Effective Practices for Mental Health Screening Across Cultures

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Caroline Dilts (CD): Welcome, everyone, and thank you for joining us today as we discuss mental health screening practices with newcomer communities. Our team is really excited to engage with you on this important topic. My name is Caroline Dilts. I am the Program Manager for the refugee-related research at the Boston College Research Program on Children and Adversity, or RPCA. I will take some time to introduce my wonderful colleagues, though, who are here today and also will be presenting.

Firstly, Mr. Farhad Sharifi is a recent Afghan evacuee. He is a social worker and serves as a cultural expert in the Family Strengthening Intervention for Refugees Project at the RPCA at Boston College. Previously, he was working with internally displaced populations in Afghanistan with Jesuit Refugee Services. Dr. Matias Placencio-Castro works as Senior Data Analyst here at the RPCA at Boston College. He also serves as part-time faculty in the School of Social Work and the School of Education, teaching applied statistics, psychometrics, research methods, and program evaluation.

His research interests include early childhood development, children and youth mental health, and quantitative research methods for the social sciences, with special emphasis on instrument development, statistical programming, experimental and quasi-experimental designs, and multi-level and structural equation modeling. We also have Ms. Nargis Ahmadi today, who is a Research Assistant at the Displacement and Health Research Center based at University of California in San Diego.

CD: She works in collaboration with the RPCA at Boston College to refine culturally adapted mental health tools for resettled Afghan youth and their caregivers. A first-generation Afghan immigrant with a background in neuroscience, Nargis is dedicated to community-informed mental health care. Her previous work includes research on dementia, cognitive aging, and hypertension in displaced populations. She currently supports patients as a TMS technician for treatment-resistant depression. Thank you for that.

We will go ahead and dive into our learning objectives for today's webinar. By the end of this session, we hopefully will be able to apply key cultural considerations and trauma-informed strategies when asking sensitive questions to newcomers; identify mental health screening tools that are appropriate for different newcomer populations; and explain the implications of recent research regarding adapting and testing a culturally validated screening tool for Afghan youth.

1. Asking Newcomers About Mental Health: Cultural Considerations and Trauma-Informed Strategies

CD: We'll just dive right into our first section, where we will discuss cultural considerations and just general trauma-informed strategies when we're doing mental

health screening. To kick off this topic, we'd like to hear from all of you. To do this, we'll be using this interactive tool called Slido throughout today's webinar. You can join today's Slido session by scanning the QR code with your camera on your mobile device, or you can go to slido.com and enter in the code 1302761 to answer the question that we have here, our prompt.

CD: Just to kick us off, to hear from the audience and see what the general audience looks like right now in terms of mental health screening, we're asking, have you ever conducted a mental health screening with a newcomer? It looks like we're pretty much 50/50 almost on this. Some people have, some people haven't yet, but will hopefully soon. It looks like mostly people haven't yet, though. All right. We can go ahead and dive into the content, but thank you all for answering that. We'll have more Slidos to come to provide your insight and feedback.

First of all, we want to talk about just… What are mental health screening tools? A mental health screening is a standard set of questions that a person answers to help a provider check for signs of a mental disorder. If a screening shows signs of a disorder, more assessment by a qualified healthcare professional is needed to actually diagnose that disorder. These can be general, checking for a broad range of symptoms, or they can be specific.

A broad range of symptoms might be like the RHS-15, which a number of you might be familiar with. Then another example, for more specific, would be the GAD-7, which specifically assesses for anxiety disorders. These are designed, though, to be quick initial step, not a definitive diagnosis. A positive screening doesn't necessarily mean you have a disorder, but it does suggest that further assessment is warranted, essentially.

CD: I'll talk about the benefits of mental health screening for newcomers. As you all are probably very familiar when working with your clients facing significant pre- and post-migration trauma, newcomer families are often burdened by a lot of resettlement and acculturative stressors, which can contribute to a higher incidence of mental health disorders. Trauma and mental health problems with newcomers are well-documented. Specifically with resettling youth, research has shown significantly higher rates of mental disorders among this population compared to U.S.-born children. The benefits of mental health screening that you can explain to newcomers when you are working with them is, first of all, early detection.

Early detection of mental health issues before the symptoms become too severe. Reduced stigma. By making mental health screening a routine part of an intake, appointment, or a health assessment, it really helps normalize the conversation around mental health and can reduce the stigma associated with it, especially in cultures where mental illness isn't openly discussed. Then screening provides a clear pathway for connecting newcomers to appropriate, culturally sensitive mental health services. Many newcomers might not know how to access this kind of care or might be hesitant to seek it out on their own, and this can help with that process significantly.

We'll talk a little bit today about strategies to ensure appropriate and trauma-informed administration of mental health screenings. We'll talk about before, who should administer, what kind of training for administering staff, and then

administration protocols, as well as referral networks and considerations regarding referrals. Then we'll also talk about what best practices and strategies are during the mental health screening process, which includes using interpreters, ensuring privacy and confidentiality, and trauma-informed communication.

CD: I do want to quickly note that while we are focusing a lot more on staff-administered screening in this webinar, obviously, there are screenings that can be done that are self-administered, and there's positives and negatives to doing both. If a self-administered tool has gone through the rigorous translation and validation processes, it can be a really good way for someone to answer the questionnaire in a more private sense. It can take less time. If staff-administered, there's also a chance to build rapport. Staff can help answer questions in case the user doesn't understand the tool.

