Interventions and participatory clinical research for the enhancement of health systems interfacing with displaced Afghan women

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Abstract

In light of the 2021 United States military withdrawal from Afghanistan and the humanitarian crises of mass displacement and health system strain that have ensued, this article focuses on Afghan family systems as a means of enhancing practitioner awareness of the potential impact of adverse life experiences on resettled Afghan women's receptivity to psychosocial interventions at least partially rooted in Western methodologies. As they bear a disproportionate impact of constraints within Afghan society, and as patriarchal systems affect most of their life domains, in addition to migration and conflict-induced stress, women from Afghanistan may have high baseline trauma levels upon resettlement. In the absence of robust literature on evidence-based psychosocial interventions for this population, ethnographic work and literature on existing clinical models alleged to be compatible with Afghan norms is reviewed and synthesized. The article finds the need for improved provider education in working with foreign-born populations, and thus proposes participatory research design considerations for future clinical studies, elaborating on important considerations for the evaluation of extant understandings following social reorganization on a massive scale.

1 Introduction

The year 2021 witnessed the U.S. military withdrawal from Afghanistan, the resultant collapse of the Afghan national infrastructure, and the subsequent takeover of the country by Taliban, Islamic State-Khorasan (IS-K), and other terrorist forces. Given the magnitude of the resulting humanitarian crisis, as well as the time it will take for the present situation to stabilize, the impact of this transition of power cannot be adequately evaluated in terms of how it may shape the life courses of families, and especially women, who remain in Afghanistan. Nonetheless, the present article should serve as a review of long-standing patterns governing Afghan women's experiences in both the public and private spheres up until the time of the 2021 crisis, assessing how it is presently theorized that social instability and past health-seeking experiences might impact individuals who lived under these circumstances for the majority of their lives. Furthermore, it will also examine how migratory and post-migratory pressures may shape mental health outcomes. Maintaining an ethnographic orientation, it builds on the exploratory work of Yaser et al. (1) in identifying how Afghans conceptualize mental health conditions relative to their definitions according to "Western" constructs, further synthesizing their understandings with other clinical studies to propose a model for psychosocial intervention, as well as a clinical study design intended to validate present assumptions against a backdrop of radically changing political contexts. In so doing, it is important to note that any references herein to dynamics within Afghanistan, unless otherwise noted, should be understood as referring to conditions as they were prior to the U.S. withdrawal. Considering the fact that previously observed trends may or may not remain generalizable within the present reality, and as events in the Afghanistan can continue to impact the wellbeing of the diaspora, there is an urgent need to reassess and validate the understandings which had been painstakingly developed over the last two decades.

Regardless of an individual's background, resettlement to a new country does not automatically translate to improved opportunities for beneficiaries within the new context (2, 3). Moreover, while offering immediate safety, such as protection from persecution or violence, in some locations, inconsistent resettlement services (constrained by low funding and limited professionalization of providers) carry the potential to further entrench cycles of poverty in that the hampered socioeconomic mobility experienced prior to resettlement are amplified by the addition of new, non-

income dimensions of disadvantage¹. Regarding Afghan women specifically, even the wives of highly educated Special Immigrant Visa recipients (in the U.S.) or recipients of a similar immigration status in other countries may still be preliterate despite the use of immigration pathways usually connoting a high level of literacy and professional skill for the principal applicant. Whatever their own education level, many, if not the majority of these women, will likely have been operating under distinctly patriarchal systems replete with challenges for most of their lives, and their well-being may be further compromised upon resettlement by fragile or disjointed social service systems in the host or destination country, as resettled women, in particular, are often underprepared to fully utilize resources ostensibly available to them (2).

These risks are worsened by the combination of low wages, as well as the excessive workloads and ethical demands placed on social service coordinators, meaning that in times of high volume, resettled women and disabled persons are at increased risk of not receiving meaningful health services. Furthermore, data on the long-term economic and health outcomes of resettled individuals are rarely made available in a quality and comprehensive manner outside of one-off academic studies with relatively small sample sizes. Given that displacement carries exceedingly high morbidity, perfunctory connection to a low-quality local healthcare system might serve as little more than just an item on a checklist despite caseworkers' best intentions. Just as precarious of an obstacle, resettled individuals may then interface with health systems clamoring to help these high-profile new arrivals, but which lack the adequate knowledge base to do so. These same systems will be vastly ill-equipped to manage this same high volume of foreign-born individuals, and by their very nature, fragmented medical infrastructures can be highly retraumatizing, discouraging, and intrusive to persons not possessing the necessary experience with which to confidently navigate them. All of these challenges often occur against the backdrop of highly celebrated public relations campaigns with very little assurance of quality or long-term positive outcomes for beneficiaries or their caseworkers.

Within social services, the lack of academic resources and experience with Afghan family dynamics (and Afghan women and minorities' health-seeking experiences in particular) threatens to have lasting impacts on newly arrived populations. However, rigid postcolonial approaches may also overcorrect in search of "cultural appropriateness," resulting in further denial of agency in the definition of preferences, potentially thwarting valuable hybridity derived from true community-engaged scholarship (5). In this vein, it would be a vast and delegitimizing leap to assert unequivocally that Western medical approaches would be wholly undesired by Afghan clients. However, tailored approaches must also be provided to those for whom the current system may appear undesirable or intimidating. These stopgap measures could be offered until such time that the client feels ready to engage the present system or until gaps in services can be better bridged through the creation of specialized, integrated migration health systems characterized by enhanced mutual understanding between clients and practitioners (6).

2 Environmental risk factors for adverse mental health outcomes

2.1 Heterogeneity within Afghan society

While the degree to which personality factors remain static across the lifespan is debated, the literature on "culture" seems to point to adaptability. As "cultural" adaptability is perhaps more easily measured by external factors than through ambiguous interpersonal and societal encounters, much of the empirical literature on cultural adaptability utilizes work performance as a means of

¹ An overview of the non-income dimensions of poverty in Afghanistan can be found in Trani et al. (4).

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understanding the business implications of an expatriate workforce. At other times, the data serves as a proxy for understanding personal adaptability from an individual, psychological perspective. Yari et al. (7) highlight how cultural competence can also be defined according to discrete domain. Nevertheless, what many studies do not evaluate is whether these behavior sets, and crucially, their meanings, become assimilated into the self-concept and cognitive schema of the individual, likely due to the difficulty measuring such highly subjective experiences.

Though the literature on the whole is most likely observing a superficial, yet near-obligatory adoption of specific behaviors compatible with the business standards of a new country, these observations, and those gleaned from similar varieties of studies, can help to understand the degree to which personal efficacy can translate across international contexts. More importantly, they give numerical validity to what the ethnographic literature (one saturated with a nuanced discussion of personal exploration, identity politics, and subjective experience) has long revealed: culture, whether in the performative or intrinsic sense, can be highly mutable, despite the commonly held presumption of "culture" as a collection of features that follow a person from context to context. Although more recent scholarship has come to regard it as dynamic, wherever possible, the word "culture" is specifically avoided due to the fixed mindset the term can be made to imply, thereby negating the immense human capacity for situational responsiveness, as well as lasting expansion of world views and behavioral repertoires.

