That the previous treatment had been unsuccessful can be attributed to a lack of knowledge about the patient's cultural identity. The advice previously given to the patient to engage with others with a similar cultural background in order to become more socially active was not followed because of his cultural identity as a stigmatized Yibir in Somalia; this cultural identity also complicated his social interactions with other Somalis in the Netherlands. After the BCI had been conducted, a positive change of behavior was noticed by the mental health professional.

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In the evaluation of the BCI in **chapter 3**, three implications for mental health professionals are provided. Firstly, the BCI can be clinically useful in treatment evaluations by clinicians on the topics of acculturation and cultural identity, more than cultural explanations of illness. Secondly, a mental health professional may benefit from an exploration of the cultural background of his or her patient when he or she regards the patient as the cultural expert. Thirdly, adopting an ethnographic approach through the conducting of the BCI contributes to an in-depth understanding of mental health problems. Such an approach starts from the microcosm of the interviewee and expands to the norms and values concerning the experience and course of the patient's mental health problems, in order to contribute to a more comprehensive view of these mental health problems.

In **chapter 4**, we postulate that a person-centered approach may deviate from the symptom-centered approach that is commonly used in Western-oriented medicine, although in this field in the past years a patient-centered approach is advancing. The chapter concludes with two key points that may be relevant for clinical practice: 1. aspects of a patient's cultural identity can affect the type and severity of risk factors for mental health problems; and 2. exploration of these aspects may improve patient engagement and the clinician's understanding of the patient's mental health problems. For mental health professionals, information about the cultural identity of their patients may improve the diagnostic and treatment process, as well as the treatment relationship with the patient.

In **chapters 5 and 6**, respectively four and six recommendations for mental health professionals in terms of cultural competency are given. Based on the research findings, the conclusion of **chapter 4** confirms that information concerning cultural identity may assist mental health professionals to develop a more comprehensive perspective on the mental health problems of their patients. Such a perspective contains a consideration of the illness of the patient from the viewpoint of the patient onto the whole person's perspective, thus contributing to person-centered care. The presented framework for cultural identity, with its distinctions of personal, ethnic, and social identity, as developed in **chapter 5**, is a simplification of the complexity of cultural identity. Therefore, mental health professionals are recommended to take the broad range of cultural aspects in the framework of personal, ethnic, and social domains of cultural identity as a starting point, but not to limit themselves to these aspects. They should take their patient as the source of contextual information. Another recommendation for mental health professionals is to be aware of the risk of stereotyping, and not to consider all persons from one country of origin to be alike; this is also mentioned in **chapter 1**.

In **chapter 6**, two vignettes are presented to illustrate far-reaching changes in cultural identity as a consequence of having experienced PTEs, post-migration stress, and acculturation problems. These illustrations aim to clarify how risk factors for psychopathology also confuse incorporated norms and values of cultural identity. When mental health professions do include the sociocultural context of mental health problems into their diagnosis and treatment sessions,

opportunities will arise for a better understanding of role responsibilities within a patient's family, which may change after experiencing traumatic events, and even more so regarding the consequences of the transition from one type of society to another. Furthermore, when a mental health professional succeeds in improving the patient's coping mechanisms for post-migration stress, it may be expected that cultural identity may become clearer than before and a more positive condition for trauma treatment may be created.

Finally, the research findings as presented in **chapter 7** may lead to a better understanding of how to increase resilience in refugee psychiatric patients, resulting in finding ways to enhance positive cognitive appraisals of their situation by mobilizing social and religious support, and by offering advice for adopting an active lifestyle and setting goals for the future.

Discussion

Cultural identity and psychopathology
The main epistemological issue in this study concerns the concept of cultural identity and its relation to psychopathology. Knowledge about the concept of cultural identity, as well as of ways to acquire this knowledge and the legitimization of this acquired knowledge, needs to be enhanced. Although the BCI covers all domains of the OCF, cultural identity was clearly the largest contributor towards a better understanding of the case study of a Somali patient, as shown in **chapter 2**. In this case study, the patient's belonging to an ethnic minority, more specifically a clan that falls outside of the clan structure in Somalia, was not only the key element in causing the experienced traumatic events, but was also key to his coping style and attitude, and his interpretation of his current psychosocial situation in the Netherlands.

Rethinking the surprising effect of the dialogue about this patient's cultural identity, several analytical thoughts crossed my mind. From an observatory point of view, I wondered about his reaction when we started talking about his clan, which was clearly filled with joy: "That is what it is all about!" Did the question concerning ethnic minorities provoke positive, healthy, and powerful emotions that were hidden underneath a depressive state? From an interpersonal point of view, I wondered whether the interest of a Dutch researcher in his cultural identity, which is presumably much safer to talk about than traumatic events, led to the recognition of him as a meaningful person rather than a patient?

In **chapter 2**, I reached the conclusion that there is more to cultural identity than just the background of cultural explanations of a patient's mental illness. This conclusion is supported by Bhugra and colleagues (1999), who postulate that the relationship between cultural identity and mental health has been underestimated by mental health professionals and that

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there is an urgent need to place cultural identity back at the core of a patient's well-being. Furthermore, mental health professionals should take cultural identity into account in order to understand the social and individual functioning of these patients (Mezzich, Ruiperez, Yoon, Liu, & Zapata-Vega, 2009b).

In several publications with single case studies based on the OCF, cultural identity also seems to play a relevant role in the process of gaining an enhanced understanding of mental health problems (Bucardo, Patterson, & Jeste, 2008; Streit, Leblanc, & Mekki-Berrada, 1998). Within the academic field of transcultural psychiatry, there seems to be sufficient recognition that gathering information about cultural identity is required for a better understanding of the mental health problems of individual patients. However, a better conceptualization of cultural identity is needed. There should be guidelines to indicate how to approach cultural identity in clinical situations, and ways should be found to understand how information about cultural identity may influence diagnosis and treatment (Bäärnhielm & Scarpinati Rosso, 2009). In this study, these questions are addressed by exploring cultural identity in two groups of refugee patients with mental health problems. Can the findings from individual studies to some extent be generalized for larger culturally diverse patient populations?

Before answering these questions, we needed to determine whether the available tool for collecting information about cultural aspects is feasible for eliciting cultural identity in a clinical assessment. In comparison to the original longer version of the Cultural Interview, the BCI is found to be more feasible and acceptable, while the clinical utility is comparable. The BCI is a narrative instrument that is different from diagnostic instruments in psychiatry (Csordas et al., 2010). A narrative approach is more suitable for eliciting cultural identity, which has been denoted as fluid, ever-changing, complex, and multilayered (Rohlof et al., 2009; Ton & Lim, 2006; Bhugra, 2005).

The complexity of cultural identity as a concept is addressed in the definition provided in **chapter 4**, which also reveals that ethnic identity is often a crucial aspect of a person's overall cultural identity. Ethnic identity is a person's perceived identity based on his or her ethnos, which is Greek for 'folk'. Nowadays, ethnic identity is regarded as part of national identity; though in relation to nationality, ethnicity is a smaller unit. In anthropology, ethnicity refers to "… aspects of relationships between groups which consider themselves, and are regarded by others, as being culturally distinctive" (Eriksen, 1993:4). Exploring this group identity is a means of looking beyond national identity, as the case study in **chapter 2** shows. Therefore, we may consider ethnic identity as a group identity that enables concentration on a specific meaningful area.