Before administering, who should administer? The mental health screening tools that we discussed can be used by non-clinical staff, but it is crucial to have the proper training, the clear protocols in place, and a system for referrals before conducting these screenings. Ideally, the person giving the screening tool should have an advanced degree or a professional background in a field like health care or social work. If that's not possible, their supervisor should have this expertise. This is a key safety measure that ensures that if a client does have an emotional reaction during the screening process, there's a qualified staff member who can step in and is available to handle that situation properly.

Now we'll discuss the training for administering staff. What should an organization do before screening? Any staff who plan to implement the screening tool should have proper training on how to approach sensitive questions using trauma-informed and culturally sensitive best practices, which again, we will be discussing today. There should be a protocol in place, though, at an agency or an organization that is planning to use any screening tool. This would include what kind of trainings the staff need to undergo in order to administer that tool; what staff positions will be responsible for the screening; which ones are going to be used, which tools.

CD: There should be a protocol in obtaining informed consent before administering; when, where, and how the tool will be implemented and scored; how to respond and manage screening scenarios; how clients will be referred; and how and when to use interpreters; how to protect confidentiality and privacy. It's really important for an organization to ensure that there are referral networks for mental health services available prior to screening and that they are durable referrals, meaning that they are affordable, they can take Medicaid, and offer meaningful language services at a minimum.

Speaking of language, we'll discuss a little bit about using interpreters. Some screeners are available in other languages and validated in them, but it is really important to discern whether a client is comfortable completing a form independently or if they would prefer to have questions read aloud and interpreted. Language barriers can make it difficult for a client to explain their situation accurately or understand the questions. It's important to think about using an interpreter in such cases.

CD: Interpreters should be trained medical interpreters who understand sensitivity around these mental health topics. If not available, community interpreters can also be used, but they should understand the fundamentals around how to approach sensitive topics with newcomers. Interpreters should be able to help with questions during the screening, and they can also debrief with the patient or the client after completing the screener. Remember, there are multilingual screeners available. I'm going to pass the mic off to my colleague Nargis, who's going to talk a little more about best practices during mental health screenings. Thank you.

Nargis Ahmadi (NA): Thank you, Caroline. When it comes to privacy and confidentiality during a mental health screening, it is very crucial that you, as an assessor, are able to provide privacy for the respondent and make sure that you reiterate confidentiality when obtaining the informed consent. It can also be even more helpful to explain again, if not done so already, about what you are doing, why you're doing it, and what will be done with the information. You also want to ensure that the screening is done in a private space where others cannot overhear the respondent. You also want to store safe records in accordance with your organization's policies.

Now, newcomers may not always be forthcoming with their information for fear of legal consequences, like if there's a questionnaire about screening around substance use. Now, in those instances, it's very important to inform the newcomer when information needs to be reported. A good rule of thumb is following the three-harm rule. One, someone's harming you, you are harming yourself, or you are going to harm someone else.

Another reason for privacy and confidentiality, which is very important in screening newcomers, is experiences with violence, corruption, conflict, and discrimination, which can lead to a mistrust of authority figures, and this can be a barrier in building rapport. It is essential that the administrator explains privacy and confidentiality policies thoroughly.

NA: If we want to go on to the next slide. Now, during a mental health screening tool for trauma-informed strategies, there are three things to consider. First one is to setting in the context. For setting the context, the assessor should provide a disclaimer that some questions may be difficult or even distressing, and that the client has a right to discontinue a screener at any time. You also want to explain the importance of the screener and why you're administering it. The second part is to build rapport with them. Now, for building rapport, as a provider, you want to provide a non-threatening atmosphere by interacting kindly with the client and taking time to build the relationship before even jumping into the questions.

For some instances where there are sensitive topics and questions, you want to consider delaying those after building trust first. It can be difficult to do this quickly when you are conducting a brief screening or questionnaire, but for newcomer clients or patients, it can make a very big difference in how they will respond. The third one is to minimize the number of questions and tools. This is to reduce the emotional and mental burden on clients. As a provider, you should minimize the number of different tools used because it may lead to fatigue.

NA: Now, moving on to the next. This is where we're going to talk about our first fictional scenario. During this webinar, we will be coming back to this scenario case again. I just want to introduce you to Maryam and Humaira. Maryam is a 36-year-old mother from Afghanistan who recently resettled in the U.S. She comes into the office to get help with paperwork and meets her case manager, Humaira. In conversation, Maryam shares that resettlement has been stressful and that she worries for her family's future. She also expresses sadness about leaving family behind in Afghanistan.

Humaira, as her case manager, believes that Maryam could benefit from mental health screening, but Maryam has never received mental health care before and is unfamiliar with it, as it is highly stigmatized in her community. Due to past experiences, she is distrustful of the government and reluctant to take any surveys, fearing legal consequences if she answers honestly.

Moreover, Maryam says that she would need her husband's agreement before participating, but also explains that he does not believe in mental health issues and fears that answering these questions could lead to family separations. Now, we just want to jump into our first Slido for this case scenario. The question is, what is one thing that Humaira should do before administering a mental health screening to Maryam?

[pause]

NA: We are getting our first responses. One is consent, building trust, informed consent. I see building trust and rapport repeated. Consent again, confidentiality.

[pause]

NA: Transparency. Three teams are replying again. There's one response, consent from her and her husband, explaining the purpose of the screening. Building trust, establishing rapport. Great. There's also explaining the three harms rule that is repeated here. Thank you, everyone, for responding to the Slido. Now, we will move on to the next slide.

2. Identifying Mental Health Screening Tools that Are Appropriate for Different Newcomer Populations

NA: Now, for this section, we want to go to the next section, calling the identifying mental health screening tools. We want to look into appropriate ways for different newcomer populations of how to identify these mental health screening tools. For this section, we want to jump off to our first Slido activity. Now, the question is, in your experience, what topics might be difficult for newcomers to discuss when they are being screened for mental health problems?