Nevertheless, in the case of Afghan women and even Afghan minorities, where so many factors have chronically aligned to narrowly define their social mobility, opportunities to profit from enhanced maneuverability as well as personal adaptations may be out of reach, even when resettled to a new country. Though some of this may be due to transplantation of familial and other social systems to the new country, this is often largely due to structural barriers, including the rigidity with which medical systems and disciplines define themselves. In discussing the challenges which resettled women are likely to face upon arrival to a new country, for lack of better terminology, the word "Western" is utilized herein to denote a specific kind of institutional approach to health with origins in the Hippocratic School (8), though to be clear, by implying marked societal delineations, this designation also remains, admittedly, a highly problematic term (as does much dichotomous thinking). In any case, there exist non-Western traditions whose wisdoms, and possibly, related "[adaptive] placebo responses" may often be disregarded due to positivistic bias, especially being that one of the distinguishing features of "Eastern" traditions is that they are "integrated within a worldview that encompasses natural philosophy, theology, empirically based clinical experience, and spiritual and moral tenets" (9). Therefore, in the face of myriad structural and ideological barriers, it is essential that health systems be prepared to interact with individuals for whom, due to multiple legacies of oppression, the present manifestations of the Western medical system might not be as desirable, but who nonetheless might benefit from some form of intervention.

As socioeconomic levels can often have significant impact on a person's outlook, life outcomes, and behavior (perhaps more so than culture of origin), some of the factors described herein may not apply as much to Afghan families of high socioeconomic status (SES) and high educational attainment as to those without these resources (10). The divide between the experiences of those with high educational attainment and those with little beyond cursory education or those with no education, might be stark enough that scholars such as Shin et al. (11) propose that "specific support and interventions are needed for two risk groups in Afghanistan: women with many years of education, and women with no education."

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Still, it is important to note from the outset that socioeconomics, tribe, region of origin, and individual family dynamics play an extensive role in the degree to which an Afghan woman is subject to potentially very strict patriarchy and limited social and spatial mobility (12). Furthermore, affirming that the designation "Western" in no way implies the absence of patriarchal attitudes, gendered social obligations, and outright gender-based abuse by both individuals and systems, there are, of course, "liberal" or Western-leaning Afghan families whose values might have greater alignment with Western ideals of women's rights and roles than those of the wider Afghan context.

Furthermore, while low relative to the overall population and very low compared to international standards, it is important to note that according to the Afghanistan Statistical Yearbook, the number of women graduating from tertiary education during the years of 2016-2020 (Table 1) was nonnegligible, and though the data reveal that while education for women was becoming increasingly accessible during this period, it remained relatively low in terms of general population and gender ratios (13, 14). In households meeting or exceeding these higher education metrics and other socioeconomic indicators, conformity with the prevailing gender norms may or may not be as pronounced, and it must be noted that many activists, men and women alike, have risked their lives in advancing human rights and equitable access to justice and education (15-17). However, the realities of the challenges facing Afghan women, including those from relatively high SES families (such as the wives of many Special Immigrant Visa recipients), should not be minimized for the sake of political correctness due to a relatively small proportion of family systems for whom the pervading norms might not apply (13, 14).

2.2 Societal constraints on the rights of women in Afghanistan

Many human rights perspectives utilize the individualistic freedoms that inform Western societies as barometers of societal health. Setting aside arguments of individualism versus collectivism vis-à-vis human rights, women worldwide face numerous challenges beyond the restriction of their personal autonomy. Still, by most human rights standards, as well as consensus in the international arena, Afghanistan has very poor accountability in the protection of women and minorities, despite language to this effect in the constitution, as well as updated penal codes and political rhetoric around the improvement of women's status in the region (18-20).

Still, one must take care to avoid exploiting women's issues to an othering effect by virtue of exaggerating Afghan women's suffering, especially being that their narratives have been repeatedly co-opted to legitimize dramatic political shifts (21, 22). On this mischaracterization, Omidian and Miller (22) observe:

The disempowering image of Afghan women simply as victims of oppressive and discriminatory practices is ultimately no more accurate than their occasional portrayal as supremely and universally resilient despite the multitude of stressors they endure. Like all women, they possess strengths and vulnerabilities; some women show remarkable resilience despite their experiences of war and the difficulties of everyday life in Afghanistan, while others suffer profound emotional distress.

In response to the usurpation of women's narratives, Schütte (19) and Fluri (21) examine women's own understandings of the implications of strict patriarchy and poverty on their lives, with both of these factors playing major roles in their access to social and material resources. They and other authors highlight how many of the norms that enable these patterns are in direct contradiction with the Afghan constitution, the rhetoric of the Karzai regime, and other laws which aimed to present a picture of a previously globalizing Afghanistan (19).

Utilizing a high-profile rape case from Afghanistan as an example, Wimpelmann (20) highlights the degree to which public discourse is dictated by the political climate. He further notes the reticence of the Afghan public and local authorities to engage in sustained, public, and collective action that would lift the stigma on discussing the violation of women's rights and their bodies, as well as on the reporting of gender-based crimes. Moreover, since crimes implicating a woman's honor can have severe repercussions for the family's reputation and safety within wider society, bottom-up pressure on the government has been slow to arise, and when present, has been further compromised by the meddling of government officials and aristocrats (20). Add to this social imbalance continuous conflict and violence endemic to the pre-2021 environment (whether by warring domestic factions or foreign presence), and the odds for an Afghan woman to emerge from her social context without some sort of major risk factor for psychological distress become ever more distant. Addressing conflict trauma specifically, Schaal et al. (23) utilize the case of the Rwandan genocide to examine intergenerational post-traumatic stress disorder (PTSD), exploring this phenomenon by conducting ethnographic work among survivors of the genocide -a gruesome conflict that eradicated more than 10% of the country's total population and which left only 8% of households without the loss of a family member by "violent death." The authors found that cumulative stressors and poor physical health were the strongest predictors of a PTSD diagnosis among survivors, who, like Afghans attempting to recover from wartime trauma, may struggle with issues of complex and prolonged grief. While Afghanistan has not suffered a genocide on the scale of the Rwandan genocide (the slower-paced trend of Hazara persecution notwithstanding), both societies share similar environmental and societal scars in that almost every household has been touched by "violent death", and in that for years, the social and physical environments were characterized by unremitting chaos and fear (23). The conflicts also left many orphans and widows assuming the role of head of household within a distinctly patriarchal system, with Omidian and Miller (22) even noting that 37% of women surveyed were widows, while none of the men surveyed were widowers.

Other studies have found that in certain areas, one in ten children had lost one or both parents (24). The mass traumas that have been inflicted on Afghan society from within its own borders, as well as the significant violence inflicted by foreign powers, have the distinct potential to create lingering inter-generational trauma, displacement, and community disruption through social reorganization (23, 25), a phenomenon perpetuated in large part by the fact that caregiver mental health is correlated with negative mental health outcomes in children (24).

2.3 Self-efficacy within the domestic sphere

Turning from the political arena to the domestic sphere, the situation of Afghan women is not wholly unique in the world, since globally, women are subject to disproportionate levels of systemic violence, familial violence, and oppression compared to men. However, the Afghan situation has a unique combination of social, legal, geopolitical, and local religious interpretations that maintain this elevated potential for adverse health outcomes among women. Naturally, many women might lead fulfilling lives despite what others might describe as an oppressive milieu (12). Far more, though, would describe some variety of imbalance between the genders, regardless of how it is framed (whether in familial, political, social, spatial, or religious terms), and while not all endorse related mental health consequences, the greater proportion does (12, 19).

