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Karolinska Institutet, Stockholm, Sweden

# REFUGEES AND ASYLUM SEEKERS: THEIR SOCIAL NETWORKS AND ENCOUNTER WITH THE MENTAL HEALTH SERVICES

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Stockholm 2021

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## THESIS FOR DOCTORAL DEGREE (Ph.D.)

By

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The thesis will be defended in public at Karolinska Institutet, Solna, on 6 December, 2021

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To my parents who gave me the stories on history, society, and migration

Till mina föräldrar som gav mig berättelserna om historien, samhället och migrationen

"Enkidu, som jag älskade, har åter blivit jord.

Är jag inte lik honom? Skall inte även jag gå till min sista vila

för att aldrig resa mig igen?"

Gilgamesh sade till Utnapishtim:

"Så reste jag till Fjärran Utnapishtim,

som folk berättar sägner om,

jag vandrade genom alla länder,

klättrade över svårbestigna bergstoppar,

färdades över alla hav.

Den ljuva sömnen fick jag inte njuta mycket av

utan sömn plågade jag mig själv,

fyllde mina lemmar med sorg.

Vad har jag vunnit på mina vedermödor?"

*Gilgamesheposet: "han som såg djupet"* (2001).

# POPULÄRVETENSKAPLIG SAMMANFATTNING

Aldrig förr i den moderna historien har så många människor varit på flykt från sina hemländer. Det är en resa fylld av stress i alla faser, från tiden före landsflykten till livet i det nya landet. Flyktingar har oftare hälsoproblem, framför allt när det gäller psykisk hälsa, än befolkningen i de mottagande länderna. Asylsökande som lever i en särskilt otrygg situation har ytterligare ökade hälsorisker. Hur påverkas flyktingarnas nätverk av viktiga personer inom olika livsområden under flykten och i exil, och hur påverkar det deras hälsa? Vad händer när flyktingar möter vården i det nya landet?

I två delstudier, som ingår i den här avhandlingen, studerade vi journalerna för 88 asylsökande som bedömts på Länsakuten i Stockholm efter självmordsförsök. Vi jämförde deras sjukdomshistoria och sjukdomstillstånd vid bedömningen på akuten samt en lång rad riskfaktorer för självmord med en kontrollgrupp med likaså 88 personer som bedömts under samma tid men som hade svenska personnummer. Vi jämförde också behandlingen på sjukhuset och uppföljningen efteråt.

De två grupperna var lika varandra när det gällde tidigare sjukdomshistoria och flera riskfaktorer. Men de asylsökande hade oftare varit utsatta för traumatiska, svåra upplevelser, och kontrollgruppen hade oftare missbruksproblem. Det saknades ofta uppgifter i journalerna om patienternas egna förklaringar till självmordsförsöken. De asylsökande kvinnorna skilde ut sig på så sätt att de hade svårare sjukdomshistorier, hade gjort allvarligare självmordsförsök, oftare vårdades med tvångsvård och längre tid på sjukhus och fick fler sorters behandlingar än kontrollgruppens kvinnor. Ändå följdes både asylsökande kvinnor och män oftare upp på en psykiatriskt mindre specialiserad nivå, oftast i primärvården.

Vi följde upp studien med att läsa journalerna för de asylsökande kvinnor som tvångsvårdats på psykiatrisk klinik efter självmordsförsöket och analyserade med så kallad kvalitativ innehållsanalys. Vi fann då att personalen hade svårt att tolka kvinnornas sätt att uttrycka sitt lidande, såväl i ord som beteenden, och även svårt att förstå beskrivningar av för dem obekanta levnadsförhållanden. De traumatiska upplevelser som kvinnorna hade utsatts för uppmärksammades sällan under vårdtiden. Inte heller utforskades kulturella aspekter och kvinnornas egna tankar kring självmordsförsöket dokumenterades inte. Behandlare och patienter hade olika perspektiv på situationen, perspektiv som aldrig möttes, och resultatet tycktes bli en upplevelse av maktlöshet hos bägge parter.

I två andra delstudier undersökte vi sociala faktorer som påverkar hälsan samt resiliensen, det vill säga förmågan att gå vidare efter svåra händelser, anpassningen till det nya samhället och hälsan hos irakiska flyktingar i Sverige. I en intervjustudie analyserades intervjuer med 31 deltagare, som fyllde i en biografisk nätverkskarta, där de beskrev hur deras sociala nätverk utvecklats från barndomen och framåt. Deras sociala nätverk hade försvagats påtagligt i exil, och ofta krympt till den närmaste familjen. De upplevde stora svårigheter i att skaffa sig nya kontakter för att komma in i det svenska samhället. Språket upplevdes som det största hindret. Många beskrev också negativa kontakter med svenska myndigheter. De som uppgav

oro för familjemedlemmar eller konflikter i familjen samt att de misslyckats att återförenas med familjen skattade också högre på skalor för psykiska problem. I en uppföljande studie fick 410 deltagare fylla i en enkät med frågor kring samma områden. När det gällde socialt stöd var det tydligt att de allra flesta var beroende av den närmaste familjen för stöd av alla slag, såväl stöd känslomässigt, som konkret, andligt och när det gällde att skaffa sig information. Myndigheter gav mycket litet stöd. En sjättedel hade inget konkret stöd alls, från någon.

En övergripande slutsats av studierna är behovet och värdet av en bredare syn på hälsa som en social process, som beror av levnadsvillkor i stort, och för professionella hjälppersoner att intressera sig för de subjektiva erfarenheterna och berättelserna hos de personer de vill hjälpa. Det skulle vara till hjälp för behandlare i vården såväl som för myndigheter som stöder flyktingar i integrationsprocessen. Att studierna av asylsökande visade på skillnader i behandling och uppföljning och att behandlarna hade svårigheter att förstå och kommunicera med de asylsökande kvinnorna pekar på ojämlikheter i vården. Personal som möter asylsökande med självmordsproblematik behöver mer kunskap om psykologiska trauman, kulturella faktorer som påverkar sättet att uttrycka lidande och om sociala livsvillkor för utsatta personer. De behöver också tid och resurser för detta och ett mandat att ge vård enbart utifrån medicinska behov. Flyktingar behöver stöd att behålla kontakterna med sina tidigare nätverk och att skapa nya sociala kontakter. Myndigheter behöver intressera sig för flyktingars stödsystem och inse att deras förmåga att stödja flyktingar beror av förmågan att skapa dialog och tillit.