[pause]

NA: I see trauma, abuse, journey to the States, marriage or relationship challenges, anxiety, suicide and self-harm, depression, home issues, war. Great. Thank you again for participating in this Slido activity. Now, we will move on to our next part of

the slides. Now, I just want to share this insightful quote by Magwood and colleagues when it comes to mental health screening approaches. It says that "When selecting the appropriate mental health screening tool, program developers must consider the specific population, the estimated prevalence of mental health disorders, cultural idioms of distress, and the complex environment of stressors and traumatic events that provoke mental health issues."

NA: Considering that, when choosing a mental health screening tool for a newcomer population, there are five key considerations to keep in mind. The first one is cross-cultural validation, the second one being screening tool for children, and third, trauma history and symptoms, the fourth one, suicide, and last but not least, substance use. Now, I would like to pass it on to Matias, who is our wonderful colleague, to share more information about cross-cultural validation.

Matias Placencio-Castro (MPC): Thank you very much, Nargis. I'm happy to be here with you all. When thinking of cross-cultural validation, there are many things we need to be aware of, but we're going to discuss four here. First, we need to be aware that mental health screening tools rely heavily on language and culturally specific concepts. A direct translation of a tool from one language to another—it's usually not enough.

We need to be aware, in second place, that cultural differences affect how distress is expressed and understood in different cultures. The cross-cultural validation, on top of ensuring that the language is appropriate and understandable, it also properly maps the way people feel and expresses their feelings. For example, in some cultures, mental health problems may manifest as more physical or somatic symptoms rather than emotional ones.

In third place, we need to keep in mind that beliefs can shape responses to screening questions. Before, you were mentioning some of the sensitive topics you have been exposed or working with, and you mentioned very, very sensitive topics that might lead to bias in participant answers. In general terms, as a final point, we need to be aware that without a proper cross-cultural validation process, we can't be sure that the tool's psychometric properties are true for a new culture or group. Basically, we cannot be sure if whatever we're measuring with the tool is actually being measured in a precise way.

MPC: Next, how do we know if a tool has been properly validated in a different culture? First, we need to pay attention to two key concepts. We need to make sure that a tool is, A, reliable, and B, valid. Reliable means that a tool, every time it's used, will yield a similar result. A typical example I would want to mention is when we want to know our weight, we're going to use a scale. Every time we get on a scale every day, we expect to see the same or roughly the same number there. Valid, we want that measure to actually measure or capture the construct that it's supposed to capture. Thinking of our weight, we want to make sure that the number we're seeing there actually refers to a weight measure and not a temperature measure, for instance.

What are the few steps that we need to make sure we take to actually learn if a measure has been validated? First, consult developers' resources. When people develop measures, they usually not only develop the instrument but also should be

developing a comprehensive set of tools or annex or appendix that will provide information about the measure, when and how it was developed and tested, who was involved in the process, et cetera. Second, you could always look in academic databases.

MPC: Usually, properly validated measures, people validating measures, publish those results and make them available to the public. Looking in academic databases ensures that the processes that the developers have gone through have been peer-reviewed, which is something relatively important. Then in third place, look for expert endorsement. A lot of these cross-cultural validation processes and working in cross-cultural settings comes from experience from the field.

The more a measure has been used in specific fields by a specific researcher, you know who to go to with questions or who to contact. To some extent, in the work we do, we rely a lot on those kinds of conversations with experts when it comes to selecting measures. We're going to come back to a few of these topics in a few minutes. Now, I'm going to pass the mic off to Farhad, who is going to continue our journey.

Farhad Sharifi (FS): Thank you, Matias, for explaining and elaborating on the first consideration when choosing and working on the screenings. I'll continue with the next four considerations, as Nargis and Matias explained a little bit about them when choosing the right screening. The second key consideration is when we want to screen children and adolescents. This is a critical area because many of the common screening tools are developed only for the adults, but the child's developmental age, cognitively, emotionally, linguistically, is vastly different from adults.

Therefore, using adult screener on child can lead to misunderstandings or inaccurate results. It's by a rule. As a rule, it's always, as it was explained previously also, we need to consult the providers for the best practices. If you are screening a newcomer under the age of 18, it is essential to look for specific tools that have been developed and validated. As Matias said, validation is not translation only. With children, if possible, the screener is validated for the children of the same culture or linguistic background.

FS: Fortunately, there are excellent resources available. One is the NCTSN or the National Traumatic Stress Network, as an example. They offer a comprehensive, curated list of screening tools that are appropriate to use with refugee children and youth. This is a good resource to find a measure that is not only age-appropriate, but also sensitive to the unique experience of the population. The link to this, I think, is at the end of the webinar. You will see in the resources page.

The third consideration focuses on a deeply sensitive and important area. It is when we want to assess trauma history and symptoms. It is a reality that many newcomers have experienced some form of trauma. I believe everyone has some sort of trauma, which can impact them in numerous ways. Because of this, asking about these events require great care. Directly asking about trauma sometimes triggers distressing memories or can create adverse reactions.

FS: Before we begin any screening, it is crucial to create a safe environment. We talked a little bit about this before. Start with a clear disclaimer. Let the person know that you will be asking about potentially difficult topics. Most importantly, assure them that they can skip some questions or they can stop the survey altogether if they want because their well-being is [the] priority.