The expectation beforehand was that an in-depth understanding of cultural identity, by means of analyzing interview reports, including attention to ethnic diversity within the sample, would reveal more detail than was known before. Such detail would include the domains of which cultural identity consists, how these domains relate to perceived stress and psychosocial changes in the acculturation process, and how these findings correspond to findings in other studies. The division of cultural identity into personal, ethnic, and social domains is in line with several publications on identity and mental health among multicultural groups. In these publications, connections to mental health are made with regard to personal identity (Jobson & O'Kearney, 2008; Radden, 2004), ethnic identity (McKenzie, 2008; Phinney et al., 2001; Vega & Rumbaut, 1991), and social identity (Smeekes et al., 2017; Taylor & Usborne, 2010).

The division into these three domains helps us to get a better grip on cultural identity – as it is conceived of as multilayered – and on how cultural identity may be related to mental health. Supported by the available literature, we were able to analyze how participants described stress and psychosocial changes due to acculturation in the various cultural identity domains. Within the personal domain, which consisted of the items age, gender, marital status, education, work, and social class (table 2 in **chapter 5**), the findings suggest that personal norms and values had become unclear due to adversities that the participants had experienced, as well as the mental health problems these experiences had caused. This finding is in line with the suggestion that:

> [M]ental disorder inevitably challenges traditional ideas about personal identity since, as the notion of disorder suggests, it can profoundly alter and transform its sufferer, disrupting the smooth continuity uniting earlier and later parts of subjectivity and, viewed from the outside, of persons and lives (Radden, 2004:133).

One of the most challenging changes in traditional ideas about personal identity that has been observed is the transition from an interdependent to an independent society. In a comparison between trauma survivors with and without PTSD from independent and interdependent societies, Jobson and O'Kearney (2008) found more trauma-related personal goals, memories, and self-cognition in trauma survivors with PTSD from independent societies, than those without PTSD. They did not, however, find differences between trauma survivors with and without PTSD from interdependent societies. These findings suggest that refugee patients from interdependent societies have to deal with more psychosocial changes in their personal identity than refugee patients from independent societies. Participants in the present study from Afghanistan and Iraq were from so-called interdependent societies. Although no comparison with patients from independent societies was performed, the findings of the present study do indicate that the participants had difficulties adapting their personal identity to independent Dutch society.

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Using the same comparison between these two types of societies, Bhugra (2005) coined the term "cultural congruency." Refugees who originate from interdependent societies are more vulnerable to mental distress or mental disorders than refugees who originate from interdependent societies when they migrate to a society that is more culturally congruent with their home society. An important consideration is that this vulnerability still depends on personality traits. The study findings in **chapter 7** seem to confirm this consideration. In the comparison between refugee psychiatric patients and refugees without PTSD or anxiety/depression, one possible explanation for resilience in the latter group was a higher level of cognitive abilities to be flexible, to overlook their current life situation, and to consider success as a result of a hard-working attitude and mentality. These resilience factors seem to depend highly on individual traits. Therefore, in efforts to gather information about the cultural identity of patients, it should not be underestimated that there could be individual traits that may be more relevant than cultural aspects.

In conclusion to the first research question, a framework of cultural identity that distinguishes personal, ethnic, and social identities offers a perspective on a patient's intrapersonal well-being, connections to the most meaningful environment where norms and values are exchanged, and social interactions in the local society. This framework additionally shows that each of these identities could be related to mental health and cultural issues. Therefore, perceptions of these issues on the personal, ethnic, and social level could potentially be distinguished, thus enabling a concentration on clearly recognizable domains of cultural identity. Each of these domains could also be related to resilience factors in a group of non-patients, which may enable a better understanding of the lack of resilience among patients in personal, ethnic, and social domains.

Potentially traumatic events, post-migration living problems, and cultural identity
The second research question focuses on potentially traumatic events (PTEs) and post-migration living problems (PMLPs), as well as cultural identity, in relation to psychopathology. To put the average number of ten experienced PTEs in our study population into perspective, the maximum number of PTEs according to the Harvard Trauma Questionnaire is twenty. An accumulation of exposure to PTEs is one of the main predictors for severity of PTSD and depression symptoms (Knipscheer, Sleijpen, Mooren, Ter Heide, & Van der Aa, 2015). PTSD was assessed at 2.93 (SD=0.55) for the entire group. Anxiety and depression were assessed at 3.01 (SD=0.55). Both scores were above cut-off scores. A recent study among Syrian refugees who have resettled in Sweden confirms the relation between PTEs, especially exposure to interpersonal violence, and PTSD, anxiety, and depression (Tinghög et al., 2017). A systematic review aimed at describing mental health problems among Afghan refugees (including asylum seekers) resettled in industrialized countries found a moderate to high prevalence of depressive and posttraumatic symptomatology (Alemi et al., 2014). A systematic review reporting the prevalence rates of psychopathology among Iraqi refugees in Western countries resulted in an 8% to 37.2% prevalence of PTSD and

a 28.3% to 75% prevalence of depression (Slewa-Younan, Uribe-Guajardo, Heriseanu, & Hasan, 2015).

The present study findings among Afghan and Iraqi psychiatric patients, as presented in **chapters 6 and 7**, show that post-migration stress is the main risk factor for PTSD and anxiety/ depression, rather than the number of experienced PTEs. Several studies have found similar results (Carswell et al., 2011; Laban, Gernaat, Komproe, Van der Tweel, & De Jong, 2005; Porter & Haslam, 2005). A study among "ordinary" primary care immigrants in Italy suggests that experienced PTEs contribute to a low capacity to handle post-migration stress (Aragona, Pucci, Mazzetti, & Geraci, 2012). The variety of study populations and methods used may explain different outcomes concerning whether the experience of a number of PTEs constitutes the main risk factor for the development of psychopathology among resettled refugees. Cross-nationally, 75% of variance in the prevalence of PTSD can be explained by the relation between exposure to PTEs and vulnerability for PTSD (Dückers, Alisic, & Brewin, 2016). However, in this study among Afghan and Iraqi psychiatric patients, post-migration stress was the only risk factor that was associated with PTSD and anxiety/depression. The scant evidence that experiencing PTEs may decrease coping abilities for post-migration stress was not considered in this study. The most mentioned post-migration stressor among Iraqi participants was fear about the fate of family members left in the home country. A possible explanation for this fear may be that during the study period, threat from the Islamic State (IS) was severe in Iraq.

In **chapter 2**, traces of experienced traumatic events and post-migration stress in the cultural identity of the Somali patient were identified. The life threatening danger of accusations of "black magic" had caused him to flee, and the lack of social support from other Somalis had caused in him a deep feeling of loneliness and isolation, both of which could be identified as post-migration stress factors in the Netherlands. Stress and acculturation factors could be identified within the abovementioned domains of cultural identity – personal, ethnic, and social – among Afghan and Iraqi patients. We found remarkable relations to stress and acculturation factors for all three domains, which enhanced our insight into how cultural identity provides meaning to the perception of stress and the evaluation of norms and values in the home versus the host society.