In mapping the outgrowths of these adverse experiences, scholars have observed that many Afghan women, including those who have experienced conflict trauma and displacement, might still cite their daily stressors as being more significant to them (22, 26). This is supported in that a number of authors throughout the displacement-related mental health literature (DMHL) at large posit that the

trauma symptoms that many resettled women face could be ascribed more to ongoing risk factors within the environment than to conflict. That is to say that they face an environment in which distress, poverty, lack of access to medical care, and stable food and water supply may act syndemically, in which women's roles are highly constrained, and in which familial violence affects many households (18, 22, 24, 27).

This is further supported by the work of van der Kolk et al. (28), who find that persons with histories of early abuse who are suffering from disorders of extreme stress not otherwise specified (DESNOS) may also prioritize functioning². Many scholars address the background stressors faced by Afghan women by framing them within an environment recovering from years of foreign occupation, civil conflict, and war-related destruction (31, 32). Since women are far more likely to be widowed than men are to be widowers, these dynamics introduce further hardship into the already complex lives of women situated within roles strictly delineated by Afghan national society.

Socioeconomics, education, tribal tradition, region of origin, and family subsystems also play an extensive role in the degree to which a woman is subject to limited social and spatial mobility (22). These and other demographic factors influence the type of medical and mental health services sought, how readily they are pursued, and whether these services are of a public or private nature (and thus the financial burden incurred). They may also constrain the degree to which a woman may pursue services rendered via a male provider (12, 33-38). In terms of gender circumscribing experiences, Rasmussen et al. (39) write, "Men and women inhabit different social and emotional spaces in Afghanistan, with downstream implications for psychosocial and physiological well-being." Moreover, the intersection of education and female sex have a very high impact on psychological and physical morbidity within Afghanistan (27, 40). Largely, though, Afghan women, especially those situated in the more resource-scarce tribal regions, are often born into poverty and restricted to minimal schooling if they are educated at all. Additionally, many women are married off quite young with the intention of protecting daughters from multiple outside dangers, economic insecurities, or perceived threats to family honor (19, 41).

The dynamics of FV occur worldwide and are highly nuanced, and natal families can sometimes confer protection from aggression or violence by in-laws and other parties (42). However, as has been observed in other Central Asian and subcontinental regions, as well as various areas of the broader Middle East, a married woman may be mistreated not only by her husband, but also by her extended family, who may not include her in family decision-making processes. Should a woman not wish to conform to the obligations imposed on her, she often has little social or legal recourse, as laws against FV are not consistently enforced by local authorities, and as these are often viewed as private, domestic issues in which it would be shameful for outside parties to intervene. Though higher income countries are not immune to this dynamic, this perception of FV as a private matter is seen in a variety of low-income countries and is rendered even more complex due to a broader understanding of kin relationships (19, 43, 44).

Metheny and Stephenson (18) provide very enlightening perspectives on the dynamics of help-seeking behavior in Afghanistan and these patterns' relationships to demographic factors. It is especially noteworthy that they find that the "acceptability of IPV in Afghanistan is widespread, with 80% of women and 72% of men in the 2015 Afghanistan Demographic and Health Survey agreeing physical IPV is justified." Kabeer and Khan (12) further observe that given the weight of

² Other, more recent studies on the conceptualization/disambiguation of stress responses can be found in Al-Kubaisy and Al Qaisy (29), as well as de Silva et al. (30).

expectations placed on them, many women feel resigned to their roles, even if they think it unjust. Moreover, Sulaiman-Hill and Thompson (45) cite that many Afghan women perceive their struggles as intractable. Feelings of helplessness can become further ingrained due to inadequate and potentially complicit lack of policing, as well as enforcement of protections for women (12, 18, 19, 46).

Various scholars speak of the prevalence of FV in Afghan households and its near-direct connection to the economic insecurity and feelings of financial powerlessness experienced by husbands struggling to maintain ever-scarce employment. An entire generation of men has been rendered increasingly incapacitated, leaving women to assume greater responsibilities despite little growth in the public protections afforded to them and despite little recognition for their contributions. The men of poorer tribal regions often are employed at nearly negligible rates, and their inability to ensure their family's everyday survival, often exacerbated by drug addiction, may lead to struggles with feelings of inadequacy. Some may subsequently displace this aggression on their female relatives (12, 19). As a result of economic hardships, women must often engage in significant amounts of domestic work, and some may add to this list of tasks by engaging in some manner of income generation, though these activities are usually limited in scope to preserve her dignity as a married woman (12, 19). Other scholars, such as Abirafeh (15), document the social friction introduced between the male and female spheres by the gendered agendas of foreign intervention, whether intentionally or unintentionally. These factors combine to create a highly stressful environment for women who must simultaneously negotiate many different roles and expectations, often in the midst of great physical and emotional suffering in their private lives. Add to this the pervasive devastation and fear instilled by several decades of constant civil conflict, the military activities of foreign forces, and the instability created by terrorist groups, and the potential for baseline trauma grows (22, 32, 47).

Speaking with Hazara women on their perspectives regarding gender dynamics, Kabeer and Khan (12) combine the findings of many interviews to provide an overview of the "typical" Hazara woman's situation with regards to her autonomy, self-perceived familiar roles, and as a member of wider society. They find that for all the scholarship which posited that women enjoyed enhanced authority in the domestic realm,

Many of the women in our study did not enjoy the respect and authority within the domestic sphere that some authors have claimed was their cultural due. Their contributions to the household economy went unrecognized until they took on a monetized form. Male privilege remained largely intact, even when men failed to discharge their responsibilities; and violence was used on a routine basis—most often by husbands against wives, but also by dominant members over subordinate ones. (12)

Although the women included in this study were Hazara and not necessarily reflective of the Sunni majority, and although the authors advocate for caution in generalizing the study, the dynamics described herein are indeed reiterated across the body of literature on Afghan women's experiences.

3 Synthesis of clinical perspectives and proposals

3.1 The impact of frequently endorsed life events on clinical presentations

Generally, in Western medical contexts, individuals exhibiting post-traumatic symptoms would be recommended trauma-focused therapy, likely through a number of possible modalities, such as cognitive processing therapy (CPT) (48), eye movement desensitization and reprocessing (EMDR)

(49, 50), accelerated resolution therapy (ART) (51), or similar treatments. However, the English language literature on Afghan family systems (as assessed from a Western mental health perspective) is not well enough developed to be able to utilize one single theory as a guiding framework (nor should only one be used, arguably). Still, enough information exists about the functioning of families and the uniqueness of Afghan women's particular social circumstances that one can draw upon these collected narratives to arrive at an understanding of their familial and environmental stressors, the elements of which (limited autonomy, a sense of isolation, financial concerns, food and water security concerns, FV, war and conflict-related trauma) are very consistent across the body of work.

The past decade has seen an increasing attempt to address the colonization of the field of international development, and by extension, international education and health's increasingly Western-centric orientations (52-54). While psychiatric diagnostic labels could be seen as useful shorthand in describing symptom clusters, studies of trauma across international contexts have resulted in an overall questioning of the universal clinical utility of Western-developed constructs, as idioms of distress can vary. Kaiser et al. (55) describe differing conceptualizations of symptoms, stating, "Ethnographic research is informative here because it facilitates the identification of cultural concepts of distress that communicate the complex etiology, meaning, and response surrounding forms of suffering." Other scholars advocate for the utility of medical ethnography beyond enhancing the "quantitative research tradition" into the direct education of health professionals (56). Nevertheless, some of the DMHL has not yet demonstrated this awareness of differing idioms of distress, nor has it addressed their implications on the development of interventions or the structuring of medical systems, yet refugees are routinely assessed in terms of their degree of system utilization (2).