When selecting a tool, it is important to recognize that trauma assessment is not one fit for all. The right tool will depend on the population and context. There are tools designated for a specific experience even. For example, designated for the survivors of torture. Some widely used validated tools that you can consider for this specific matter is the Harvard Trauma Questionnaire, HTQ, the famous RHS-15. I know a lot of providers are using this, which stands for Refugee Health Screener. Then the PTSD checklist for DSM-5 or PCL-5.

Saying that, it is always encouraged to have this, what we call, especially within social work, strength-based approach, just to have this lens even [when] choosing screenings or when you are administering that. This means that we don't just screen for problems and deficits. We also want to find out or get an idea of the resilience and protective factors of the newcomers or the population you are working with, that just, we want to understand their community ties, their coping skills, their family support, all that. It's good to have strength-based approach also for a holistic understanding of the mental health of the population you are working with.

FS: The next consideration is when we screen for suicide risk. As a lot of you already indicated in the questions that you're engaging [in], this is one of the most challenging yet critically important parts of the comprehensive mental health screening. There are several significant barriers we must be aware of when we are approaching this topic. The first is the stigma and shame. In many cultures, talking about mental health [is] considered taboo, and [it's] simply not discussed openly.

For example, maybe in Muslim culture, suicide is haram, or forbidden. The local language, I think they call it haram. Because of these deep-seated beliefs, asking someone about suicidal thoughts can feel like a direct accusation. They might feel that… They are feeling, "Something is wrong with me." They might feel a deep sense of shame, believing their struggles are a sign of personal weakness or a failure to adapt to their new life. This can make them very reluctant to disclose their feelings or just engage in the survey altogether.

FS: The second major barrier, specifically for this area, is the fear of consequence. A lot of people, particularly newcomer populations, they might be terrified of admitting to suicidal thoughts because of severe repercussions. They might worry about they might face legal consequences or being involuntarily hospitalized or even having their kids removed from their care. These are all real, understandably, worries that they might have because of stigma around that, and sometimes because of the way it is administered.

This fear is powerful, and it can cause individuals to hide their true feelings, which can make the screener or the survey process very ineffective. It's crucial to acknowledge that no suicide risk assessment is completely free of bias. However, there are evidence-based tools that are widely recommended and that could be effective. Some examples are the Columbia-Suicide Severity Rating Scale or C-

SSRS. The next is the Ask Suicide-Screening Questions tool or ASQ, and the famous PHQ-9 or the Patient Health Questionnaire, which is specifically asking about thoughts of self-harm.

FS: Our last consideration is when we screen for substance use. Again, this is another stigmatized and highly sensitive topic. It's different across cultures, of course. Beliefs and social norms around alcohol and drug use are dramatically different across cultures. In some cultures, it is forbidden. As I said, if we talk about Muslim culture, they might call it haram. It's also important to recognize that the process of resettlement itself can be a major risk factor.

The immense challenge of adapting to a new country, I think they call it acculturative stress, can sometimes lead to newcomers to just seek refuge to substance as a coping mechanism. We must remember that substance use disorders do not discriminate. Anyone can be affected regardless of their cultural background. Another significant barrier is the fear of legal consequences. They might be unwilling to just talk about this because of the fear they have. Maybe they think they'll be reported to authorities or face legal troubles if they talk about this.

FS: To build trust, it is crucial to be transparent about your organization's confidentiality and the reporting policies that you have when you are administering this kind of screenings. There are, again, some validated tools that can be effective on these particular areas. Two examples: I think one of them is the CAGE questionnaire, and the other one is the Alcohol Use Disorder Identification Test or the AUDIT questionnaire. These two are specific for this.

Now, I'm going to resume reading the Maryam case that we just started. If you remember, Humaira was the caseworker dealing with this. After Humaira explains the purpose, Humaira was the caseworker, she explains the purpose, the benefits, and confidentiality of this screening, and then Maryam agrees to participate. However, she insists her husband must also approve. Humaira calls the husband, listens to his concerns, and reassures him about the safety and confidentiality of the process. Once he also agrees, Maryam confirms her willingness to participate. Again, please scan the QR code just to answer this question. What should Humaira consider when choosing the right screening tool for Maryam?

[pause]

FS: Linguistic background, stigma, if it has been validated, cross-cultural, cultural validation, needs, client needs, cultural beliefs, of course, her background. A lot of cultural validation. Thank you. Thank you for all the engagement. Next, I'm going to ask my dear colleague, who is also a fantastic soccer player, to continue with the next portion of the presentation.

3. A Culturally Validated Screening Tool for Afghan Youth: What the Research is Telling Us

MPC: Thank you, Farhad. Now, we're going to dive a little deeper into the work we're doing when it comes to culturally adapting measures. The Boston College team and Switchboard, we are currently validating a screening tool for Afghan youth, and we're

going to briefly discuss a bit about that process. Before, I would like to ask you another question that you can answer in this Slido. The question is, how might we ensure that an instrument has been properly culturally adapted?

[pause]

MPC: You can scan the QR code and participate. Read the literature. Great. Review evidence, yes. Great. Survey bilingual users in both languages, review these instruments, talk to expert, review literature, testing it. Great. Using everyday terms, lay terms. Great. Fantastic. Thank you very much for the participation. You're hitting all the spots. When we think of adapting screening tools, there are multiple considerations. First, I want to focus on three general criteria.

First, as we briefly discussed before, a tool needs to be culturally suitable, cover relevant symptoms, and [use] appropriate concepts or ideas. This is extremely important because we have a lot of research that is documenting that failure to take culture into consideration may lead to, first, weak diagnosis, and after that, underuse of mental health services and adverse clinical outcomes in general because of non-treated illnesses.