Because of this relatively unexplored subject, similar studies are scarce. Personal identity has been related to PTSD among trauma survivors in Australia (Jobson & O'Kearney, 2008). The authors refer to personal identity in terms of setting personal goals, self-defining memories, and self-cognitions, which were often more trauma-centered among PTSD participants than among those who do not develop PTSD. Personal identity becoming trauma-centered indicates that trauma survivors define themselves along the experienced traumatic events (Berntsen & Rubin, 2007). Ethnic identity is clearly related to a high risk of experiencing traumatic events,

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as numerous studies on ethnic minorities and mental health problems have shown (e.g., McKenzie, 2008; Kaylis, Waelde, & Bruce, 2007; Vega & Rumbaut, 1991).

Adaptation to a new society appeared to be problematic for ethnic minorities among the Afghan and Iraqi participants of this study as well (**chapter 5**, table 3). In the interviews, participants for example pointed out that they were illiterate because of the limited education opportunities afforded to members of their ethnic minority, something that complicates their acquisition of the Dutch language as well as their mobility. A low, weak, or diffuse ethnic identity is related to low self-esteem and psychological well-being (Phinney, 1991; Phinney et al., 2001), both of which are potential risk factors for developing psychopathology. Post-migration stress appears to be high for social identity among the participants in this study, in the sense that social contacts and social support are much less frequent and intense in the host country than in the home country. The absence of family who are left behind in Afghanistan or Iraq causes a strong change or weakening of social identity: "living without family is like having no life at all." Social identity may be crucial for self-esteem as well (Taylor & Usborne, 2010).

Based on these results, it seems that stress and acculturation factors are deeply interwoven with norms and values in the personal, ethnic, and social domains of cultural identity. Two vignettes in **chapter 5** illustrate how sociocultural changes may have far-reaching consequences for these three domains of cultural identity.[2] When compared to non-patients from Afghanistan and Iraq (**chapter 7**), differences in the need for mental health care in terms of resilience became apparent in these three domains. These Afghans and Iraqis were more flexible towards changes in their personal identity and therefore less susceptible to confusion. They were also better able to put ethnoreligious causes of experienced traumatic events into perspective and to distinguish between political and personal conflict. The availability of social and religious support and an active lifestyle prevented them from confusion in terms of their social identity.

Implications for mental health professionals
On the basis of the results presented in **chapters 2 to 7**, there seem to be two main contributions in terms of exploring cultural identity in refugees: 1. information on the cultural identity of refugee psychiatric patients may contribute to a better understanding of their mental health problems; and 2. the process of assessing information about cultural identity may contribute to a better understanding between patients and mental health professionals.

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[2] Confusion of cultural identity is also mentioned in the second of two video illustrations of the supplementary module on cultural identity in chapter 4.

Addressing the first contribution, the description of cultural identity in **chapter 4** offers the prospect that the greater amount of detail a clinician is able to ascertain about cultural identity, the better his or her understanding will be of the individual's perspectives on health, illness, and the mental health system (Ton & Lim, 2006:10). The case study of the Somali patient in **chapter 2** offers a first glimpse of the amount of detail a clinician may ascertain. By contextualizing mental health problems with regard to this patient's biographical history, the clinician was offered a recognition of what was really at stake (Kleinman & Benson, 2006). Initially, the findings of this case study seemed to justify the exploration of cultural identity in refugee patients, in terms of how it can help clinicians to better understand the mental health needs of patients and how it could potentially lead to more adequate and culturally sensitive diagnosis and treatment. Connecting mental health problems to the inner core cultural values that altogether build up cultural identity, and contextualizing them in terms of the patient's life history, could offer more possibilities in treatment for the mental health professional than no contextualization.

In the analysis of the clinical utility of the components of the OCF (**chapter 3**), when discussing psychiatric assessment evaluations, cultural identity appears to be an important factor in the additional information that the BCI provides. Although the numbers in the small-scale research were insufficient to jump to any conclusions, it seems that mental health professionals who engage in treatment evaluation sessions appreciate information on the cultural identity of refugee patients more than the other OCF components. Considering the event-centrality in the cultural identity of patients who suffer from trauma-related disorders, trauma seems to be a reference point for defining oneself with respect to past and future experiences (Berntsen & Rubin, 2007). Therefore, information about how patients define themselves, and the norms and values that are attached to that definition, offers mental health professionals a more comprehensive view on the mental health problems of their patients.

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Regarding the second contribution in relation to exploring cultural identity, the case study in **chapter 2** shows how the mental health professional was better able to understand the context of the patient's mental health problems, and his motivations and attitudes, after the mental health problems had been contextualized. The suggested conceptual framework of cultural identity in **chapter 5** may further contribute towards a better understanding of mental health problems in general. Mental health professionals are encouraged to explore personal, ethnic, and social identity and the ways in which these domains of cultural identity may inform them about perceived stress and cultural differences between the home and the host country. Most participants in this study felt bereft of their "old" cultural identity, while a "new" cultural identity had not yet been established. This cultural bereavement suggests that besides experiencing traumatic events, developing psychopathology, and experiencing resettlement and post-migration stress, they also lost "… social structures, cultural values, and self-identity"

(Eisenbruch, 1991:674). Several recommendations have therefore been proposed in **chapter 5**, based on the conceptual framework of cultural identity. An exploration of personal, ethnic, and social identity may inform mental health professionals about post-migration stress factors, acculturation problems, and potential resilience factors, all of which were found to be grounded in cultural identity.

Methodological reflections

In this study, several methods have been applied. In this section, I will reflect on the interview that was used – the Brief Cultural Interview – and on the mixed-methods approach used in **chapters 6 and 7**. The order of questions in the BCI follows the DSM-IV's OCF, and includes the cultural identity of the individual, the cultural explanation of the individual's illness, cultural factors related to the psychosocial environment and levels of functioning, and cultural elements in the relation between the individual and the mental health professional. Methodologically, three issues concerning the BCI must be addressed.

Issues in the standardization/comparability of the interviews
Whether or not a clinician chooses to follow the order of the questions in the BCI depends on the patient's answers. Firstly, because of the open-ended and dialogical character of the questionnaire, a patient might provide an answer to one of the first questions that may also be (part of) an answer of one of the following questions. For example, a patient might answer the question of belonging to a certain group in the country of origin and reveal how this group is different from other groups and why belonging to this group is important to him or her. In this case, one of the following questions may not be necessary or may be further probed. While using the BCI, the interviewer is encouraged to react to the patient's answers in order to establish a graceful flow of questions and answers in an open inquiry with empathic concern (Mezzich et al., 2009a). In the presented case study, the Somali patient explained that belonging to the minority clan was the major reason for experiencing traumatic events, which were part of his illness explanation. In this case, questions concerning reactions from others in the country of origin may already have been answered.

Secondly, for reasons of contextualizing the mental health problems of patients, further inquiry may be required in order to construct ad hoc BCI reports. In several chapters, some historically relevant events, sociodemographic characteristics, and types of potentially traumatic events in the patients' countries of origin have been included. In **chapter 1**, this type of contextual information with respect to Afghanistan and Iraq has, for comparative reasons, been included as equally as possible.