Numerous research teams over a wide array of destination countries speak of "low mental health literacy" as a strong predictor of poor help-seeking behavior among Afghans suffering from PTSD, and therefore, poor health outcomes (as theoretically evidenced by health service uptake trends). However, while many scholars do account for obstacles in service uptake rates, practitioners should still be cautious in taking assertions about help-seeking behaviors at face value, especially across social contexts, as they could vary according to the landscape of logistical variables (2, 32). It should also be noted that individuals of alleged low health literacy might very well be aware of the situational etiology of their symptoms, whether or not they understand them in biological terms (1). Inflexibly holding assumptions about the meaning of health literacy can be perceived as dismissive and may create oppositional dynamics where perhaps none were warranted (45).

In a fictitious example, a previously rural, but now resettled Afghan woman may know that a recent miscarriage and the violent death of her brother two years ago lead her to say "*jigaram khun hast*" (literally, "my liver is bloody") and that her *fishar* is high ("*fisharam-bala hast*"). In other words, she is grief-stricken and also anxious as manifested in certain symptom clusters, and she finds herself "thinking too much" about images of her brother's body. In terms of *jigar-e-khun*³, she likely knows that her liver is not actually bloody, as this is metaphorical, but it points to her grief feeling somehow physically manifest, including physical agitation and possibly aggression. This somatization would be corroborated through articles on chronic pain in displaced and survivor of torture or targeted

³ Idioms of distress such as *jigar-e-khun* serve to highlight how populations may perceive certain bodily sensations and emotions as being grouped together in manners different than those prescribed in the Diagnostic and Statistical Manual (DSM-5) and the International Classification of Disease (ICD-11), and therefore how targeting certain symptom sets without addressing others may seem to the client to offer incomplete resolution.

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violence (TTV) populations (40, 57-60), especially since the physical consequences of TTV can serve as ever-present reminders of the humiliations endured.

More importantly, regardless of how her anguish is expressed, she may identify this grief as problematic due to decreased functioning in important life domains or in her ability to fulfill reasonable responsibilities. In terms of symptom alleviation, she may know of several ways to help remedy these concerns, whether or not through formal intervention, and she may take efforts to restore her psychological health via her physical health or vice versa. In a certain regard, this could constitute a relatively high form of mental health literacy, just a locally informed one that may not adhere fully to the Western clinical model. Ascribing low mental health literacy to such a person may therefore accurately describe her unfamiliarity with biological principles, but when reduced to statistics within research, it can ascribe incorrect reasoning to her and similar women's decreased pursuit of medical resources in a resettlement context, where their low utilization may be due to repeated failure to reach adequate help or the inability pursue it through the prescribed channels. The woman may also be dissuaded from using the available health systems due to the number of men with which she may have to interface prior to obtaining the desired help from a female provider, and certain providers may fail to see her concern about the perceived integrated nature of her ailments, which can lead to her feeling dismissed. Studies assessing service uptake would thus have to ensure a low level of barriers to service and should first provide substantial, proactive education in a format acceptable to the client about how to access the health system in question before being able to accurately measure willingness to engage with the available systems.

Unfortunately, rather than a comprehensive effort to bridge the gap from both ends, most psychoeducational approaches, though they may begin with the intention of "meeting the client where he or she is," may ultimately skew towards the edification of, or "fixing" of the client rather than the education of the practitioner. Certainly, resettled individuals would do well to gain fluency in the scientific language of how physical and mental health are understood and practiced in their new social contexts, but such an approach assumes that the simple eradication of medical "ignorance" would suffice in improving help-seeking behaviors. This manner of one-sided approach is negligent in that practitioners should be equally bound to learn as much as possible about their clients' understandings as their clients are to learn the Western medical model of mental illness. Furthermore, social programs and health systems must consider the elimination of systemic barriers as a crucial part of the therapeutic process – one critical to rebuilding self-efficacy, as well as social trust where it has been lost. This restoration of trust is especially important when designing interventions addressing the needs of populations which have witnessed cataclysmic societal and institutional collapse.

In addition to outlining considerations for research, this article therefore advocates for offering client systems sustained education on how to access services in tandem with scientific education about mental health and bodily systems. Critically, it should be paired with an equal if not greater level of effort in better educating practitioners who may interface with unfamiliar populations, especially those with high trauma loads. It should also emphasize the integration of core concepts of "community-based system dynamics" within program development for improved monitoring of feedback loops (61).

3.2 Limitations of current literature on displacement-related mental health

When faced with high numbers of individuals from a relatively new or underserved population, the response by the provider community might naturally be to turn to the closest body of information.

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However, while interventions should indeed be evidence-based (as sourced from studies on populations most closely resembling the client populations in question if there is not enough literature on an exact group), the degree of applicability of literature on other displaced populations to the Afghan situation should be validated, and at minimum, questioned.

In terms of therapeutic options, the preponderance of literature arising as a result of the 2015 mass displacement of Syrians will likely help to inform responses to the fallout of the 2021 crisis in Afghanistan in some manner, and health systems are also likely to be more aware of better practices in managing large-scale influxes today than they were in 2015. Still, as often occurs, popular interest in the Syrian crisis led to numerous, not particularly substantive articles exploring migration-trauma symptomatology. On the whole, most studies did not lead to practicable outcomes through the development and piloting of appropriate, therapeutic modalities, and many seemed to have only superficial grounding in the mechanisms at play in the migrant experience logistically, psychically, and "culturally." Though future studies would have to bear it out, it's also possible that the political contexts of these two crises may result in differences in the specific nature of feelings of betrayal by the international community, especially when considering the perspectives of those qualifying for SIV and similar status based on records of distinguished service. Where environmental factors are considered, other articles include only a cursory nod to logistical challenges, effectively deemphasizing their importance in outcomes.

Though the overall result of this interest in "refugee mental health" is a net positive, along with the benefits, intense surges of interest in a given crisis may also cause harm in that entities not grounded in the practice of working with distinct populations can reinforce hurtful paradigms, such as overemphasizing that low literacy *universally and necessarily causes* low utilization, as well as counterproductive underestimation of client-agency. Even the work of established authors may also employ stigmatizing terms, such as "war-torn," "traumatized refugees," and conversely, hyperbolic references to resilience. Additionally, while some displaced individuals and persons with refugee status will freely embrace the term "refugee" as part of their personal identities, political abuse and exploitation by humanitarian bodies has rendered the term problematic and widely misunderstood. Moreover, its imprecise use makes "refugeeness" (and associated perceptions of neediness as opposed to agency) core to the person's identity rather than a product of circumstance. Perhaps most harmful, researchers less grounded in practice may also exhibit the flippant labeling of challenging client reactions as being necessarily culturally rooted when there may in fact have been a significant lack of cultural competence on the part of the provider or researcher.