# ABSTRACT

**Background**

Migrants run a greater risk of poor mental health than host populations, but there are large variations depending on diagnosis, pre- and postmigration experiences, gender, and regions of origin. Some studies show lower suicide rates for refugees than for host populations, whereas other studies indicate that asylum seekers have higher rates of suicide and suicide attempt. Little is known about the contexts of the suicidality of asylum seekers and about what happens in the encounter with mental health services, including cultural aspects of the encounter. There are few studies of how refugees themselves perceive changes in their social networks through the migration process, and on how this is related to their health situation.

**Aim**

The overall aim of this project was to study postmigration conditions for refugees and asylum seekers with respect to their social networks, and their encounter with health care when they had mental health problems, with a special focus on the presumably vulnerable group, asylum seekers who had attempted suicide.

**Methods**

Studies I and II were studies of the medical records of asylum seekers assessed in mental health services after a suicide attempt. In Study I, 88 asylum seekers were compared with 88 matched controls with respect to known risk factors for suicide, and to the assessment and treatment offered after the suicide attempt. In Study II, the medical records of 18 of the asylum-seeking women were analysed, using qualitative content analysis, with a focus on their communication with the clinicians.

Study III and Study IV were part of a larger two-phase study of two populations of resettled Iraqi immigrants with an interview study followed by a survey. In Study III Iraqi refugees were interviewed about migration experiences, perceptions of illness, health care consumption, and traumatic experiences. A biographic network map was drawn and three health assessment scales (CES-D-20, PHQ-15, MINI 5.0.0) were administered. The interviews were analysed with a focus on the refugees' perceptions of changes and challenges to social networks and social supports, using thematic content analysis. In Study IV, surveys of 410 resettled Iraqi refugees were analysed with a focus on social determinants of health, including social support, resilience factors, including cultural perceptions of illness, mental health, and acculturation. The participants in both phases were convenience samples, part of which in Study III was recruited in primary care or psychiatric services where the subjects were patients.

**Results**

In Study I, the asylum seekers showed about the same burden of earlier mental health problems, including suicidality, as the controls, whereas there were differences in clinical

pictures and other diagnoses. The asylum-seeking women stood out as having more severe conditions requiring more treatment. Yet, both asylum-seeking men and women were followed up at a less specialised care level. Analysing the communication between asylum-seeking women and clinicians in Study II, we found that the clinicians had difficulties decoding the women's languages of distress. Neither trauma nor the meaning of the suicide attempt were explored. The perspectives of the women and the clinicians were never combined, and there was a mutual sense of powerlessness expressed in the records.

Both studies on Iraqi refugees showed a weakening of the personal network, with the family being the most important provider of all kinds of social support. The participants found it difficult to form new social contacts, and authorities were often perceived as negative. Language difficulties were the most reported barrier to integration. In the interview study 61% of the participants screened for mental health problems. Family issues was the subtheme most strongly related to mental health problems. The most common perceptions of mental illness were social and situational, but not related to the premigration experiences.

**Conclusions**

The results of the studies of the asylum-seeking suicide attempters indicate a lack of health equity in Sweden. The analysis of the communication between clinicians and asylum-seeking women suggests that clinicians would be helped by increasing their awareness of the asylum seekers' living conditions, cultural languages of distress, traumatic experiences, and of the subjective meaning of the suicide attempts for their patients.

The studies of the Iraqi refugees give voice to the participants' subjective experiences, describing the challenges of disrupted social networks and the difficulties of building new networks. The results suggest the importance of facilitating the building of new social networks for refugees, and the importance for authorities to build trust with the newcomers.

A conclusion from the four studies is the value of adopting a broader view of health as a social process, and for professional helpers to address the subjective experiences of the persons they want to help. In clinical contexts, such an approach amounts to applying and integrating the concept of person-centred care with a focus on persons' narratives. Clinicians need time and empowerment, training providing both knowledge and experiential learning, and support in the emotional work of following this path.

**Key words:** refugees, asylum seekers, mental health, social networks, social support, suicidal behaviour, resilience, trauma, cultural idioms of distress, perceptions of illness

# LIST OF SCIENTIFIC PAPERS

I. Sundvall, M., Tidemalm, D. H., Titelman, D. E., Runeson, B., & Bäärnhielm, S. (2015). Assessment and treatment of asylum seekers after a suicide attempt: a comparative study of people registered at mental health services in a Swedish location. *BMC Psychiatry, 15*, 235.

II. Sundvall, M., Titelman, D., & Bäärnhielm, S. (2018). Challenges of combining perspectives. A qualitative study of the communication between female suicidal asylum seekers and mental health clinicians. *Crisis, 39*(5), 326-334.

III. Sundvall, M., Titelman, D., DeMarinis, V., Borisova, L., & Çetrez Ö. (2021). Safe but isolated - an interview study with Iraqi refugees in Sweden about social networks, social support, and mental health. *International Journal of Social Psychiatry, 67*(4), 351-359.

IV. Çetrez Ö., DeMarinis, V., Sundvall, M., Fernandez-Gonzalez, M., Borisova, L., & Titelman, D. (2021). A public mental health study among Iraqi refugees in Sweden: Social determinants, resilience, gender, and cultural context. *Frontiers in Sociology, 6*, 551105

# CONTENTS

# LIST OF ABBREVIATIONS

| | |
|---|---|
| ADAPT | Adaptation and Development after Persecution and Trauma |
| APA | American Psychiatric Association |
| CFI | Cultural Formulation Interview |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| ICD | International Classification of Diseases |
| IOM | International Organisation for Migration |
| OCF | Outline of Cultural Formulation |
| PTSD | Posttraumatic stress disorder |
| UNHCR | United Nations High Commissioner for Refugees |
| WHO | World Health Organisation |
| WMA | World Medical Association |

# 1  FOREWORD

Graduating from medical school I did not want to do research. Not primarily because I had been put off by the somewhat disdainful attitude of the junior doctors as they strolled away to some archive on a calm Saturday at the emergency room, to "do research". No, because I wanted to be immersed in reality, in the real world of encounters with individual patients, getting to know their stories and learning about their diseases.