Second, before we mentioned talking to expert was something very important, the tool we're using, it has to be theoretically reasonable. By that, I mean we need to make sure that the tool has the ability to assess or to capture the theoretical construct of interest and not something else. This is particularly important because when we develop instruments or adapt instruments, we need to pay attention to the content of the items. We want to make sure that each of the items that are included in the measure are actually tapping into a very specific portion of the construct.

If we want to develop or adapt a measure that it's screening for, let's say, anxiety, we want to make sure that we are actually capturing or using items that capture behavioral manifestations of anxiety and not, for instance, specific manifestation of post-traumatic stress disorder. Even though they might be related—of course, they are—the content of the measure comes from a theoretical background and theoretical expertise that we shouldn't overlook.

MPC: Third, the tool has to be methodologically appropriate. By that, I mean it has to combine qualitatively informed research, and it has to be quantitatively validated. Before we mentioned translating an instrument is not enough. On the other hand of the story, running a specific statistical test or a structural equation model or a confirmatory factor analysis, and making sure that those models are providing proper statistics is not enough. Usually, we follow a very specific set of steps to ensure that we are working with a culturally validated and adapted tool.

Now, in the field of cross-cultural validation or adaptation of health and mental health instruments, it is important to keep in mind four things. First, understanding local expressions and manifestations. Scientific evidence indicates that simply translating three instruments is insufficient to obtain accurate information on the burden of mental disorders. That's why it's important to understand local expressions and behavioral manifestations of those constructs. Unfortunately, many settings lack providers and validated measures to consistently identifying mental health concerns.

MPC: Because of that, local experiences and definitions of diagnostic categories are often overlooked. In fact, when it comes to working with Afghan resettled populations, previous research has identified that using unvalidated instrument leads to inflated prevalence, for instance, of estimates of mental disorders among Afghans, and misdiagnosis of adaptive stress response to trauma with mental illnesses. Unfortunately, resources to develop, validate, train, and pilot research teams for varying contexts are always scarce.

That is what we, at Switchboard, are trying to do in order to make contributions to the field. What we have come up with is a mental health screening toolkit for resettled Afghan youth and their caregivers. It's going to be comprised of three open access measures, and it's going to be available soon in the Switchboard website. In order to come up with this mental health toolkit, we have been working over the past three, four years in a very specific set of steps that I'm going to summarize in the next slides.

First, we started back in 2022 and 2023 when we first conducted qualitative fieldwork with Afghan resettled populations. Part of that qualitative research was actually conducted in a military fort right after the operationalized welcome. Part of that research was conducted in Boston with Afghan resettled populations in temporary housing or recently resettled to the greater Boston area. During that stage, we conducted free listing and key informant interviews, and we collected data from more than 100 Afghan individuals.

MPC: Roughly half of them were Afghan caregivers, and half of them were Afghan youth. We asked them about problems or what kind of problems are resettled Afghan children suffering from. We identified locally derived, culturally specific syndrome terms in Dari and Pashto. The most relevant constructs and behavioral manifestations identified were mapping onto depression, anxiety, grief, and youth conduct problems. That was our first step, and it has to do with the proper construct definition and identification of syndrome terms that I mentioned before.

After that, our team looked at other measures that have been used around the world for this to capture depression, anxiety, and youth conduct problems. The inclusion criteria for looking for these measures were three. First, that the measure was capturing a construct similar to what we identified in our qualitative work with Afghan populations. Second, that it has been used across cultures with youth. Third, that the measure had strong psychometric properties across diverse cultural settings.

MPC: That process of identifying instruments that capture those empirical manifestations gave us 28 potential measures that we could translate and adapt. Three screening tools were the ones that most closely aligned with these syndrome terms we identified, and those were the GAD-7 that matched 63% of the syndrome terms listed in our qualitative data. The second one is the CESD, the Center for Epidemiological Studies Depression Scale for Children, that matched 58% of the syndrome terms identified in our data.

The final one was the War-Affected Youth Psychosocial Assessment battery, which matched 88% of the agreement with syndrome terms identified. After that, when we identify those measures, we translate those measures into Dari and Pashto, and then we back-translated them following WHO best practices. We asked experts to

identify the cultural relevance and the appropriateness of the measure. After the translation process, we discussed with experts, we asked them to look at the measures and identify, item by item, whether or not those items were properly matching syndrome terms.

MPC: Of course, we expected they were. However, because we collected those syndrome terms from Afghan resettled populations, but we wanted to make sure that from a theoretical standpoint, we were also going in the right direction. Once the culturally relevant set of measures was produced, we tested them. We conducted cognitive testing with Afghan families. The first step was identifying the syndrome terms. Then we identified potentially relevant measures. Then an expert reviewed it. After that, we went to families, youth, and caregivers.

We actually conducted the assessment with them, not necessarily to map their symptomatology, but to ask about the understanding of the measures. As somebody mentioned during the Q&A before, [this was to make] sure that the terms we're using were appropriate for the populations in which they are intended to be used. We asked about comprehension. We asked about semantics. We asked about conceptual understanding of the questions that were being asked.

After that, we refined the instruments and we piloted them with 25 youth and 25 caregivers in order to gather some psychometric data on the measures related to internal consistency of the measures. Currently, the final step in our journey is a larger study that we are closing these days with a larger sample of 109 caregivers and youth dyads. The measures that we selected, as I was mentioning, are the CES-DC, the GAD-7, and the War-Affected Youth Psychosocial Assessment battery.