Moreover, however useful the resulting body of literature might be in understanding "refugee mental health," one might encounter challenges in applying the observations gathered from the Syrian crisis to the current crisis in Afghanistan. In exceedingly broad strokes, the economic and educational contexts of Syria (in which prior to the war, 93% of the general population had or was in the process of attaining basic education, and in which during the 2012/2013 academic year, approximately 659,394 individuals were enrolled in higher education institutions) were much higher as compared to those in Afghanistan up until 2021. In 2015 Afghanistan, the adult literacy rate was 38%, a level substantially lower than the international average (84%), and also lower than the averages of Iran (87%) and Pakistan (56%) (62, 63). It's also worth considering that while ISIS eventually rose to power to occupy the vacuum created in the Levant after the collapse of the Syrian state, the Afghan milieu differs significantly in that known terrorist groups have held considerable sway over geopolitical realities for decades, including violence against the Hazara and widespread violence against women (64, 65). With these and many other factors considered, including the highly

gendered stratification of society on which the present article focuses, advances promulgated by articles addressing the Syrian exodus may or may not be as advantageous as one might hope.

There exist many studies employing standard, Western clinical interventions, as well as other “alternative,” yet still essentially Western approaches, such as art therapy with displaced, asylee, and survivor of TTV populations. These are mostly conducted in group settings, presumably for the sake of efficiency and cost reduction. Currently, the overall literature on both Western and non-Western clinical approaches as applied to Afghans specifically is seriously lacking and at times contradictory. Most conspicuous is the absence of rigorous, evidence-based interventions appropriate and specifically designed for Afghans' psychosocial needs, and furthermore, as shaped by the voices and preferences of Afghans themselves, reflecting a wider problem within health system development. On the overall lack of beneficiary informed services, Trani et al. (61) observe:

‘The broad framework of ‘participation’ in global health and development efforts has been variously embraced and critiqued as a solution to engaging with diverse local needs. Yet there is little uptake of approaches to designing policies and programs that engage with complexity, respond to the needs and promote the capabilities of the most vulnerable, and provide concrete steps for action.’

Where there exists information, certain scholars and their perspectives easily emerge as overrepresented due to the lack of alternative proposals. Fortunately, some studies on working with Afghan clients do exist in order to begin conceiving of models that might help to at least mitigate the challenges encountered when mass arrivals threaten to overwhelm already inagile systems.

3.3 Previous studies on interventions for Afghan clients

Although PTSD has good construct validity in that it aligns with reported symptom clusters in Afghans having experienced trauma, and though it has a positive, yet "modest" correlation with war-time events, it has been postulated that it has overall poor clinical utility in the Afghan context.

War-related traumatic stress was not more strongly related to PTSD than to depression, anxiety, or general distress (as measured by the ASCL); in fact, traumatic stress was marginally more highly correlated with depression, and significantly more highly correlated with generally [sic] distress, than it was with PTSD. Previous studies note that results may be partly affected by the constraining influence of “gender-appropriate” expressions of emotion; however, numerous and sometimes cumulative lifetime challenges lead to sadness being among the most salient experiences in high-conflict environments. (47, 66)

Also noted within the literature is the fact that individuals may feel that divulging too much of their experiences might burden others suffering from the same, and those to whom they turn are usually confidants within their social circles, including the approximately 20% who do seek support for FV (18, 47). To this end, Ahmad et al. (67) note, “The high prevalence of PTSD, its association with social support and self-rated health are important issues to be considered for refugee resettlement programs.” They also add that this might be particularly true of client systems that “originate from communities with strong social bonds and ‘collectivist’ values” (67). The importance of enhancing the social environment is a sentiment also echoed in the work of Bolton and Betancourt (68).

It is critical to understand that while Western clinical models may often prioritize the emotional aspect of daily functioning, Afghans suffering from grief tend to prioritize the completion of tasks and fulfillment of social obligations over sentiment in terms of motivation for seeking help (47).

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Additionally, programs centered on ill-fitting diagnostic models can be alienating to the intended beneficiaries and may therefore have limited, if not poor viability, and they may also be perceived as invasive among individuals who have already been subjected to severe incursion on their bodily autonomy and rights throughout their lives. Given this, there exist mental health models proposed for emergency contexts and which may be of interest to those adapting interventions for specific populations, but as sustained intervention is rarely feasible in camps or other emergency settings, approaches such as the World Health Organization's PM+ do not target the trauma itself to any great degree and instead focus on building problem management skills (69, 70). These types of approaches should not be the ultimate aim, as they constitute the minimum which should be provided, but the perspective that the PM+ and similar systems afford could certainly reinforce tailored programming. Furthermore, help-seeking behavior among Afghans differs in host-country contexts, and a limitation of many articles performed in resettlement contexts is that they make a connection to conflict and resettlement-related PTSD, but make little direct reference to the other pervasive social factors to which Afghan women might attribute more weight (e.g., FV, child marriage, seclusion/isolation, and poverty) (71, 72).

Although the current sociopolitical environment in Afghanistan is frequently thought of as entirely repressive to women, it is important to explore the creative ways in which women have chosen to empower themselves, especially as many households lose their men's support to disaster, disability, unemployment or drug use (12, 19, 36). Some authors, though, maintain that claims about women being respected in the performance of their social duties are a sweeping generalization, as many receive no recognition for their contributions until they can gain leverage by generating income. Anecdotally, enhancing their economic power through microfinance has also led to some women claiming reduced beatings by their husbands (12). Given that monetization of their activities has at times been seen to enhance financial stability and serve as a protective factor, individuals working with family systems could consider supporting women in seeking employment. Granted, any program proposing work-based or educational intervention should consider contradictory findings and would need to monitor for an escalation of violence due to perceived imbalances, as Ackerson et al. (73) observe can happen when women from India begin to receive more education relative to their husbands.

In the light of available literature on interventions, it seems that therapeutic practice with Afghans experiencing grief and trauma, has also been approached through "alternative" modalities falling outside of the standard one-to-one talk therapy format, and were plausible, group-based work (71, 74-78). Droždek et al. (77) conducted a ten-year study which followed male Iranian as well as Afghan refugees and asylum seekers who had survived torture and had been resettled in the Netherlands. The study participants, all of whom spoke either Farsi or Dari, were enrolled in trauma-focused group therapy administered within several different intensive day program regimens. The study compared the efficacy of different treatment intensities between the various treatment groups as measured by the number of weekly sessions. The major findings of the work were that intensive, yet less expensive day treatment programs decreased symptoms greatly as compared to the control group, and furthermore, they improved symptoms at least as much as inpatient treatment based on other studies and evidence (77).

Importantly, the authors found that vicarious exposure to others' traumatic histories in a group context was not found to have any harmful effect despite the concern about secondary traumatization, nor did it cause any group members to drop out, since, as the authors speculate, the universality of these narratives among the members appeared to create cohesion (77). Though it offers an interesting perspective, a limitation of this study is the inclusion of only men since Afghan women's issues could

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be argued as being far more nuanced and multidimensional (22, 26), especially in the case of widows, who have been reported as having the highest levels of stress (26).

In other interventions specifically designed for the psychosocial needs of Afghans, Berdondini et al. (79) worked alongside Afghan mental health professionals to develop a research-based program aiming to ameliorate trauma symptoms (both male and female). In this study, the Afghan clinicians themselves served as clients. The colleagues then exchanged perspectives arising from the experience of having been clients themselves, deliberating about how to address (or not address) taboo topics, as well as how to draw out information from the client without seriously violating norms (79).