In that attitude I was more influenced by the era than I realised at the time. After all, these were the years when stories from reality - be it life under apartheid in South Africa, or the working conditions in a Swedish mine - erupted into public life. A strong influence stemmed from the Swedish author Sven Lindqvist who in 1978 wrote the book Gräv där du står! ("Dig where you stand", 2009/1978), a book that actually inspired a movement of popular education, or even "grassroots research". Lindqvist argued against workers in industry being seen only as objects of research and urged people to start investigating their own everyday realities. He wrote that they had important experiences: "Those who write rarely have that experience. Those who have the experience seldom write and do not take part in the journey" (p. 9).

So, even if I did not want to investigate, I wanted to find a reality in which to stand firmly and to dig into its secrets. These wishes were amply fulfilled over the years. Working in specialities - family medicine for a short period and then psychiatry - and places - northern Sweden and the southern less privileged areas of Greater Stockholm - where doctors were scarce, I met a lot of patients. Not only experiences but, with time, also questions in my mind related to those experiences grew. In the 90s I worked in psychosis care in the multicultural town of Södertälje, south of Stockholm, and participated in a reform of our services. After our newly started First Episode Psychosis team had been the object of an investigation that showed some positive results, I felt that the subjective experiences of the patients were missing in the evaluation. That led me to a fruitful course on qualitative research methods at Umeå University, and I realised I was eager to dig deeper.

As a doctoral student I started with a qualitative pilot study influenced by the growing research at the time on increased prevalence of psychotic disorder in some migrant and ethnic minority groups, and its presumed link to psychosocial background factors. I wanted to study cultural aspects affecting help-seeking behaviour among patients from the Syriac-Assyrian minority, the largest foreign-born minority in Södertälje at the time. The first lesson I learnt was about the difficulty of recruitment. In the end, I did not manage to recruit a big enough sample, and even if I learnt a lot and could publish a non-peer reviewed article in a family therapy journal in 2011, I could not continue along that path. This first experience led to continued reflections on the encounters between researchers and persons in vulnerable conditions, as between clinicians and professional helpers in general and those they want to help.

Instead, I found two other research projects and teams that I could join, leading to the studies in this thesis. Unlike Lindqvist, my focus was and still is more on describing the experiences of the refugees and asylum seekers, than of the workers in the sector. However, my interest in the encounter as well as the fact that we got access to sources in the form of medical records have made me think that if we really want to dig deeper, we have to study both parts in the encounter.

I have been fortunate to be able to move between questions that arose directly in clinical work, explorations in research and communicating what I learnt in training. However, I have also realised that the doctoral education system is not adapted to this meandering approach. Irrespective of logistical problems on the road, it has been a rewarding process for me. In the future, I do wish that this approach will be seen as a more normal learning process for clinicians, providing them with the support, especially time and financing, needed.

Finally, I want to point to an example of art as another way of exploring subjective experiences and cultural encounters. Gilda Perna (1948-2010), whose work of textile art is on the cover of this thesis, came from Argentina to Sweden in 1982, and in her work as a painter, sculptor and set designer she often depicted cultural histories from both her continents.

# 2 INTRODUCTION

Never, in modern history, have more people been forced to flee from their homes and take refuge inside their own country or abroad than today. At the end of 2020, the United Nations Refugee Agency, UNHCR (United Nations High Commissioner for Refugees), reported that 82.4 million persons were forcibly displaced worldwide because of "persecution, conflict, violence, human rights violations, or events seriously disturbing public order". This is the highest number on record in available data. The overwhelming majority – 86% - of the forcibly displaced were hosted in developing countries. Of the globally displaced persons, 42% were children (UNHCR, 2021, pp. 2-3). The displaced persons' ordeals were increased by the COVID-19 pandemic making it more difficult for refugees to reach safe destinations, to find resettlement through the UNHCR, or to return to the home country (UNHCR, 2021, pp. 5-8).

## 2.1 MIGRATION FROM AND TO SWEDEN

Most of the asylum seekers and refugees whose conditions I studied arrived in Sweden in the first decade of this century. They are part of a more than one-hundred-year long history of immigration to Sweden.

At the end of the 19th century, industrialisation as well as national, social, and ethnic conflicts in Europe led to increased emigration in search of better living conditions. Sweden was a country of emigration up till 1930. During a period of 100 years, 1.3 million persons emigrated to the USA, Canada, South America, or Australia, motivated by poverty, religious persecution, the lack of political rights and sometimes just the hope for a better life (Swedish Migration Agency [*Migrationsverket*], 2021a).

After 1930, immigration to Sweden has always been higher than emigration. Migration politics remained restrictive until the Second World War, at the end of which almost 200,000 foreign citizens lived in Sweden. However, before, and even during the war thousands of Jewish refugees were denied entry or extradited.

The first modern Swedish Aliens Act [*Utlänningslagen*] 1954, was influenced by the UN Geneva convention of 1951, acknowledging the right to seek asylum and refugees' rights in society. During the post-war period, Swedish industry expanded rapidly, and refugees were integrated into the labour market. At this time a common labour market was introduced in the Nordic countries and companies recruited workers from war-devastated Central and South Europe. The Swedish trade union federation LO accepted organised labour immigration on the conditions that immigrant workers were granted the same rights as the labour force in general with respect to trade union affiliation, collective agreements with employers, social security, and other social benefits. However, as early as 1972, in the wake of the first post-war economic crisis, LO rejected continued labour immigration, except from the Nordic countries (Byström, 2012).