Thirdly, language is an important factor to consider in the comparison of the qualitative results. Requiring interpreters for the conduct of BCIs with refugees might complicate the patient's level of understanding of the questions, the interviewer's level of understanding of the answers provided, and the quality of the translation. In all chapters that include interviews, the requirement of interpreters has been noted. In terms of the quality of the translation, the interviewer could not know whether the translation was accurate, whether everything in the patient's answer was translated, or whether certain words/phrases such as "culture," "ethnic group," or "mental health problem" were translated in the same way in all interviews. All interpreters were official interpreters of the TVcN (Interpretation and Translation Centre of the Netherlands), but the same interpreter was not used for all interviews in Dari or Arabic. The interviewer may also have been only partially aware of the attitude of the interpreter towards the patient, the character of communication in the sense of like or dislike, or of implicit meanings that were exchanged. When interpretation was not required, the interviewer depended on the patient's level of Dutch language abilities for completion of the interview, which might have influenced the level of understanding on both sides and the time required for asking all questions.

Issues in the mixed-methods designs

In **chapters 6 and 7**, both interviews and structured questionnaires were applied in consecutive mixed-methods designs. The structured questionnaires were officially translated from Dutch into Dari and Arabic by the Translation Service of the Free University in Amsterdam. The translation procedure was not back-and-forth, but a second interpreter was used to control and adapt the translation when necessary. There were no comments concerning the quality of the translation made by the interviewees. Previous comments on the translation of the interviews also apply to the translation of the questionnaires.

Two of the questionnaires, the Harvard Trauma Questionnaire (HTQ) and the 25-question version of the Hopkins Symptoms Checklist (HSCL-25), were completed at De Evenaar. Both are questionnaires that the patient needs to fill in him/herself, but assistance was given when necessary. Interpretation in Dari or Arabic was also provided when necessary. It is inevitable that a patient might be influenced during the completion of the questionnaire by the assistance provided by the psychodiagnostic interviewer or the interpreter. Comparable to the conduct of the BCI, the level of understanding of the items of the HTQ or the HSCL-25 may have influenced the results, although both have been validated in various populations (Mollica, 1992; Mollica, Wyshak, De Marneffe, Khuon, & Lavell, 1987). There were a number of items in the HTQ that most participants found hard to understand, such as "brainwashing" or "feeling as if you are split into two people and one of you is watching what the other is doing." Nevertheless, the participant population might have had considerably less experience in filling in Likert scales than a Dutch population that is accustomed to multiple choice questionnaires in daily life; this is something that needs to be taken into consideration when interpreting the data.

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The four other questionnaires – the sociodemographic questionnaire, the Post-Migration Living Problems-Checklist (PMLP-CL), the Cortes Rogler Malgady-Bicultural Scale (CRM-BS), and the Centrality of Event Scale (CES) – were completed without researcher assistance. Except for the sociodemographic questionnaire, the questionnaires include Likert scales. With a few exceptions, all questionnaires were completed without major problems. In a few returned questionnaires, some remarks were made in Dari or Arabic. These remarks were translated, and did not have any consequence for the analysis.

The mixed-methods design was chosen to compare quantitative and qualitative analysis, or to complement the quantitative analysis with the qualitative analysis. Quantitative methods were used in order to analyze the associations between the risk factors for psychopathology in **chapter 6** and to compare these risk factors and psychopathology itself between a patient and a non-patient group in **chapter 7**. The design in **chapter 6** is somewhat different from the design in **chapter 7**. The difference of designs is related to the research questions in both chapters.

In **chapter 6**, a concurrent design of quantitative and qualitative methods was applied (Creswell & Zhang, 2009). Analysis of the quantitative and qualitative data was performed simultaneously. Such a design offers opportunities for a multiple-angles approach to the data. In **chapter 7**, an exploratory sequential design was applied (idem, 2009). Firstly, differences in risk factors for psychopathology as well as psychopathology itself between participants who were patients and participants who were not patients were analyzed in order to find out whether mental health problems were indeed above the cut-off points of the HTQ (2.50) and HSL-25 scales (1.75) in the first group and below the cut-off points in the second group. Additionally, the quantitative analysis made clear which risk factors made the difference between the two groups. Secondly, a qualitative content analysis was aimed at retrieving resilience factors and components of cultural identity. Thereafter, a qualitative comparative analysis was performed in order to trace the grounding of resilience factors in cultural identity. In this design, the quantitative analysis served to analyze differences in both groups that were further explored in the qualitative analysis.

The results of the CRM-BS measuring acculturation preferences in **chapter 6** were unexpected, because Afghan and Iraqi participants both had a slight preference for Dutch norms and values. According to the Berry model of acculturation as presented in **chapter 1** (Berry, 2005), they could be categorized as integrated. There was no difference between both groups. In a number of studies in the Netherlands, acculturation difficulties are associated with mental health problems (Ince et al., 2014; Fassaert et al., 2011; Kamperman, Komproe, & De Jong, 2003). Apparently, participants in this study did not suffer from acculturation difficulties. However, in the BCI reports, a considerable proportion of participants reported that they did not

feel well understood in the Netherlands, and they perceived cultural differences between their country of origin and the Netherlands. Qualitative analysis seemed to give the impression that when participants were asked to describe their opinion in their own words instead of answering prescribed items on a scale from totally disagree to totally agree, acculturation difficulties did play a role in their cultural identity after migration. This finding is in line with other studies on acculturation, cultural identity, and mental health (Schwartz et al., 2006; Bhugra & Becker, 2005; Bhugra, 2004).

The size and design of this study are both insufficient to conclude that qualitative analysis offers a more accurate near-patient view than quantitative analysis. Additionally, the qualitative approach may be biased by ways of asking, the type of interpersonal contact between participant and interviewer, and the researcher's interpretation. Therefore, I cannot conclude that acculturation difficulties influence mental health. Supported by other previously mentioned studies, the qualitative analysis did lead to the conclusion that acculturation difficulties do contribute to cultural identity confusion.

Strengths and limitations

This study has several strengths. First, the mixed-methods design in **chapters 6 and 7** allow for a multi-angle perspective on the complex interplay of risk factors for psychopathology. The designs are discussed in the methodological reflections. Quantitative analysis helps to understand the ways in which various risk factors are interrelated with each other, and to ascertain differences in risk factors and psychopathology between patient and non-patient participants. Qualitative analysis helps to describe the ways in which participants regard their cultural identity and risk factors as they intervene in cultural identity. On the one hand, qualitative analysis offers an in-depth understanding of the quantitative findings. On the other hand, quantitative findings clarify the extent to which risk factors and psychopathology play a role in the mental well-being of the participants.