Their work highlighted a potential incompatibility of approaches largely dependent on frank speech with Afghan norms. In their assessment, not only are certain subjects and emotions entirely taboo in the Afghan context, but too candid of expression of familial conflict, personal worries, or insecurities also violates social convention within a highly collectivist and interconnected society (79). One might thus be able to regard Berdondini et al. (79) and Droždek et al. (77)'s studies of group therapy as potentially at odds in some respects, though results may be dependent on the topics that emerge when debriefing members' feelings about traumatic experiences. Nevertheless, a possible takeaway of Berdondini et al. (79) is that group-based approaches that too overtly name feelings or that too explicitly detail personal matters might therefore be considered inappropriate.

Berdondini et al. (79) ultimately conclude that using psychodrama, molding, and other activity-based methods to arrive at understandings of interpersonal conflicts could be much sounder than questioning or probing some issues directly: "This methodology proved it was possible, in a culture where clients cannot explicitly disclose their worries and concerns, to run therapeutic sessions that are non-diagnostic, non-directive, [and] very respectful of client's needs and [which] are healing" (79). These suggestions were then reworked into a clinical trauma-focused approach based primarily on the use of psychodrama and symbolic object work. Certainly, though, the learning derived from this program and future iterations of this work may have international applications as well when working with expatriated Afghans.

Interventions of similar varieties could also integrate the principles of a growing movement which emphasizes the inclusion of restorative justice within trauma-based work. The Center for Victims of Torture (CVT) has worked on such an initiative. In addition to providing other interventions as appropriate, CVT and its partners have also offered survivors the opportunity to share their torture narratives in a manner which not only has therapeutic utility for the interviewee, but which also augments the documentation of mass human rights abuses. In so doing, the practitioners also afford survivors the opportunity to articulate their own visions of what proper justice might entail, and reports compiled from the aggregate data could then be made available to entities with the capacity to act upon these insights (80, 81)

An increased emphasis on justice is also supported by the work of Cardozo et al. (46), who found that "a substantial number of respondents reported that revenge would not be necessary if a justice system existed. Establishment (or reestablishment) of a justice system may be essential for postwar societies to decrease feelings of hatred and revenge" (46). Therefore, though projects of this nature would not constitute formal justice, the fields of restorative and transitional justice continue to evolve, imparting enhanced perspective to the meanings and responsibilities inherent to working with individuals who have sustained TTV, emphasizing the development of methodologies that simultaneously attend to individual well-being, as well as the health of the broader society.

Other studies by Kananian et al. (57, 82, 83) provide an excellent template for addressing the mental health of resettled Afghan and Iranian males in a manner akin to that proposed here. However, given that their 2017 study was a pilot, a limitation of this piece is the small sample size. Also, much of the article is understandably devoted to describing the methodology and to reporting results, and therefore, the specific manners in which the treatment itself was made to be culturally sound are not described in sufficient detail for true replication. Nevertheless, beyond delivery in the target language, ensuring congruence in the articulation of mental health concepts with existing linguistic frameworks, as well as following the *Manual for Culturally Adapted Cognitive Behavioral Therapy* (84), the study is also very noteworthy in: the centrality of somatic concerns to the project (and thus sensitivity to TTV history), the consideration of logistical challenges faced by the men (which they reduced through schedule optimization), the important aspect of client psychoeducation, and the real-time incorporation of client feedback. As the authors themselves note, a program for women would require further optimization to account for other variables, including domestic obligations.

This variety of study could be replicated and then described in greater qualitative detail, and after developing trust with participants and reducing initial anxiety levels, future researchers could explore different modalities (potentially more somatically/processing-oriented ones) outside of models based on Cognitive Behavior Therapy (CBT), given that CBT is among the most frequently used modalities in the literature on interventions for displaced populations.

Indeed, this sentiment is echoed in Kananian et al. (57) article on the modification of the PM+⁴ for Afghans who observe that “The [Culturally Adapted] CBT+ intervention produced a major improvement in general psychopathological distress [General Health Questionnaire] (GHQ-28) at posttreatment, as evidenced by large effect sizes,” but they and other scholars remark on non-exposure, CBT-based modalities’ appropriateness for those needing, tolerating or desiring only lower-intensity treatment (57, 69)⁵. However, in any more intense treatment, psychoeducation would be essential, as some clients may question how exposure to uncomfortable stimuli could be a pathway to relief from the disturbing symptoms which they elicit (such as intrusive thoughts and flashbacks) and as populations experiencing ongoing adversity may default to avoidant coping strategies which may be correlated with PTSD (67), though as Wildt et al. (66) write, “the direction of causality is unclear.”

Future research should also consider examining responses through the lens of C-PTSD as defined by the International Classification of Diseases (ICD) than the Diagnostic and Statistical Manual (DSM)’s PTSD, since as Silove et al. (85) write:

...some studies undertaken among refugees in resettlement countries have documented a poor symptom response to conventional treatments for PTSD and depression. The chronicity and complexity of the cases that receive treatment at specialized refugee-mental health services in these settings raise important questions whether the difficulties encountered in providing effective treatment relate in part to a failure to acknowledge the extent of the [Traumatic Stress (TS)] response which extends beyond core PTSD to encompass symptoms defined in ICD-11 as C-PTSD. It may be that refugees with this more general TS response which

⁴ Another study of the PM+ with resettled Afghans had also been underway in 2020, prior to the onset of the COVID-19 pandemic (69).

⁵ This trend likely reflects the general palatability of CBT approaches for a variety of clients, as well as its flexibility and ease of incorporation into other methods, but it may also reflect the relatively higher barrier to qualification in more expressly trauma-focused modalities.

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encompass difficulties in functioning and adaptation, warrant more extensive, multimodal approaches to treatment and rehabilitation which go beyond a focus on overcoming fear-related symptoms thought to underlie core PTSD.

Another major consideration relates to how to best engage in participatory research while still observing the highest level of medical standards. Mental health provider training within the Basic Package of Health Services (BPHS) has been found to be inconsistent, with Missmahl et al. (86) stating that, “even doctors trained in internal medicine and specializing in mental disorders within mental health hospital require training in basic neurological examination skills.” This aligns with their findings that some psychosocial workers conflated “giving advice” with having performed quality intervention. They state that within the BPHS, many psychosocial workers received only a year or so of specialized mental health training. Therefore, research teams should be aware of these potential gaps in training rigor and potential inclinations toward directive approaches.

All that said, what little theory existed on appropriate interventions may have to be re-evaluated given the fact that not only will many Afghans now be repatriated (thus potentially rendering patterns within family and community systems pliable), but also given the fact that many of those resettled in high-income countries will be from the relatively higher SES bracket. Still, it is important to understand the environment in which such clients were living prior to the onset of the crisis in order to keep these considerations in mind when designing studies aimed at further refining understandings.

3.4 Proposals

Afghans arriving in various host countries will bear the impact of environmental stress and chronic war trauma, all of which could be compounded by the extremely acute, fundamentally life-altering 2021 collapse of the state and subsequent, emergency relocation to a new environment. It will therefore be important to isolate how these various factors can interact to impact an individual's mental health outcomes to better design programming and interventions in response to these specific needs, as opposed to basing interventions wholly on the aggregate findings of the existing DMHL, much of which already does not take into account the unique dimensions of the Afghan experience.