From the 1970s refugee immigration increased, starting with refugees from dictatorships in Latin America. Subsequent successive waves of refugee migrants have reflected evolving political conflicts worldwide. The legislation has allowed residence permit based on refugee status as defined by the Geneva convention (based on experiences of personal persecution), but also as subsidiary protection, if returning to the home country would lead to a risk of suffering the death penalty or being submitted to degrading corporal treatment or violence. Environmental disaster is another reason for granting a person residence. It has also been possible to grant a person residence due to distressing circumstances in the person's situation. This rule which has often been claimed when applying for asylum on medical grounds, has, however, been successively restricted in the last decade. Labour immigration has increased again from 2008 and onwards as a consequence of a government decision to de-regulate decisions on work permits and allow the employers' needs to decide who can receive work permit or not.

## 2.2 THE "REFUGEE CRISIS" AND CHANGES IN MIGRATION POLICIES

In the recent period, after the years when the study persons of the here presented studies arrived in Sweden, migration has become an issue of wide concern in Sweden, as in Europe as a whole. Public - including media, political and research - interest in migration issues increased against the backdrop of the so called "refugee crisis" of 2015, when 1 million people walked, sailed, and flew to Europe from the Middle East and Africa. In the same period neighbouring countries received an even higher number of refugees from crisis-ridden countries, such as Syria, Afghanistan, Somalia, and Eritrea. The country that received most refugees in Europe then was Germany, followed by Sweden receiving around 163,000 asylum seekers in 2015. However, already the following year the number of asylum seekers in Sweden had decreased to a little less than 30,000 due to the introduction of more restrictive migration policies (Swedish Migration Agency, 2021b).

A temporary Limitation Act was introduced in 2016, limiting the granting of permits based on distressing circumstances. In June 2021 amendments to the Aliens Act were passed in the parliament, restricting the possibility of having permanent permits of residence, and making family reunion more difficult. A humanitarian reason for residence was reintroduced in exceptional cases (Swedish refugee law center, 2021).

## 2.3 IRAQI IMMIGRATION TO SWEDEN

In studies III and IV, I studied Iraqi refugees in Sweden. Immigration from Iraq to Sweden started increasing in 1980 and has followed the successive wars the country has suffered: the war with Iran 1980-88, the Kuwait war 1990-91, and the war and the following civil conflicts after the US invasion in 2003. The year when most Iraqis – 16,000 – arrived in Sweden was 2007. This was during an intense period of conflict in Iraq but the reason for the peak was also the temporarily widened possibilities of obtaining a residence permit. During the periods of war, most Iraqi immigrants have been men, especially unmarried men. During 1999-2002, which was a period without major war activities, women and children constituted 67% of the

Iraqi immigrants. Half of the Iraqis arriving during those years received a permit of residence based on the principle of family reunion (Statistics Sweden [*Statistiska centralbyrån*], 2016, pp. 65-68). The overwhelming majority of Iraqis have stayed in Sweden. In 2020 Iraqis were the second largest group of foreign-born persons living in Sweden, after Syrians (Statistics Sweden, 2021).

In the following background chapters I will address the main fields of inquiry in the thesis – migrant health, suicide, social networks, and culture – and describe the context of historical development of knowledge in each field, at the same time as I introduce the relevant literature.

## 2.4  DEFINITIONS

**Migrant**

The term is not defined in international law but is understood as a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for different reasons (International Organization for Migration [IOM], 2019).

**Asylum seeker**

An individual who has applied for protection as refugee in a foreign country but who has not yet received an answer to his or her application for asylum (IOM, 2019).

**Refugee**

An individual "who is outside the country of his or her nationality, because he or she feels a well-founded fear of persecution on grounds of race, nationality, religious or political belief, or on grounds of gender, sexual orientation or other membership of a particular social group, and is unable, or because of his or her fear is unwilling, to avail himself or herself of the protection of that country" (Aliens Act [*Utlänningslagen*], 2005).

**IDP, internally displaced person**

A person who has been forced to leave his or her home, especially because of situations of conflicts, violence, or disasters, but who has not crossed an internationally recognised state border (IOM, 2019).

**Undocumented migrant**

A person who resides in a country without the proper permit, for instance after the rejection of an appeal for asylum (IOM, 2019).

**Quota refugee**

A person who has fled his or her country and has been selected by the UNHCR to be resettled in another country. Before entering Sweden, the quota refugee has been granted permanent

residence within the refugee quota decided by the government and the parliament. The journey to Sweden is organised and paid by the Migration Agency (Swedish Migration Agency, 2021c).

**Torture**

In United Nations' Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, the term "torture" indicates all acts that inflict severe physical or mental pain or suffering on a person with the purposes of obtaining information, punishment, or intimidation. An act can only be called torture if it is committed by or with the consent of a public official or another person acting in an official capacity, and it does not include lawful sanctions. (Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1984).

# 3 BACKGROUND

## 3.1 MIGRANTS AND HEALTH

### 3.1.1 Healthy migrant or increased risk?

Do migrants run increased risk of poor health in general and especially mental health? This has been a long discussion and focus of contradictory findings. In the early 1930s Ødegaard found that Norwegians having migrated to the USA had a higher risk of developing schizophrenia and hypothesised that this was due to selection. The more psychosis-prone individuals would be more inclined to emigrate (Ødegaard, 1932). This hypothesis has since been contested in other studies (Selten et al., 2002).

The concept "the healthy migrant effect" dates to the 80s and was based on the finding that migrants in large studies were shown to be healthier than host populations (Marmot et al., 1984). An argument against seeing this as a rule has been that immigrants have to fulfil different criteria in different countries before being allowed to immigrate (Kirmayer, Narasiah, et al., 2011). In North America, for instance, labour migrants who are often younger and more fit to enter the labour market are often prioritised.

In the last decades there has been an increased interest in the variability of the health of migrants from different subgroups and in different contexts and phases. A summary of earlier research would be that migrants still tend to be healthy but that their health often deteriorates over time in the new country compared to the host population (Kirmayer, Narasiah et al., 2011).

In Sweden, foreign-born persons reported higher level of self-assessed ill-health, a measure that is considered to reflect real disease well (National Board of Health and Welfare [Socialstyrelsen], 2009). In a literature study, migrants in Sweden had poorer mental health than Swedish-born persons, but the findings varied according to country of origin and gender (Gilliver et al., 2014).

### 3.1.2 Social determinants of health

The World Health Organisation sees the social determination of health as the result of "the unequal distribution of power, income, goods, and services, globally and nationally, [and] the consequent unfairness in the immediate, visible circumstances of people's lives" (Commission on Social Determinants of Health [CSDH], 2008, p. 1).