The large sample is another strength of the qualitative analysis, but the size is still a limitation for the quantitative analysis. In some mixed-methods studies, larger samples are used for the quantitative analysis, after which a smaller portion of the sample is used for the qualitative analysis. Practical reasons did not allow for such a larger sample in this study, which would have enlarged the quantitative analysis. Nevertheless, prior to the study, the study group calculated a power size that was sufficient for the specific design. Furthermore, the inclusion period of participants did need to be extended in order to reach the actual required inclusion; further extension would have complicated the progress of the study. The inclusion of refugees seems to be difficult for this kind of study. An inquiry into the willingness or hesitation to participate among gatekeepers in the Afghan community

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resulted in the finding that distrust existed that the information shared could harm a person's asylum procedure, that there was anxiety over sharing private information and confidentiality, as well as fear about stigmatizing reactions and gossip within the Afghan community.

There are also some other limitations to this study that need to be taken into account. First, the generalizability of the study results for the entire refugee psychiatric patient population is limited due to the selection of participants from two of the largest refugee populations in the Netherlands, based on country of origin. Participants from two countries of origin were included for reasons of comparison between both groups, that would at least allow for better cultural competence perspectives than one single group. In the discussion of several chapters, comparison of the findings with other studies that included a larger variety of multi-ethnic backgrounds was attempted. There is wide ethnoreligious variety within the sample of Afghan and Iraqi refugees, which could limit generalizability; but the inclusion of Somali, Kenyan, or Sudanese refugees would have led to even more complexity.

Another limitation is that in some chapters, attention to differences between refugees and asylum seekers is not strongly evaluated. In the qualitative analysis of cultural identity domains conducted in **chapter 5**, uncertainty over whether the participant would be granted residency status could have influenced relations between the cultural identity components and stress, and between cultural identity and acculturation. However, there were no strong indications in the study findings that this uncertainty or fear of being sent back to the country of origin played an important role in the analysis of cultural identity. In **chapter 6**, one of the potential reasons for a higher rate of non-response among the Afghan group might have been that most of them were asylum seekers. Despite the emphasis on confidentiality when obtaining informed consent, these respondents may nevertheless have been reluctant to participate because they might have been afraid that participation would endanger their asylum procedure. In **chapter 7**, differences between refugees and asylum seekers were evaluated in the quantitative analysis. Juridical status appeared not to be a significant confounder in the multivariate regressions.

A third limitation concerns the data that have been gathered within one single mental health institution that offers specialized mental health care to refugees, asylum seekers, and other immigrants. A multi-sited study might have improved generalizability. But while a comparison with patients from other mental health institutes might have enhanced the findings, it might also have complicated the analysis because of differences in terms of types of treatment, inclusion procedures, patient-clinician relationships, considerations in the use of interpreters, and so on.

A fourth limitation may be unclear differences in the clinical history of participants who were patients and participants who were not receiving mental health care during the research

period. During the selection of eligible non-patient participants, individuals were excluded if they were receiving current psychiatric treatment, but a past history of psychiatric treatment was not an exclusion criterion. Some non-participants had indeed received such treatment, and some were considering psychological assistance in the future.

A fifth limitation may be the bias of the primary researcher, who designed the BCI, conducted the interviews with patient participants, and performed the qualitative analyses. In order to reduce this potential bias, research assistants conducted the interviews with the non-patient participants and contributed to the qualitative analyses. The decisions regarding the methodology and tools used were based on practical considerations. Their purpose was to explore the relevance of (inquiring into) the cultural identity of refugees, in order for mental health professionals to gain a better understanding of their mental health problems. Still, the potential theoretical preoccupations of the researcher, which are driven by debates in the field of transcultural psychiatry, might have biased the interpretation of the results.

Future studies

One of the findings in **chapter 7** is that despite differences in experienced potentially traumatic events, the line between refugee psychiatric patients and non-patients is thin on an individual level. More than a third of the non-patients scored above the cut-off point for anxiety and depression disorders. The risk factors that may have caused these results is as yet unclear. In the qualitative analysis, it appears that many non-patient participants had received mental health care in the past or were considering psychological help in the future. Further research may be needed to understand which factors contribute to motivations to consider mental health care, or conversely not to take the step to receive mental health care, among those refugees who score above the cut-off for anxiety and depression.

There is some evidence that cultural identity confusion is involved in emotional problems after the death of a loved one (Boelen, 2017). Cultural bereavement also seems to play a role in prolonged grief disorder. A new questionnaire has been developed to assess cultural aspects of bereavement and grief (Smid, Groen, De la Rie, Kooper, Boelen, 2018). Cultural identity confusion after the death of a loved one among refugees may be assessed using this questionnaire, as well as other questionnaires that assess PTSD, anxiety, and depression disorders.

One of the potential reasons for the underutilization of the OCF is that clinicians believe that they do not have time for it (Lewis-Fernàndez, 2009). Often, time seems to be the enemy in

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contemporary restricted and protocol-led psychiatry. But if time is an enemy, it also needs to be embraced for a higher quality of mental health treatment. Future research on the effectiveness of a culturally sensitive time investment in clinical assessment for better perspectives in mental health treatment may be important, but building trust by showing an interest in the cultural identity of a patient and having more of a grip on the complexity of the mental health problems among mental health professionals may be even better.

The conceptual framework of cultural identity that is presented in **chapter 5** is based on interviews with 85 Afghan and Iraqi refugee psychiatric patients, but may be challenged by other patients groups. The items that were distinguished may be biased by norms and values that are apparently relevant in Afghan and Iraqi society. Research among African patients may challenge the proposed conceptual framework. The resilience factors that are distinguished in **chapter 7** are based on interviews with 48 Afghan and Iraqi refugees who did not receive mental health treatment. Research among African patients may challenge these resilience factors as well.

Concluding remarks

This thesis may be regarded as a plea for a contextual approach in contemporary transcultural psychiatry that is entangled in evidence-based protocol-oriented medicine. This thesis is also an attempt to "fix the problem" of cultural identity in the OCF, after questions have been raised (these questions are presented in the introduction). Epistemological and methodological issues, as well as practical implications for mental health professionals, have been addressed. What needed to be clarified was the meaning of the concept of cultural identity, methodological guidelines to discuss how to approach patients' cultural identity, and practical implications concerning the ways in which cultural identity may influence assessment and treatment plans.

As was noted in **chapter 1**, in transcultural psychiatry a balance is sought between evidence-based medicine and cultural competency (Kirmayer, 2012b). The chapters of this thesis aim to convince that a better understanding of refugee patients' mental health problems must lead to culturally sensitive, resilience-oriented diagnosis and treatment. This has been shown in this study. For an anthropologist who is a relative outsider in psychiatry, and who has an interest in the meaning-making process of mankind, the search for a better understanding of mental health in various cultures is at the same time an exploration of various accounts of culture. Similar to what medical anthropologist Els van Dongen noted in her research on closed-ward patients with schizophrenia, I have tried to understand culture through madness (2002:9). Although we are dealing with patients who suffer from other, maybe less invasive mental health problems here, together their narratives shape a subjective version of culture. Exploring local circumstances that

to some extent are intertwined with the cause of traumatic events offers an account of various aspects of daily life in Afghanistan and Iraq.

From the case study of the Somali patient to resilience factors that are grounded in cultural identity, it has been an interesting, complicated journey that has brought me more than I expected. After fifteen years of conducting more than 2,000 BCIs, there was "never a dull moment," as Kees Laban would have said. And there is still a lot to learn. New BCIs still result in new insights for diagnosis and treatment. The more cultural assessments that result from the conducting of the BCI, the higher the level of contemplation. During the journey of this thesis, the number of recommendations for diagnosis and treatment has increased. This increase implies that approximately the same amount of information is being retrieved from the BCIs at the end of the journey as at its beginning, which is leading to a higher the level of analysis. And still, one has never learned enough.