Since an expanded social circle may help the client cope with her pressures through logistical and emotional support and assuming the acceptance of help by the decision-making parties in a family system (ascertaining firstly that offering a family social services would not jeopardize the woman's safety), one viable first step might be for practitioners to continue to provide informal in-home psychosocial support to family systems with women unable to exit the house or for those who would need to travel long distances to obtain services. This could be coupled with opportunities for the client to explore her creativity, either as a pastime or as a means of empowerment through remuneration. Upon gradually becoming more financially stable, the client could begin to explore other creative or economic outlets that she finds empowering and which afford greater socialization within her community, further decreasing isolation. Lower-intensity activities of this type could continue so long as they do no harm and bring some manner of interpersonal interaction to the family that would, at minimum, reduce loneliness. This monitored support, however rudimentary, could be offered in group or individual format and ideally, would be led by a female counselor.

As for subsequent clinical interventions, based unquestioningly on the synthesized literature alone (and public health situation permitting), it would seem that the ideal intervention would be enrollment in a day treatment program, though this may be problematic for women who might be encouraged to remain largely at home. Regardless of whether services would be delivered in the

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home or another location, the program could first employ adapted versions of the PM+ and other management-oriented strategies that would help in the prioritization and emotional contextualization of everyday tasks. Depending on client receptivity and absent other barriers, were a client to feel ready to entertain formal counseling, clinical engagement could commence, especially with trust having already been established between the client and social service systems or the clinicians involved. In this case, preparatory psychoeducation sessions could be offered prior to introducing modalities specifically targeting emotional concerns or traumatic stress responses so that they are better prepared for the temporary discomfort that might arise over the course of therapy. Any of the above approaches could also integrate elements of justice-focused or socially conscious models, allowing women to articulate what they would like to see in terms of redressing the wrongs perpetrated against them and in creating a social environment which they would deem acceptable.

It must be noted, though, that this design is clearly hypothetical, since in the real world, simply amalgamating positive findings does not necessarily yield an effective intervention. Of course, major logistical challenges also exist in realizing each of the above proposals (not least of which would be funding), and executing this combination of interventions simultaneously is likely to be difficult given the many social constraints that exist in host countries already struggling with health inequalities among their non-immigrant population. Most notably, for newly arrived individuals, there is a severe lack of competent mental health resources available to the uninsured, those with low incomes, or those with transportation problems. Linguistic barriers are also seldom accommodated to a sufficient degree, leaving the client at a further disadvantage in accessing treatment.

Even with all these criteria being met, it would be unlikely to find enough local, qualified clinicians with experiences that would enable them to understand alternative models of viewing and talking about mental health, let alone clinicians who could competently perform sustained exposure or effective group work across societal lines. However, as previously stated, the current crisis creates not only a great need, but also a unique opportunity to reevaluate assumptions surrounding ideal modalities, key topics, and sequencing of interventions, as well as modes of delivery (in person or electronic). This is only one such idea, proposing a high-level overview of possible strategies for debate, recombination and evaluation.

Another important question to explore in the development of programming would be whether prioritizing cumulative daily stressors or addressing the histories of acute conflict trauma would be paramount in decreasing stress levels. The next layer of exploration could then ascertain participant interest in and receptivity to engaging in varying intensities, modalities, formats, and sequencing of themes during treatment. This could include overlaying modalities which directly target PTSD-like concerns (processing/exposure/desensitization/somatic therapies), versus more “actionable” modalities oriented towards overcoming impairment in functioning through the management of cognitively-rooted symptoms or problems, such as standard CBT. These could also be compared to supportive talk-therapy. Stratification of modalities as described here is encouraged by Panter-Brick et al. (24), who observe, “Emerging consensus advocates several layers of support for mental health programmes in emergency settings: those targeting the family and community, as well as those offering more specialist care for those in clinical need.”

As a note, some studies have found very high numbers of respondents attesting that the solution to their problems and their greatest comfort lies in religion (11, 66, 87). This information might lead one to conclude that the integration of spiritual components may be indicated, though it should be noted that this may not be appealing to all women. Firstly, education may modulate religiosity, and while the majority would likely be religious to some degree, respondents may feel socially or

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personally obligated to overemphasize the importance of religion within their coping strategies. Furthermore, women may also have been injured by the rhetoric of religious figures, so practitioners would do well to gauge the degree of a client's religious attunement through means other than direct questioning.

As for reevaluating what has been learned to date, assuming the availability of sufficient subjects, a first step in identifying ideal clinical approaches for adults could be to enroll married or previously married Afghan women who have met the following three conditions: 1) suffered some acute trauma in connection with war or conflict, 2) have been exposed to chronic, non-conflict environmental stress, and 3) have experienced FV.

The women would then be placed into one of nine separate groups, as described in Table 2. One such group would serve as a true control in that the members would not receive any intervention, and interaction with staff and other participants would be minimal (due to rejecting treatment, waitlisting, or other limitations), but they would be asked whether they would be willing to undergo the same assessments used with the other groups⁶. There could also be an experimental group (Group 1) in which no specific type of stress would be directly addressed (conflict trauma, routine environmental, or FV), but in which mindfulness or other benign techniques are taught for the women to use in their self-regulation. Having this first group would be a built-in means of identifying the impact of increased social contact and light mindfulness work alone.

Experimental groups 2-9 would utilize this same basic mindfulness or other bio-feedback training in addition to isolating the effects of specific concerns by addressing them either simultaneously or in succession at the discretion of a group of expert clinicians. Symptom improvement could thus be tracked over a few months using the Afghan Symptom Checklist (26), the Hopkins Symptom Checklist (88), the Harvard Trauma Questionnaire (89), or other applicable instruments. Results could be analyzed to generate preliminary conclusions regarding which types of issues are most critical to address for quickly lowering baseline stress levels. If desired, those groups addressing war/conflict-related trauma and related feelings of betrayal could be further divided to better isolate the effects of trauma prior to the 2021 withdrawal, as well as the trauma endured as a result of this event. Critically, insights gained should also be verified through qualitative data in the form of participant interviews/focus group discussions.

As with the previous suggestions, such a study design is clearly aspirational, as: 1) the participants may not be sufficiently forthcoming with their concerns to be properly categorized, 2) logistical barriers are often insurmountable in accessing services, and 3) some individuals may not be permitted by their families to participate. Attention should also be paid to the ethnic groups to which the women belong, since some members may be opposed to mingling with individuals of other ethnicities, thus discouraging participation.

There are also important ethical considerations surrounding FV. Given the vulnerable intersection of refugee status and FV, the reality may be that until legal and social service systems in the destination countries catch up to their ideals, systems may not be equipped to handle the specific needs of refugee survivors of FV, especially given the lack of literature on appropriate responses to gender-based violence in displacement settings. The lack of informed guidance is conspicuous, and in their analysis, Asgary et al. (90) wrote, "We did not find a single article evaluating either the prevention or

⁶ See Bolton and Betancourt (68) for suggestions regarding controls and timing of intervention.

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treatment/management of GBV and its health consequences in displaced populations that met the inclusion criteria.”