MPC: The CES-DC, its measure [is] comprised of 20 items, 4 of them reverse-worded, with a 4-category response structure going from 0, not at all, to 4, a lot. This assessment measures depressive symptoms in youth, and it includes emotional, behavioral, and somatic indicators such as sadness, hopelessness, trouble sleeping, loss of appetite, and fatigue. The GAD-7, the Generalized Anxiety Disorder 7, is a 7-item instrument also with a 4-category response structure going from 0, not at all, to 3, nearly every day.

The final measure is a 10-item checklist mapping behavioral problem or externalizing problems in youth, and [it] also has a 4-category response structure, going from 0, to never, to 3, all the time. As I mentioned a couple of minutes ago, the final version of these measures will be available in the Switchboard website in the upcoming weeks. What did we find? First, the best-performing measure when it comes to a psychometric assessment was the GAD-7. It showed a relatively high Cronbach alpha of 0.93, and we also found that the CESD and the AYPA had poor psychometric properties for both children and adults.

That was a very interesting result, and we're going to dive deeper on that in a second. Finally, we also found that the CES-DC was the best-performing measure for test-retest reliability. Part of our testing was using the measure, let's say, one day of the week, let's say on a Monday, and a couple of days later, we used the same measure and the same participant, trying to evaluate whether or not it stayed consistent. Now we were asking ourselves why some of the measures did not perform well. First, it was a very practical reason.

MPC: We have a very small sample size, 25 participants, 25 youth, 25 caregivers reporting on those youth. It's a relatively small sample size for quantitative data analysis. That's the first limitation. Second, we have potential underreporting of youth, probably because of all the issues you identified before—bias, fears. What we identified [is] that a lot of youth, of course, were underreporting conduct problems. Some of the items included in the AYPA are asking about drug consumption, alcohol consumption, reckless behaviors, misbehaving with parents.

We already know, we knew that some of those issues could arise, and our data confirmed. That could speak a little bit about poor cultural alignment. The question is how to deal with those more sensitive topics with the Afghan populations. As a final point, we found that specifically in the CES-DC, that has four of the items negatively worded or reverse worded, we found that when we remove those items, the reliability of the measure, the psychometric properties improve a lot. That is something that is very common in psychometrics, in instrument development.

MPC: Hopefully, we want to avoid reverse-worded items. That is a lesson learned from us, and it should be something that all of us as practitioners keep in mind. What are the implications of this research? First, this research provided the Afghan community insight into mental health problems among youth. We know some of these issues are happening. We just need to find the best ways of capturing them. This is a contribution on that end. Second, there are existing mental health assessments that map onto these syndromes that illustrate very good content validity.

To some extent, we don't need to reinvent the wheel. We need to go back and properly map those behavioral manifestations and use the right terminology, the right concepts, in order to have a culturally grounded measure. Third, we know that screening tool sets were mixed in their psychometric properties. That might not only be because there is a problem with the translation or there is a problem with the concepts being used. That's a very specific statistical problem. In order to evaluate the psychometric performance of a measure, we need variation.

MPC: We need people answering in different categories—in the Likert scale, for instance. That is something that we didn't see. The next step that what we are doing now, it's actually trying to evaluate this measure with a larger sample. We're seeing actually, very promising results. Additional refinements and testing of this assessment with larger sample size was warranted. That is what we are actually doing now. As I said, some of the poor results are not necessarily due to not having a culturally appropriate or culturally valid measure.

They're due to a relatively small sample size. Last but not least, we learned that these measurements and adaptation processes can be reproduced in future studies for research adopting mental health screening tools. What we try to do is something that should work like a blueprint for future research doing these types of processes. This is a very interesting discussion. Most of these steps are very common in other fields, specifically in education. Mental health testing and psychometric testing is something that is super common in education.

They have very specific steps to develop, let's say, math assessments, language assessments. We need to replicate those very specific steps, mostly focusing, again,

on culturally relevant concepts, language, and meanings in order to be able to properly validate, or develop, or adapt mental health screening or, in general, mental health tools. In terms of lessons learned, challenges, and next steps, first, one of the biggest challenges was the limited network of Afghan mental health professionals who can also read and write in Dari and Pashto.

MPC: A very important portion of this is building rapport, as we already discussed. Building a relationship that is based on trust so participants feel comfortable sharing their experiences. That is very hard to do when we want to match the professional with a cultural background with the patient's cultural background. Second, there's a lot of distrust of research and interviews due to negative experiences and fear of legal consequences, as we already discussed. Third, mental health is a topic [that is] very stigmatized in the Afghan community, and families are reluctant to share some of their experiences with us.

That is, again, something that might be affecting the reliability of a measure. People are not reporting if, let's say, [their] children are using drugs. Even though the problem is there, we need to find better ways to capture it. In terms of solutions, something that our team always aim—our fabulous research assistants in the field are doing is actually networking within community spaces. Meeting participants in mosques, community events, having RAs embedded in communities, participating in communal activities, and using some sort of a recruitment coordinator that has rapport in the community and can connect us with families that actually we know need these kinds of services, so they can trust us.

Using social media groups, that was also something that our group found as a good solution, and last but not least, word of mouth, what we called snowball sampling. Part of engaging participants, part of building their rapport, is actually connecting with multiple people and multiple participants in the community. That is a lot of mouth-to-mouth enrollment in these processes. In terms of next steps, the current project we are working on right now, enroll, as I said, a larger sample.

MPC: We now have 109 dyads, 218 participants from the greater San Diego area. With that, we actually were able to overcome these small sample size problems, and we actually found that the psychometrics properties of the measures—I'm kind of giving a few hints of the findings—are actually great. A lot of the measures are showing great internal consistency, very high reliability coefficients, and that makes us confirm our hypothesis about the fact that it wasn't a problem before with the cultural adaptation of the measure, but a very empirical problem related to sample sizes.