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Explanation of the relative contribution of the co-authors to the Chapters

Chapter 2

Groen, S. (2009). Recognizing cultural identity in mental health care: Rethinking the Cultural Formulation of a Somali patient. *Transcultural Psychiatry,* 46(3), 451-462.

SG conducted the interview and drafted the manuscript.

Chapter 3

Groen, S.P.N., Richters, A., Laban, C.J., & Devillé, W.L.J.M. (2017). Implementation of the Cultural Formulation through a newly developed Brief Cultural Interview: Pilot data from the Netherlands. *Transcultural Psychiatry*, 54(1), 3-22.

SG designed the study, conducted the interviews, analyzed the data, and drafted the first version of the manuscript.

AR and WD contributed to the writing of the manuscript.

CL co-designed the study, contributed to the analysis of the data and to the writing of the manuscript.

Chapter 4

Groen, S., Rohlof, H., & Jadhav, S. (2016). Aspects of cultural identity related to national, ethnic, and racial background; language; and migration. In: Lewis-Fernández, R., Aggarwal, N.K., Hinton, L., Hinton, D.E., Kirmayer, L.J. (Eds.) *DSM-5 handbook on the Cultural Formulation Interview*, pp 107-117. Washington: American Psychiatric Association Publishing.

SG drafted the manuscript.

HR and SJ contributed to the manuscript.

Chapter 5

Groen, S.P.N., Richters, J.M., Laban, C.J., Devillé, W.L.J.M. (2018). Cultural identity among Afghan and Iraqi traumatized refugees: Towards a conceptual framework for mental health care professionals. *Culture, Medicine and Psychiatry*, 42(1), 69-91.

SG designed the study, conducted the interviews, analyzed the data, and drafted the manuscript.

AR contributed to the data analysis and to the writing of the manuscript.

CL contributed to the design of the study, as well as to the data analysis and to the writing of the manuscript.

WD contributed to the writing of the manuscript.

Chapter 6
Groen, S.P.N., Richters, J.M., Laban, C.J., Van Busschbach, J.T., Devillé, W.L.J.M. (2019). Cultural identity confusion and psychopathology: A mixed-methods study among refugees and asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease*, 207(3), 162-170.

SG designed the study, conducted the interviews, analyzed the data, and drafted the manuscript.

AR contributed to the writing of the manuscript.

CL contributed to the design of the study, as well as to the data analysis and to the writing of the manuscript.

JvB contributed to the data analysis and to the writing of the manuscript.

WD contributed to the design of the study, as well as to the data analysis and the writing of the manuscript.

Chapter 7
Groen, S.P.N., Richters, J.M., Laban, C.J., Van Busschbach, J.T., Devillé, W.L.J.M. (submitted). Resilience grounded in cultural identity: A comparison between refugee psychiatric patients and non-patients in the Netherlands.

SG designed the study, conducted the interviews, analyzed the data and drafted the manuscript.

AR and CL contributed to the writing of the manuscript.

JvB and WD contributed to the design of the study, as well as to the data analysis and the writing of the manuscript.

Summary

Cultural identity is a component of the Cultural Formulation of Diagnosis in the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5). It is an operationalization for clinicians to assist them to structurally account for cultural factors that affect the clinical encounter between patients and clinicians. But what do we mean exactly by "cultural identity" and what does this have to do with the mental health of refugee patients of various cultural backgrounds? If we want to consider the mental health of these patients more closely, then we need to pay attention to the experiences that have led to their flight and subsequent mental health problems. Additionally, living in another society following involuntary migration may cause problems among refugees, since adapting to a new culture is yet another challenge. These are all processes that may cause pressure on the cultural identity of refugees; they are described in the **first chapter** of this thesis. The research questions that are central in this study are:

1. What is the relation between cultural identity and psychopathology?
2. What is the relation between potentially traumatic events and post-migration living problems on the one hand and cultural identity on the other?
3. What are the implications of these new insights for mental health professionals, with respect to person-centered and culturally sensitive diagnosis and care in transcultural psychiatry?

In the **second chapter**, I focus on the cultural identity of a patient from Somalia. The ethnic group to which he belongs appeared not only crucial for the traumatic events he had experienced, but also for his cultural identity and level of functioning in the Netherlands. Being able to talk about his cultural identity and to be recognized as a meaningful person apparently triggered him to become more active than before. This finding was the primary reason for investigating the intertwinement of deep traumatic experiences and subsequent mental health problems in some groups of patients. But because cultural identity is a complex construct within a complex interplay of various processes that refugees have to deal with, I needed to clarify how to describe cultural identity. To begin with, I describe a questionnaire from the DSM-5 Handbook on the Cultural Formulation Interview that includes a supplementary module concerning cultural identity. This questionnaire is based on international consensus and focuses on a number of key factors that elicit the national, ethnic, and racial background of a patient, including language and migration. The more information about these cultural identity factors a mental health professional is able to ascertain, the better the mental health professional will understand the patient's mental health problems, which may offer better perspectives for treatment. By zooming in on a patient's specific background, his/her mental health problems may be better understood in their social-cultural context.

In order to elicit cultural identity from patients' own perspectives, I apply an anthropological approach to cultural identity. This approach includes a collection of norms and values that together shape an image that an individual holds of him- or herself, which leads him or her to decide between what is good or bad, what kind of behavior is appropriate or not. This is to a greater or lesser extent shared and exchanged within the group to which the person belongs and with the society in which he or she resides. I chose patients from Afghanistan and Iraq for this study, because they are two of the largest groups of refugees in the Netherlands, as well as in the patient population of the center for transcultural psychiatry where this research was performed. In the **fourth chapter**, I analyze interviews conducted with patients from these countries to explore meaningful domains of their cultural identity. These domains appear to be grounded on the personal, ethnic, and social level. The personal domain concerns personal characteristics, such as age, gender, education, and social class. The ethnic domain concerns the group to which a person belongs, and this distinguishes the group from other groups; for example, Kurdish Iraqis are distinct from Arab Iraqis. Ethnic differences can be related to language, religion, and problems between groups in the country of origin. The social domain covers the family or a person's position within the family, as well as social contacts with others. All of these three subdomains of cultural identity appear to be connected to stress and deal with cultural differences between the Netherlands and the country of origin. As seen in **chapter 5**, applying such an approach to cultural identity leads to a better understanding of the depression of an Afghan woman and the layers of meaning underlying her depression.

Next, in **chapter 6**, I investigate in another group of Afghan and Iraqi patients the key risk factors for psychopathology, and how these may be intertwined with the patients' cultural identity. Post-migration problems in particular appear to be crucial for their mental health problems. Remarkably, these post-migration stressors appear to be more important for Iraqi refugees with residence permits who seem to be better settled in Dutch society than much younger, often single and lower educated Afghan refugees who are often also asylum seekers. All risk factors appear to have repercussions on the three designated domains of cultural identity. Experienced traumatic events in the country of origin as well as post-migration stress are often interrelated with personal characteristics and attached norms and values. At the group level, most of the patients in the study belonged to an ethnic minority, and this was also a risk factor for experiencing traumatic events. At the social level, differences between living in the country of origin and the host country were conceived of as most important, and not knowing anything about family members who remained in the country of origin was considered the most stressful.