The difference between social risk and protective factors and social determinants is that the former can be proximal, immediately related to health outcomes, and often individual, whereas social determinants are more distal, "root causes" that act on a population level, the understanding of which are linked to policies. Thus, exploring social determinants means shifting from individual health to public health with a focus on prevention, health promotion and an emphasis on wellness. Durkheim's suicide study is one of the first

examples of an investigation of the role of the social environment related to mental health (Compton & Shim, 2015, p. xxi, pp. 5-8).

The WHO report underlines the societal background of the social gradient of health: "This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (CSDH, 2008, p. 1). In a widespread model Dahlgren and Whitehead (1991/2007) gave a general overview depicting social determinants as layers of influence on an individual's health. The model emphasises how different layers of determinants interact with each other, from the closest network to societal factors. (See figure 1.) The authors consider that the model has proven particularly useful due to its focus on health promotion rather than risk factors for disease, the wider view of health it encourages and hence, also, the possibility for collaboration between different sectors of society that it opens for (Dahlgren & Whitehead, 2021).
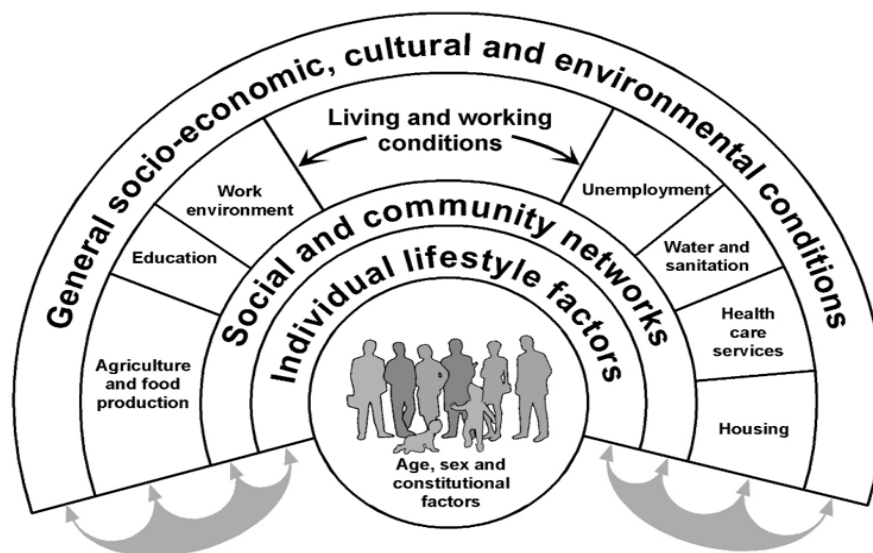


Source: adapted from Dahlgren and Whitehead, 1991

**Figure 1.** The main determinants of health (Dahlgren & Whitehead, 2007; adapted from Dahlgren & Whitehead, 1991).

Migrants are exposed to the same social determinants as everyone else, but also determinants that are specific to their situation. Among the general determinants, migrants often have worse living and working conditions (housing, unemployment, work conditions, access to health care services, access to education), weaker social and community networks, and earlier experiences of traumatic events than host populations. Individual lifestyle determinants vary and depend on social as well as cultural factors. Migrant-specific determinants include insecure legal status, ethnic discrimination, and difficulties of acculturation to the new society (Tinghög et al., 2010).

Determinants of health for migrants have been analysed in terms of *premigration, migration* and *postmigration* stress. Premigration stress includes war, persecution, socioeconomic burdens, displacement, and loss in close networks. Migration stress refers to the often painful process of leaving your country, a process that may last years or even generations and imply exposure to violence and socioeconomic hardship. Postmigration stress includes insecure migration status, socioeconomic conditions, changes in the social network, difficulties of learning a new language and of adjusting to a new climate, environment, culture and health care system, and experiences of discrimination and racism.

Trauma and torture are well-known premigration and migration stress factors affecting refugees' health (Porter & Haslam, 2005; Steel et al., 2009). However, many studies show the strong impact of postmigration stress factors, such as long asylum period, detention during the asylum period, worries for the family, temporary residence, and socioeconomic conditions, for the mental health of refugees (Foo et al., 2018; Laban et al., 2005; Porter & Haslam, 2005; Steel, et al., 2006, Steel et al., 2011). In a systematic review and meta-analysis restrictive entry and integration policies were linked to poor health outcomes for migrants in high-income countries (Juarez et al., 2019).

Social determinants are also focused in studies exploring the background of the nowadays well-documented increased risk of psychosis in migrants and ethnic minorities. Trauma, social adversity, and social exclusion, for instance by discrimination and racism, are among the possible explanations (Cantor-Graae & Selten, 2005). The term *ethnic density* has been used to describe the finding that rates of psychosis have been shown to be higher among minority ethnic groups in areas where they form a smaller proportion of the local population (Boydell et al., 2001; Kirkbride et al., 2007). It has been postulated that the causes of this discrepancy might be the buffering effect of the social support network in your own community as well as the higher risk of being exposed to racism in another neighbourhood. Also, it might be difficult to access culturally and religiously appropriate services if you do not live close to your community (Bosqui et al., 2014). Morgan et al. (2019) observed that recent research indicated that the most relevant social adversities for migrants and ethnic minorities were those involving threats, hostility (including discrimination) and violence, and that this was particularly detrimental in contexts of poverty, disadvantage, and isolation.

### 3.1.3  Variations in risks for different mental disorders

Research has also focused on different mental health problems, showing varying results. Concerning common mental health problem, mostly mood disorders, studies have not shown any increase in migrants in general, but risks vary over groups (Foo et al., 2018; Kirmayer, Narasiah et al., 2011; Posselt et al., 2020). Studies of posttraumatic stress disorder, PTSD, have shown high prevalences in refugees and asylum seekers but also considerable variations in prevalence (Fazel, Wheeler & Danesh, 2005; Posselt et al., 2020). For several decades now, a vast number of studies have shown an increased incidence of psychosis for migrants and ethnic minorities (Bourque et al., 2011; Selten et al., 2020). Regarding suicide and suicidal behaviour, findings are more complex and sometimes contradictory (se chapter 3.2).