The analyses, as I was saying, are underway. Some of the lessons learned from that phase is that having Afghan female RAs approaching families in familiar spaces was a very good strategy. Nargis, who is here with us today, was one of the RAs, so I'm sure she'll be happy to take any questions about that. Friendly conversations, rapport-building activities before the interviews helped a ton. Then we leveraged community connections, like community advisory board members and local leaders, kind of endorsing our activities to address the sentiments of distrust with research and, of course, with the current socio-political climate in the United States.

MPC: Third, we learned that we need to be flexible in interview settings, such as homes or mosques, to overcome logistical and schedule issues. Research needs to be a respondent to the needs of the participant. We need to adapt to their needs, and that is something that our field team were very good at doing. Third, as somebody mentioned before in the Slido, using simple language during screening and consenting instead of academic terminology. Most of the time, academia is very cryptic, is very research-y focused.

When we're conducting community-based participatory research, specifically in the field of mental health, we need to be aware of the limitation of that approach. Simple language, familiar terminology that everybody can understand might encourage participation from marginalized communities. Now, briefly, we are going to keep discussing our Maryam scenario. After successfully screening Maryam using the Refugee Health Services 15, she is able to document specific symptoms.

From this course, she determines that Maryam could benefit from services, but she is not a high-risk case at this time. She refers Maryam to an Afghan woman support group that meets weekly at the agency. Maryam is enthusiastic about this. Maryam shares that her niece has become quiet and sometimes cries secretly since arriving in the U.S. The niece and her mother, Maryam's sister, are also clients of Humaira's. She recommends she get screened so that she can be referred to appropriate services. The niece's mother is reluctant.

MPC: She insists on staying in the room and even tries to answer for her when she is asked negatively worded questions, such as, "In the past, I felt like crying." The question for us now is, based on the lessons we have learned from research, how can Humaira navigate this situation? Let's see what the research tells us. You can scan the QR code, explain the importance of privacy for the daughter, build trust, reward questions. Great. Great suggestion. Have a conversation with the mom. Privacy and confidentiality for the mom and daughter.

Provide psychoeducation to the mom. Yes. Great. Keep language simple. Provide an opportunity for mom and daughter to both answer questions privately. That's a great suggestion, and it's, in fact, something that we're doing with this mental health screening toolkit. Discuss importance of daughter's perspective. Amazing. Keep language simple. Build rapport. Fantastic. Thank you, everybody, for those amazing ideas. I think we're revisiting all the topics we have discussed, so super happy to see them all. With that, we are concluding. Caroline, back to you.

4. Q&A

CD: Yes. Thank you, Matias, and thank you to all our presenters. We are going to go ahead and move into our Q&A. We have a couple questions that we can answer for you all. I think there was one interesting one that came up in the chat that I would like to ask our group first. If you all can put your cameras on and unmute, that would be great. Thank you. An interesting question that came up, and this might be a tricky one to answer, is, can you share more about how cultural backgrounds affect the manifestation of distress?

CD: How can we know if a particular population is more likely to experience distress somatically? Does anyone have any thoughts on that?

MPC: I can mention a few things as soon as I find my Zoom.

CD: Oh no.

MPC: I lost you all. Sorry. Am I unmuted? Yes, I'm unmuted, right?

CD: You're good. You can just--

MPC: Sorry about that.

CD: No worries.

MPC: That's an interesting question. I think the first thing that comes to my mind is the difference between collectivist cultures and individualistic cultures. For instance, in collectivist cultures, sometimes they might discourage open emotional expression to maintain social harmony kind of thing. In individualistic cultures, the self is something very relevant, and often it's encouraged to practice emotional openness. That is actually something that when we start thinking of behavioral manifestation, like somatization of distress, for instance, might be very different when we compare cultures or countries like China, Somali refugees, or Latinx populations.

In Latin America, I'm from Latin America, when you're nervous, the behavioral manifestation of that is actually being extremely active, and is recognized as syndrome of involving emotional and physical symptoms. When you're nervous, you actually move a lot, and you express a lot, and you talk fast, and you use gestures and whatnot. That is something that is very common in Latin America. In other cultures, something like that can be interpreted plainly as disrespect or whatever other things.

In Latin America—and more in Chile, specifically; I'm from Chile—when you're acting like that, you immediately can think of something as being nervous, which is actually a behavioral manifestation of that distress kind of thing. That's something that comes to my mind, really, in general terms. I don't know if that answers the questions.

CD: Thank you. Nargis and Farhad, I don't know if you have more to add to that or not. Okay. [chuckles] We had a good question also just come up in the chat from a therapist, Sarah, over at Family Health Centers of San Diego. Shout out to San Diego for Nargis. She was asking if our team is still early in that process of working with refugees, and that our research about screening tools and are we looking into clinical interventions to actually treat those symptoms. That is a great question.

Our organization specifically does have an intervention that we have adapted for Afghan families called the Family Strengthening Intervention for Refugees, the FSIR. We are currently implementing it in the state of Michigan. It was piloted in the state of Maine. We have been using it for a couple of years now, since we began this research. What we did was we integrated a lot of the findings from that research into our curriculum. Using the non-stigmatized mental health language in Dari and Pashto, and integrating that into our curriculum and the delivery of that intervention.

CD: It's specifically a preventive intervention that promotes mental health, but it does so in a non-stigmatizing way, delivered by home visitors who are from the community, who speak the language and are from the culture. That's a good question. I think that it's a great point to make that, along with measurement development, there's also usually intervention development. Using our findings from that measure development to help inform on interventions. Thank you for bringing that one up.