Finally, I consider the reasons why some Afghan and Iraqi refugees do not seem to need mental health care, and what we may learn from descriptions of their cultural identity. For the group of non-patients, all of the risk factors for being a patient or not were different compared

to the patient group, with the exception of preferences for Dutch norms and values versus those in the country of origin. In this comparison, post-migration stress once again appeared to be the most relevant risk factor, and this made a difference between being a patient or not. Refugees who were not patients showed a higher level of resilience with respect to a more positive appraisal of their situation in the Netherlands, they had more social and religious support, had a more active lifestyle, and they had more plans for the future than patients. They were more flexible in dealing with all of the aforementioned differences, considered themselves to possess a strong mentality, and were open-minded. Participants in this group received moral support from their partner, their nuclear family, their external family, and others. Their religion was an important support for them too. Patients, in turn, saw their religion as a source of stress, as the cause of all of the troubles in their country of origin. The most striking differences between the two groups were that non-patients were more active in terms of learning the language or following education, they possessed an active or disciplined attitude, and/or were more busy with work. Learning Dutch and following education made these non-patients more oriented towards the future. The norms and values underlying these resilience factors can be traced in their cultural identity. The "healthy" group was mentally much more flexible when it came to dealing with differences at a personal level and they were not so disturbed by problems concerning their ethnic origin. At the social level, this group also experienced problems, but these problems were resolved by focusing on the nuclear family and other social contacts. Although on the individual level differences in mental health problems were sometimes small, cognitive capabilities and especially introspective skills made the difference between being a patient or not.

In the final chapter, answers to the research questions are provided. With respect to the first research question, psychopathology appears to interfere with cultural identity, defined as incorporated norms and values that are central to thought and action. Cultural identity can be distinguished in the personal, ethnic, and social domains. All three domains can be related to all kinds of stress, and the findings also show confusion of cultural identity in all three. With respect to the second research question, post-migration stress is clearly quintessential for psychopathology. The qualitative analysis shows that all risk factors for developing psychopathology intervene regarding the norms and values of all three domains of cultural identity. With respect to the third research question, the exploration of cultural identity among refugees who require mental health care does indeed offer opportunities to better understand their mental health problems. On the basis of the study findings, it may be expected that the structural inclusion of cultural background in the clinical assessment with respect to refugees, especially an exploration of their cultural identity, may lead to better insights into the complex problems of this group.

Samenvatting

Culturele identiteit is een onderdeel van de Culturele Formulering in de vijfde editie van de Diagnostic and Statistical Manual of Mental Disorders (DSM-5), een operationalisering voor hulpverleners van structurele aandacht voor culturele factoren die het klinische contact tussen patiënt en behandelaar beïnvloeden. Maar wat verstaan we precies onder culturele identiteit en wat heeft dat met de geestelijke gezondheid van patiënten uit andere culturen te maken? Als we de geestelijke gezondheid van deze patiënten nader onder de loep nemen, dan moeten we aandacht hebben voor de gebeurtenissen die hebben geleid tot de vlucht en de daaropvolgende psychische problemen. Ook het leven in een andere samenleving na de migratie kan problemen opleveren bij vluchtelingen, waar nog bij komt dat zij zich moeten aanpassen aan een nieuwe cultuur. Dit zijn allemaal processen die de culturele identiteit van vluchtelingen onder druk zetten en die beschreven staan in het eerste hoofdstuk. De onderzoeksvragen die centraal staan in dit onderzoek zijn:

1. Wat is de relatie tussen culturele identiteit en psychopathologie?
2. Wat is de relatie tussen potentieel traumatische gebeurtenissen en post-migratie leefproblemen aan de ene kant en culturele identiteit aan de andere kant?
3. Wat zijn de implicaties voor professionele hulpverleners in de GGZ van deze nieuwe inzichten met het oog op persoonsgerichte en cultuursensitieve diagnostiek en behandeling in de transculturele psychiatrie?

In het tweede hoofdstuk zoom ik in op de culturele identiteit van een patiënt uit Somalië. De etnische groep waar hij toe hoort bleek niet alleen van alles te maken te hebben met de traumatische gebeurtenissen die hij meemaakte in zijn land, maar ook met zijn culturele identiteit en functioneren in Nederland. Door voor het eerst daarover te praten en herkend te worden als een betekenisvol persoon werd kennelijk iets in hem aangewakkerd, waardoor hij zich veel actiever ging opstellen dan voorheen. Dat was reden genoeg om bij groepen patiënten te gaan kijken hoe diep traumatische ervaringen en klachten verweven zijn met culturele identiteit. Maar omdat culturele identiteit een complex construct is in een complex samenspel van processen waar vluchtelingen in verkeren, moest ik eerst duidelijk krijgen hoe ik culturele identiteit kon beschrijven. Dat deed ik, om te beginnen, aan de hand van een speciale vragenlijst over culturele identiteit in het DSM-5 handboek voor het Cultural Formulation Interview. Op basis van internationale consensus is die vragenlijst samengesteld uit een aantal kernfactoren zoals de nationale, etnische en raciale achtergrond van een patiënt, maar ook taal en migratie. Hoe meer informatie een hulpverlener over deze culturele identiteit kan vergaren, des te beter zal die hulpverlener zijn of haar patiënt begrijpen, waarmee betere vooruitzichten voor de behandeling kunnen worden geboden. Door in te zoomen op de specifieke achtergronden van patiënten kunnen klachten die daarmee samenhangen in hun sociaal-culturele context beter begrepen worden.

Om op basis van interviews te achterhalen wat patiënten zelf over culturele identiteit zeggen, ga ik uit van een antropologische benadering van culturele identiteit. Deze benadering beschrijft culturele identiteit als een verzameling normen en waarden die tezamen een beeld vormen dat iemand van zichzelf heeft, die iemand laten beslissen wat goed en wat slecht is, welk gedrag passend is of niet en die uitgewisseld worden in de groep waar iemand bij hoort en in de samenleving waar iemand verblijft. Voor het onderzoek koos ik voor patiënten uit Afghanistan en uit Irak, twee van de grootste groepen vluchtelingen in Nederland en ook van de patiëntenpopulatie van het centrum voor transculture psychiatrie waar het onderzoek is uitgevoerd. In het vierde hoofdstuk vergeleek ik interviews van patiënten uit deze landen om uit te zoeken wat voor hen belangrijke onderdelen van culturele identiteit zijn. Dat bleek op persoonlijk, etnisch en sociaal gebied te liggen. Het persoonlijke gebied betreft persoonlijke kenmerken, zoals leeftijd, man of vrouw zijn, opleiding en sociale klasse. Het etnische gebied betreft de groep waar iemand bij hoort en die zich onderscheidt van andere groepen, bijvoorbeeld de groep van Koerdische ten opzichte van die van Arabische Irakezen. Etnische verschillen kunnen samenhangen met taal, religie en problemen tussen groepen in het land van herkomst. Het sociale gebied bestrijkt de familie of de positie binnen de familie, maar ook de sociale contacten met anderen. Deze drie deelgebieden van culturele identiteit bleken allemaal verbonden te zijn met stress en met omgaan met culturele verschillen tussen Nederland en het land van afkomst. Door zo te kijken naar culturele identiteit is bijvoorbeeld de depressie van een Afghaanse vrouw en het krachtenspel dat zich daaronder afspeelt in hoofdstuk vijf veel beter te begrijpen.