### 3.1.4 Mental health in different migrant groups

Many studies have shown that different migrant subgroups have different health risks. Several reviews and studies have reported poor mental health in *refugees* (Bogic et al., 2015; Hollander et al., 2013; Kirmayer, Narasiah et al., 2011; Porter & Haslam, 2005). In a survey in Sweden, Tinghög et al. (2016) found that one third of studied refugees from Syria with permit of residence reported considerable symptoms of depression and anxiety and 30% reported symptoms typical of PTSD. In a Swedish cohort study, Hollander et al. (2016) found that refugees had an increased risk of developing schizophrenia and other non-affective disorders compared with the native population and with non-refugees from the same regions.

In a review, Bogic et al. (2015) found that mental health problems in refugees persisted even after many years in exile. In a prospective study in Norway with 20 years of follow-up of Vietnamese refugees, the refugees reported improved mental state, but in the group with higher level of self-reported distress at arrival, a higher proportion were still impaired after more than two decades of resettlement (Vaage et al., 2010).

*Asylum seekers* are considered even more vulnerable to mental health problems: they have been exposed to trauma and other stressors more recently than persons with permanent residence, and their right to stay in the new country is still not granted (Kirmayer, Narasiah et al., 2011). Several studies of asylum seekers have shown high levels of mental ill-health, such as PTSD, depression, and anxiety (Posselt et al., 2020), and some studies have shown asylum seekers have higher risks than refugees as a group (Gerritsen et al., 2006, Posselt et al., 2020; Tinghög et al., 2016). A study of refugees in Sweden showed that quota refugees had a lower risk of PTSD compared to the non-quota refugees who had arrived in Sweden as asylum seekers (Duggal et al., 2020).

*Undocumented migrants* are presumably in an even more vulnerable situation, with difficult living conditions including lack of housing, lack of social security and income, possible traumatisation, and fear of deportation. In a Swedish study of 104 undocumented adult migrants, the interview persons reported high levels of depression, anxiety, and PTSD (Andersson, Hjern & Ascher, 2018).

*Gender* has been the focus of some studies, with contradictory results, showing both higher and lower or equal prevalences of common mental disorders for refugee women (Bogic et al., 2015, Posselt et al., 2020). Women who migrated alone had an increased psychosis risk compared to women who migrated with family (Dykxhoorn et al., 2019).

### 3.1.5 Help-seeking behaviour and the encounter with healthcare

Migrants have been shown to use psychiatric care less than majority populations, with variations depending on region of origin and length of residence in the new country (Hollander, Mackay et al., 2020; Kirmayer, Narasiah et al., 2011; Straiton et al., 2014). Migrant women are particularly underrepresented in healthcare services for mental health problems (Carta et al., 2005; Straiton et al., 2014, 2019).

In many countries asylum seekers' access to healthcare is legally restricted, and they may also abstain from seeking help for fear of being deported. In Sweden asylum seekers and undocumented persons have access to "treatment that cannot wait", a rule that has been subject to different interpretations. Carta et al. (2005) described how asylum seekers and undocumented persons in Europe fell outside health and social services, independent of legal rights. Barriers to help-seeking might also be reluctance on the migrants' part due to negative experiences of authorities, lack of knowledge of the care system, linguistical difficulties, and perceptions of illness, including stigma related to mental health issues. Economic difficulties, including not affording patient fees or collective transport tickets, may also be barriers to seeking help (Kirmayer, Narasiah et al., 2011; Priebe, 2016).

When migrants do seek care, they risk receiving different treatment than the native population (Bursztein Lipsicas et al., 2014; hjel et al., 2019; Katsampa et al., 2021; Maier et al., 2010). A Swedish population-based cohort study showed that migrants and children of migrants with diagnosed psychotic disorder had a higher risk of compulsory admission at first diagnosis of psychosis. There were considerable variations depending on country of origin (Terhune et al., 2020). In a Dutch study, Mulder et al (2006) found that immigrants with non-Western ethnicity who were assessed in mental health emergency settings were more often admitted with compulsory admission. This association was not explained by diagnosis but by severity of symptoms, greater level of threat, more lack of treatment motivation and lower level of functioning. Possible explanations discussed by the authors are lack of knowledge of the care system, leading to delayed help seeking, but also ethnic bias on the part of the staff affecting their assessment of threats and motivation.

## 3.2    SUICIDALITY

### 3.2.1    Historical view of suicide and its causes

Through history suicide has been understood in different ways, in different time periods and contexts, from an escape from military defeat to a way of defending one's honour, a crime or a sin. Suicide as an expression of mental disorder gradually became a more common explanation and in 1783 Auenbrugger described suicide as a disease (Rosen, 1971). Since the 18th century the question "Is suicide increasing?" has been asked by researchers. During the 19th century the collection of systematic data on suicide rates in populations was developed, and the association between suicide and social problems was discussed in the wake of the industrial revolution. Studies of suicide during that century focused on the role of poverty and urban life. In the same period medical investigations of suicide started, relating clinical findings to anatomical changes found at autopsy (Rosen, 1971).

The most prominent representative of the sociological approach to suicide was Emile Durkheim, whose book *Le suicide* was published in 1897 (Durkheim & Simpson, 2002). Durkheim's main thesis was that "suicide which appears to be a phenomenon relating to the individual is actually explicable aetiologically with reference to the social structure and its ramifying functions" (Simpson, p. xiii). Rejecting what we would call socioeconomic

determinants as well as individual causes of suicide, Durkheim described suicide as a sign of the deep moral crisis in modern society. He identified four types of suicide:

*Egoistic suicide*, reflecting a lack of integration of the individual in society at large or in family life.

*Altruistic suicide*, which means that a person commits suicide because of higher ideals, political or religious.

*Anomic suicide*, which is the result of the individual not being controlled by the collective authority of society. Durkheim saw this as a chronic state in the modern industrial economy with its limitless expansion.

