Cultural Identity and Trauma Construction of Meaning Among Afghan and Iraqi Refugees under Treatment in Dutch Mental Health Care
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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, we 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 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 five, 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 six, 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 any kind 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.