Vervolgens onderzocht ik in hoofdstuk zes bij een andere groep van Afghaanse en Irakese patiënten welke oorzaken van psychische problemen op de voorgrond stonden en hoe deze verweven zouden kunnen zijn met hun culturele identiteit. Vooral post-migratie problemen bleken van doorslaggevende invloed op de psychische klachten. Opvallend genoeg bleken die post-migratie stressoren belangrijker voor Irakese statushouders die veel meer gesetteld lijken in de Nederlandse samenleving dan de veel jongere, vaker alleenstaande, lager opgeleide Afghaanse vluchtelingen die ook nog eens vaak geen verblijfsstatus hadden. Alle ingrijpende gebeurtenissen bleken ook hun weerslag te hebben op de drie onderscheiden gebieden van culturele identiteit. Meegemaakte traumatische ervaringen in het land van herkomst, maar ook post-migratie stress hadden vaak te maken met persoonlijke kenmerken en daarmee verbonden normen en waarden. Wat het groepsniveau betreft, behoren tot een etnische minderheidsgroep bleek voor de meeste patiënten te gelden en een risicofactor voor het meemaken van traumatische gebeurtenissen te zijn. Op sociaal niveau bleken de grote verschillen tussen het leven daar en hier belangrijk en het niet weten hoe het met de achtergebleven familie gaat werd het meest stressvol gevonden.

Tot slot bekeek ik hoe het komt dat er ook Afghaanse en Irakese vluchtelingen zijn die geen geestelijke gezondheidszorg nodig lijken te hebben en wat we uit de beschrijvingen van hun

culturele identiteit kunnen leren. Alle risicofactoren om patiënt te zijn of niet bleken in ieder geval te verschillen met de patiëntengroep, met uitzondering van een voorkeur voor Nederlandse normen en waarden versus die van het land van herkomst. Ook hier bleek post-migratie stress de grootste boosdoener die het verschil maakt tussen wel en niet patiënt zijn. Vluchtelingen die geen patiënt waren bleken over meer veerkracht te beschikken, zoals een positievere waardering van hun nieuwe situatie in Nederland te hebben, meer sociale en religieuze steun te hebben, een actievere levensstijl er op na te houden en vaker toekomstplannen te hebben dan patiënten. De eerste groep was flexibeler in het omgaan met alle bovengenoemde verschillen, vond zichzelf een sterke mentaliteit hebben en was open-minded. Steun was er van de partner, van het gezin, de familie of van anderen. Ook het geloof was voor deze groep een belangrijke steun. Patiënten konden het geloof ook als stressfactor zien, namelijk als de veroorzaker van alle ellende in het land van herkomst. Het al dan niet actief zijn met leren van de taal of met een opleiding, een actieve en gedisciplineerde houding hebben en bezig zijn met werk waren opvallende verschillen tussen beide groepen ten gunste van diegenen die geen patiënt waren. Nederlands leren en een opleiding volgen was wat hen toekomstgericht maakten. De normen en waarden die ten grondslag liggen aan deze veerkrachtfactoren waren te vinden in de culturele identiteit. De "gezonde" groep was mentaal veel flexibeler in het omgaan met verschillen op het persoonlijke gebied en tilde minder zwaar aan etnische problemen. Problemen op het sociale gebied waren er ook wel bij deze groep, maar werden beter opgelost door zich op het gezin en andere sociale contacten te richten. Hoewel op individueel niveau de verschillen in psychische klachten soms klein waren tussen beide groepen, leken cognitieve vaardigheden en vooral zelfinzicht doorslaggevend.

In het laatste hoofdstuk geef ik antwoord op de onderzoeksvragen. In antwoord op de eerste vraag lijkt psychopathologie in te grijpen op de culturele identiteit, gedefinieerd als geïncorporeerde normen en waarden die centraal staan in het denken en handelen. Culturele identiteit is onder te verdelen in persoonlijke, etnische en sociale domeinen. In alle drie domeinen ervaren patiënten stress. De resultaten geven blijk van verwarring in de culturele identiteit in alle drie domeinen. Wat de tweede onderzoeksvraag betreft, is postmigratie stress duidelijk van doorslaggevend belang voor de psychopathologie. De kwalitatieve analyse laat zien dat alle risicofactoren voor het ontwikkelen van psychopathologie ook ingrijpen op de normen en waarden van alle drie domeinen van culturele identiteit. In antwoord op de derde onderzoeksvraag, biedt het verkennen van de culturele identiteit van vluchtelingen die psychische zorg nodig hebben voor behandelaren mogelijkheden om de psychische klachten van patiënten beter te begrijpen. Op basis van de onderzoeksresultaten valt te verwachten dat het structureel betrekken van de culturele achtergrond in het psychiatrisch onderzoek bij vluchtelingen, met in het bijzonder een verkenning van de culturele identiteit, zal leiden tot meer inzicht in de complexe problematiek bij deze patiëntengroep.

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About the author

Simon Groen was born on the 19th of October 1968 in Bergen (North-Holland) in the Netherlands. After finishing high school at RSG Noord-Kennemerland in Alkmaar in 1987, he started graphic school in Amsterdam. After a few years of working in the graphic industry he travelled around the world where he made up his mind to study Cultural Anthropology at the University of Amsterdam (UvA). Combining study with work at the UvA and half a year of studying European Ethnology at the Humboldt University in Berlin, he graduated in 2002 after a field work study on the symbolic construction of the reworked past among former East-Germans in a former East-German district of Berlin. The Master's thesis was nominated for the Master's Award of the Department of Anthropology and Sociology. In 2004 he started working as an anthropologist at De Evenaar, Center for Transcultural Psychiatry of GGZ Drenthe Mental Health Care. De Evenaar is a mental health institute for refugees among whom psychopathology and cultural factors converge. He developed a brief version of the Cultural Interview, the topic of a number of publications and presentations. He is a reviewer for a number of academic journals, such as Transcultural Psychiatry; Culture, Medicine & Psychiatry; The Journal of Nervous and Mental Disease; and the European Journal of Psychotraumatology. In 2011, he started combining his practical work with the position of researcher at De Evenaar. Since 2017 he is a member of GGZ Drenthe Research. In 2018, he was a member of the Scientific Committee of the 5th World Congress of the World Association of Cultural Psychiatry in New York City. His main topics of interest are: transcultural psychiatry, medical anthropology, the cultural formulation of diagnosis, cultural identity and trauma, refugees, cultural resilience, and grief and cultural bereavement. Simon is married to Leontine and father of Milan, Veerle and Eva.

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