In a footnote to his book, he added the fourth type of suicide, the *fatalistic suicide* which is the opposite of the anomic suicide. It is the result of excessive control of the individual and one of the examples he takes is women being "sacrificed" in marriage. Interestingly enough, Durkheim thought that this fourth type had "little contemporary importance" and that examples were very hard to find (Durkheim & Simpson, 2002, p. 239). Since the publication of Durkheim's book, use of statistics in suicide research has increased and suicide has been studied in relation to a whole range of sociodemographic factors.

Salander Renberg (1998) described three main contemporary models for suicide: the biological-psychiatric, the psychological, and the sociological. However, she also noted the development of a "wide consensus on the fact that suicide is a very complex and multifactorial problem, best described as a biopsychosocial phenomenon" (p. 2).

The sociological theories since Durkheim have continued to search for social correlates to suicide. Durkheim's theories have been scrutinized by later researchers, among them Mäkinen (1997a) who claimed that Durkheim's categories do not sufficiently explain recent variations in suicide rates in Europe.

Psychological theories on suicide have their origins in Freud's writings (1914; 1917) and there are examples of psychoanalytical studies on unconscious intrapsychic conflicts and on unintegrated narcissism interacting with external adversity, and on the interaction with professional helpers (e.g., Beck-Friis, 2005; Maltsberger & Buie, 1974; Titelman, 2006, 2021). According to an overview article by O'Connor and Nock (2014), psychological research into suicide on a broader scale began in the 1950s. Diathesis-stress models and cognitive approaches dominate contemporary research. In several models, there is an interest in the afflicted person's suicidal process (Wasserman, 2001), that is, the passage from painful feelings leading to suicidal ideation and acts, driven by stressors, social influence but also cognitive, internal factors, including the after-effects of psychological trauma.

In the second half of the 20th century, the psychiatric focus on suicide shifted towards theories that view mental disorders as the main cause of suicide. An estimate that is often cited is that more than 90% of all those who commit suicide have a diagnosable mental

illness (Mann, 2002). This claim has, however, been increasingly contested. Population-based studies have shown that the association between mental illness and suicide varies between countries (Phillips et al., 2002; Radhakrishnan & Andrade, 2012), and the WHO (2014), in its guidelines for suicide prevention, admonishes against what it calls a "myth", formulated in this pregnant way: "Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder" (p. 53).

### 3.2.2  Suicidality and social determinants

In a general stress-vulnerability model of the suicidal process, Wasserman (2001) summarised the central pathway of the suicidal process as related to stress consisting of a broad range of social determinants as well as of individual vulnerabilities, such as somatic and mental illness and alcohol and drug abuse. (See figure 2).

Natural disasters, such as earthquakes, have been linked to increased suicide rates. Societal disasters, however, have had more varied impacts. Wars have been known to lead to decreased suicide rates, a fact that has been interpreted as a sign of the increased cohesion in the community when attacked by an external enemy (Hawton & van Heeringen, 2009).

Social changes with disruptive effects often lead to increased suicide rates. An illustrative example is how suicide rates changed in the Baltic states, especially Lithuania, with a decrease in the last years of the Soviet rule and an increase in the first years after the fall of the Berlin Wall. Initial hopes of a positive social development, introduction of restrictive alcohol policies and the later dismantlement of those restrictions, and de-industrialisation and male unemployment have been suggested as causal factors (Wasserman & Värnik, 2001). The suicide rates have decreased after that period, but Lithuania is still the country with the highest reported suicide rate in the world in the WHO's statistics (WHO, 2019).

A common trait of many determinants of suicide seems to be that they increase isolation, both physical and psychological isolation. Or inversely, strong social networks with many strong and fruitful contacts of long duration seem to be protective from suicide risk. Family bonds are seen to be the most important, with married persons in general having lower risk than unmarried, divorced, or widowed. The fact that being unemployed or cut off from the labour market because of disability is related to suicide risk also testifies to the importance of social bonds, as well as to the importance of more material, financial factors (Mäkinen & Wasserman, 2001; Hawton & van Heeringen, 2009).