Additionally, and with the exception of cases involving minors, isolating a woman from her family system before she feels empowered to leave on her own could be argued as causing considerable hardship, as seen with South Asian immigrant women who often face many obstacles in leaving their abuser (43, 91). Among resettled women, this dynamic can be even more severe given the brief time which systems allow for resettled individuals to attain financial security, noting that in these cases, "poverty interferes with women's ability to meet basic needs, forcing survivors to prioritize housing, food, and employment over safety and well-being" (92). Abusive family members, and especially intimate partners, may grow wary of outsiders being privy to personal information, so assuring that the abuse is no longer ongoing (likely meaning that the partner is deceased or that ensuring that the woman is removed from the family system and thus safe from reprisal), would make the study safer for participation, while still helping to account for the impact of FV on Afghan women's lives. These measures would not rule out all risks, though, and it would be incumbent on researchers to properly mitigate these and any other possible risks to the woman's safety, including possible breaches of confidentiality when working in group settings. Nevertheless, if feasible, collecting qualitative data on variables may also help isolate those elements most salient to a woman's experience. Of note, if properly facilitated, even participating in these focus groups may have beneficial results in that they may enhance group cohesion and may foster social connections (41).

Whether utilizing this model or designing any other study with understudied or marginalized populations, any results observed and programs subsequently derived should then be tailored through focus groups involving the population in question to verify compatibility. Additionally, all phases of the process should involve Afghans themselves in research and leadership positions so that they may shape the structure of the intervention and its implementation. Distributing assistant roles among some of the more educated women (and Afghans at large) wherever appropriate may have some benefit in ethically managing health system overload. Furthermore, Afghans should have the critical function of optimizing the study environment so as to avoid re-traumatization, and ideally, of establishing an atmosphere conducive to participation.

Implementation of the resulting modality would have to be compatible with the limitations of the insurance and logistical environments encountered by participants in accessing services, and as mentioned, could involve a component such as that of CVT, whereby survivors are encouraged to proactively contribute to a body of proposals on how to correct wrongs at the societal level, engendering a sense of healing and meaning through constructive critique. Most certainly, other studies could be proposed, but based on the various dimensions that the body of literature repeatedly highlights, learning which stressors are most amenable to intervention would be beneficial in quickly attenuating distress.

4 Conclusion

The people of Afghanistan have endured significant violation of their self-determination from all manner of injustices, from foreign intervention in the form of sustained wars, the dependence on foreign support created by said wars, corruption within the Afghan government, and the presence of extremist ideological factions, all of which had significant impacts on day-to-day living. Despite increasing access to education and social resources in the decades prior to the 2021 U.S. withdrawal from Afghanistan, women continued to be further marginalized by pervasive abuse in the domestic and wider social spheres, and they have also continuously endured the international co-opting of their

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narratives, thus compounding baseline trauma potentials within the environment. Yet, though studies exist on the prevalence of trauma symptomatology within Afghan family systems (both for those resettled and those not resettled), few propose specific models for intervention, and fewer still incorporate the voices of Afghans themselves.

Limitations of this article include: 1) limited resources available for a more systematic investigation of the gap identified; 2) only the English language literature is addressed, potentially overlooking local knowledge and language which could be informative in developing tailored health systems; and 3) internal program implementation documents used in the establishment of systems such as the BPHS are not considered (38). However, while other literature on interventions may exist, such studies are infrequent relative to the overall literature describing trauma sequelae. Furthermore, as English is currently the primary language of social scholarship and one of the primary languages of international development at large, including of many of the major donors and bodies involved in Afghan affairs, such as the U.N./World Bank system, U.S. Agency for International Development (USAID), and the European Union, it would seem that here too, relative to the amount of foreign investment in Afghanistan and given the country's interest to academia, coherent, research-driven theory surrounding mental and behavioral health, as well as access to social resources within the country, is limited (at least in a manner which could be readily utilized by the international community). This scarcity in turn stunts the cyclical creation and testing of knowledge, and the absence of a certain degree of redundancy could unintentionally amplify and distort the importance of any given research product.

Nevertheless, and acknowledging that maintaining the perspectives of Afghans themselves within clinical design is paramount, this article proposes initial considerations in the development of future participatory research leading to actionable information which could inform programming for resettled Afghans (focusing on Afghan women in particular), and which also approaches physical and mental health from an integrated perspective.

Conflict of Interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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5 Tables

Table 1: Tertiary education statistics for Afghanistan 2016-2020.

Year	Unit	Students enrolled in higher education institutions at the beginning of academic year			Students graduating from higher education institutions		
		Female	Male	Total	Female	Male	Total
2016	Total	41,041	141,303	182,344	5,865	22,291	28,156
	Percent	22.5	77.5		21	79	
2017	Total	44,692	139,930	184,622	7,218	25,551	32,769
	Percent	24.2	75.8		22	78	
2018	Total	49,071	136,954	186,025	9,439 ^a	30,480 ^a	39,919 ^a
	Percent	26.4	73.6		23.6	76.4	
2019	Total	54,861	142,386	197,247	9,937	29,687	39,624
	Percent	28	72		25	75	
2020	Total	62,730	142,750	205,480	960 ^b	8,955 ^b	9,915 ^b
	Percent	31	69		9.7	90.3	

Note. ^a Indicates that the data are from the 2020-2021 *Afghan Statistical Yearbook* (14). ^b Indicates that the data are from the 2018-2019 *Afghan Statistical Yearbook* (13).

Table 1 is adapted and consolidated from similar charts from the 2018-2019 *Afghan Statistical Yearbook* (13) and the 2020-2021 *Afghan Statistical Yearbook* (14) on national tertiary education by gender. For the 2018-2019 report, the tables referenced are Tables 4-2 (total students) and 4-6 (graduates), and for the 2020-21 report, the tables referenced are Tables 4-20 (total students) and 4-24 (graduates). The data from both reports differ slightly, therefore wherever indicated with an asterisk, the more recent 2020-2021 data prevail.

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Table 2: Structure of groups for evaluating stressor impact

Control group: Persons not enrolled in any treatment group, but who agree to undergo screenings at similar time intervals.	
Group 1: <ul style="list-style-type: none"> Consists of individuals who are brought together in some manner (public health situation permitting). No type of stress is directly addressed, though appropriate self-regulation strategies (SRS) are taught. 	Group 2: <ul style="list-style-type: none"> Self-regulation techniques Address: <ul style="list-style-type: none"> Conflict/war trauma (CWT) Exclude: <ul style="list-style-type: none"> Routine environmental stressors (RES) Familial Violence (FV)
Group 3: <ul style="list-style-type: none"> SRS Address: <ul style="list-style-type: none"> CWT RES Exclude: <ul style="list-style-type: none"> FV 	Group 4: <ul style="list-style-type: none"> SRS Address: <ul style="list-style-type: none"> CWT FV Exclude: <ul style="list-style-type: none"> RES
Group 5: <ul style="list-style-type: none"> SRS Address: <ul style="list-style-type: none"> RES Exclude: <ul style="list-style-type: none"> FV CWT 	Group 6: <ul style="list-style-type: none"> SRS Address: <ul style="list-style-type: none"> RES FV Exclude: <ul style="list-style-type: none"> CWT
Group 7: <ul style="list-style-type: none"> SRS Address: <ul style="list-style-type: none"> RES CWT Exclude: <ul style="list-style-type: none"> FV 	Group 8: <ul style="list-style-type: none"> SRS Address: <ul style="list-style-type: none"> RES CWT FV