FS: An intervention which can be adapted to many other cultures also. [laughs]

CD: We hope so. [laughter] Then I did have a couple other questions that also were put in the pre-survey of this webinar that I think are interesting. One of them is asking, “How can we ask scaling questions with clients who maybe don't grasp mathematical abstractions?” In some cases, some people might have traumatic brain injury, or there could be also people who maybe are children and they're not fully in their development. I guess the question is, how do we ask those questions if we're thinking about a specific measure like the GAD-7, for example, asking the question of "How often were you feeling nervous?"

It's like sometimes, a little bit, something like that. How do we explain those response items, I guess? I think that we have a couple of good options there.

FS: I think in our practice, what we tried was just give them an example of this is how—in the local language, simple local language, as simple as possible, that these are your options, and this is one of them. You explain that in the local language to them, and then after that, you just ask, and they will get it. If I get the question, that was one way we practiced.

MPC: Yes, and thank you, Farhad. I know, Caroline, you were talking about specific subpopulations with certain disabilities or special needs. What you are actually mentioning, it's extremely relevant, in fact, for any population. When we have Likert scales, like "sometimes" or "never", "most of the time", or "all the time", from a psychometrics or measurement perspective, what you want to have is that each of those categories is very distinguishable and clear. Not only for you as the person who is developing the instrument, but for the user.

That sometimes doesn't happen. My question, every time I see a Likert scale, is what does "sometimes" mean over a 30-day period? 50%? What we try to do is provide, for the population, subpopulations you were mentioning, visual cues, or specific vignettes, or drawings, or some other manipulative, sometimes to answer, to grasp the magnitude of the intensity of our response. For the rest of the populations, even a very specific number, or amount of times, or something like that, could help to frame the response.

MPC: If we're thinking on a weekly basis, how many times did you do something over the last seven days? Providing specific counts, like one day a week, or more than one day a week, or only one time per week. [Not] everybody knows what "often" means, what "sometimes" means. It doesn't make sense. It's crucial because then we compute average scores from those 0, 1, 2, 3 from Likert scales. If participants are not clear what each of those categories means, your average score after you compute it, it's not going to be as meaningful as you expect it to be.

CD: Yes, thank you. Something we've also practiced within our lab is using the visual cues of the water glass, where it's a little bit full, this much full, that much full. Things like that are actually really helpful, especially working with children. Yes, thank you, Matias. I think we have time for one more question. My question might be geared a little more for Nargis. Sorry, Nargis. Since you did just do such great work as a research assistant, something that people often deal with, obviously, with assessment is, as we discussed, the fear of legal consequences.

How can we assure newcomers that they will not face legal consequences when we're beginning that mental health screening process? Are there any specific examples or words that you like to use when you're speaking with your clients to assure them?

NA: Thank you, Caroline. A great question. I think when we were doing this project in San Diego, we ran into this problem a lot, and then we had a discussion between you guys and the team. One of the things that we have to consider is, even before starting the interviews, doing what we did during our recruitment part, we had to go within the communities. Our best practice was to find community leaders and speak to them about our research project and gain their trust.

Use them as a leverage to go to the community and talk about our research project, and [mention] that we are not part of the government. That we won't be reporting any of this unless something is necessary that we have to. Those things were aligned ahead of time. We also went door-to-door to participants' houses or potential participants, explaining what we're doing, what is the benefit of the screening tool, where it would be helping the community in general. There may be potential for bringing in new interventions, as Farhad and you mentioned.

NA: Those were the best practices we did. Even during each interview, as I mentioned earlier, starting the interview, it was mainly about the first 30 minutes that we always used was just talking to participants and how relating to stories about back home in Afghanistan or living life in here, what stretches you're using. It's just mainly conversational. It was a back-to-back before even jumping into the interview. Starting the consenting form, we made sure to explain what was the reason for this questionnaire.

The times about substance use and everything about legal consequences that they might fear, we clearly mentioned that there's nothing to fear. There may not be any harm unless we know there are certain things within our rules that we may have to report, whether it be suicide or the three-harm rule. Those are the things that we mentioned, [that] we practiced in our case with the San Diego population. It has been effective for us overall. I hope that answers the question.

CD: Thank you so much. That's very helpful. I think we're unfortunately going to have to wrap it up. Hopefully, by now, you are all able to apply your key cultural considerations and trauma-informed strategies when asking sensitive questions to newcomers. You can identify the mental health screening tools that are appropriate for different newcomer populations and explain the implications of the recent research, adapting and testing a culturally validated screening tool for Afghan youth. I think our e-mails might be in the resources or will come out with this resource.

CD: If any of you have other questions that follow up since we did run out of time, that would be great if you would like to reach out. Also, if you could please scan the QR code or click the link in the chat to access our feedback survey. It's really important. It helps us do better in each Switchboard webinar. If you could just answer the five questions, it'll take you 60 seconds and help us with future training. I'll give you guys a second to access that.

[pause]

CD: Oh, yes. In the chat, also, if you would like to e-mail switchboard@rescue.org or submit a TA request on their website with any outstanding questions, that would be wonderful as well. We also have our recommended resources. A lot of these are some specific tools that we mentioned in our presentation today. These will be, again, in the slide deck that you'll receive within 24 hours of this webinar. You can access these resources there. Thank you again for coming. Please stay connected. Follow Switchboard on all our different platforms.

We hope that all of you got a lot out of today. We really want to thank the presenters again for all of your hard work on this as well. We hope that everyone has a good rest of their day.

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