Shared ideas or world views that build a person's sense of belonging to a community also reduces isolation. A world view that has been extensively studied in suicidology is religion, and religious belonging is known to be protective against suicide. All world religions instruct their followers not to commit suicide, and it is assumed that this prohibition explains the lower suicide rates, for example, in areas where Islam is dominant. For the same reason, increasing suicide rates during the 20th century in Catholic countries in southern Europe,
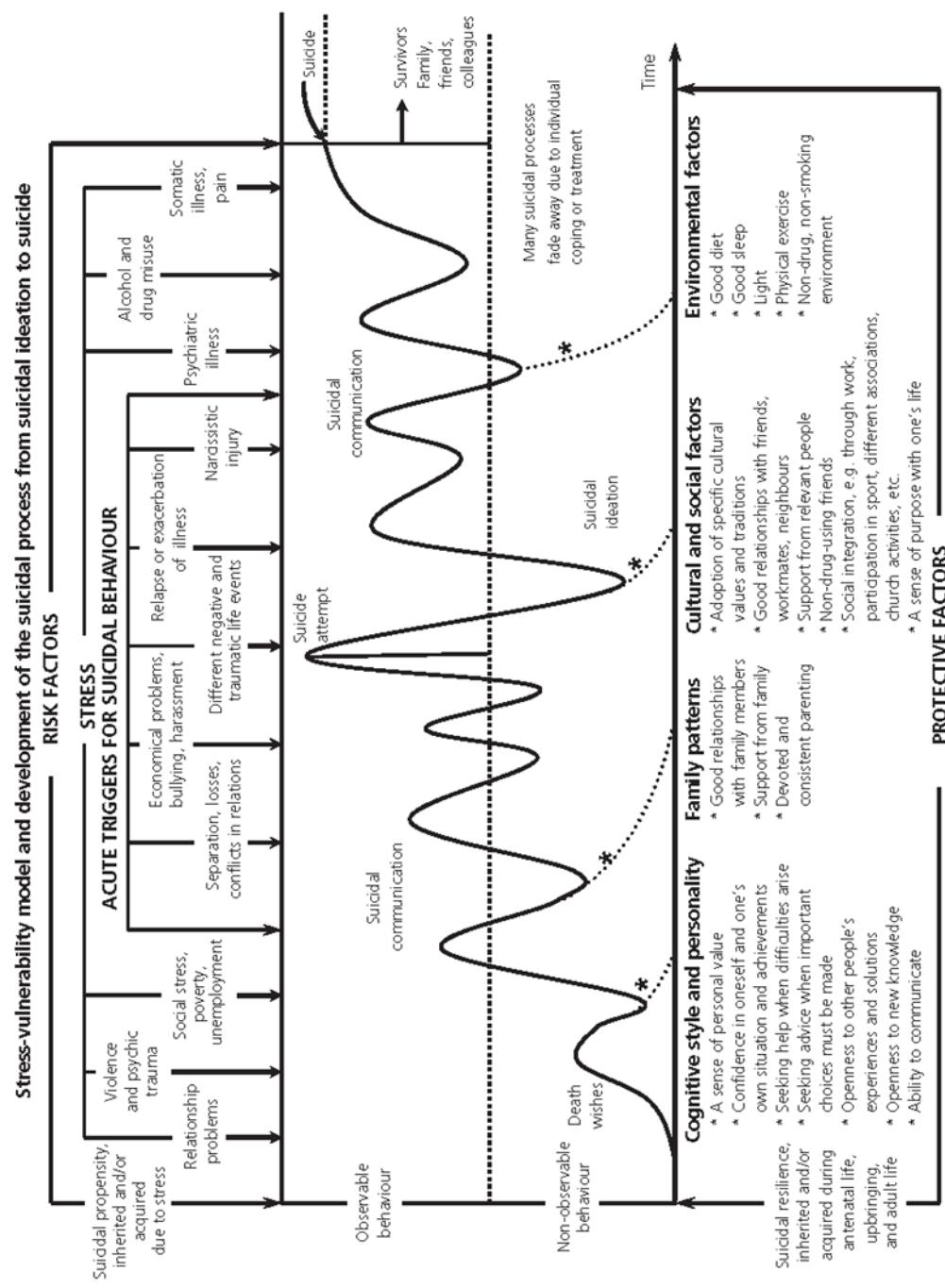
Figure 2. Stress-vulnerability model and development of the suicidal process from suicidal ideation to suicide. Adapted from Wasserman, D. Suicide: An unnecessary death, Figure 2.1 (2001) Reproduced with the permission from Oxford Publishing Limited through PLSclear.

which used to have low suicide rates are often ascribed to secularisation. Studies have found both religious practices exercised together with other followers and the internal feeling of religiousness to be protective (van Praag, 2009). However, Lawrence et al. (2016) noted that the empirical evidence is inconsistent. In a systematic review they found that religious affiliation and attendance at religious services protect from acting on suicidal ideas. If religious affiliation does not connect to a community but leads to more isolation, it is less likely to protect against suicide. Feeling abandoned by the religious community or by God or seeing God as a punishing authority even may increase suicide risk (Lawrence et al., 2016; van Praag, 2009).

### 3.2.3 Migrants, migration status and suicidality

Given that migrants experience stress in three phases (premigration, migration, and postmigration), it is natural to assume that they may have a heightened risk of suicide. They often suffer the effects of accumulated social adversity, such as lack of housing, unemployment, financial problems, and losses in their personal social networks. This assumption of increased risk is intuitively strengthened by the repeated findings that migrants have an increased risk of mental ill-health, which in turn has strong links to suicide (Fazel, Wheeler & Danesh, 2005). Repeated studies, however, show a more mixed picture, testifying to what a complex and contextually influenced, multifactorial process suicide is. To elucidate the links between migration and suicide it is necessary to consider subgroups of migrants as well as different suicidal behaviours.

Suicide rates differ between countries, even though the statistics showing those differences sometimes vary in quality. South-East Asia, Europe and Africa have the highest age-standardised suicide rates. Although high-income countries have high rates, the majority of the world's suicides occur in low- and middle-income countries (WHO, 2019).

**Migrants in general and suicide.** For a long time now, studies have confirmed the finding that *migrants* tend to bring their suicide risk from the home country (Hawton & van Heeringen, 2009; Ratkowska & DeLeo, 2013; Spallek et al., 2015). Studies in Sweden showed higher suicide rates for migrants compared to Swedish-born persons, but the increased rate was related to a few groups, mainly Finnish-born immigrants, whereas migrants from Southern Europe and the Middle East had lower risk. The Finnish immigrants were at the time the largest immigrant group in the country and came from a country with higher suicide rate than Sweden (Ferrada-Noli et al., 1995; Ferrada-Noli, 1997; Hjern & Allebeck, 2002; Johansson et al., 1997; Westman et al., 2006; Gilliver et al., 2014). These findings were confirmed and strengthened in a large Swedish population-based register study that found lower risk of suicide in first-generation immigrants with one exception: immigrants from other Nordic countries, mostly from Finland (Di Thiene et al., 2015).

Hjern and Allebeck (2002) and Di Thiene et al. (2015) found that second-generation immigrants had higher suicide risk than first-generation immigrants. In Di Thiene et al.'s study all differences in risk except for the increased risk for second-generation immigrants

from the Nordic countries disappeared when adjusted for sociodemographic variables, labour market marginalisation and earlier health care consumption. The increased risk for the second generation has been interpreted as reflecting acculturation difficulties and intergenerational conflicts (Bhugra et al., 2011; Di Thiene et al., 2015; van Bergen et al., 2021).

Adoptive children have a higher suicide risk than the majority population and second-generation immigrants (Hjern & Allebeck, 2002). In a follow-up study of international adoptees, the risk of suicidal behaviour decreased with age. Further, the oldest birth cohorts had higher risks than the later ones, and risk for suicide and suicidal behaviour increased with the adopted child's age at adoption (Hjern et al., 2020).

**Migrants and suicide attempt.** One of the paradoxes of suicidality is that earlier suicide attempt is a risk factor for suicide, but at the same time the demographics are different for the two outcomes, with an increased relative risk of suicide attempt for younger persons and for women. Studies have shown higher risks of attempted suicide for migrants compared to the host populations with variations that depend on country of origin and gender. In a Swedish study, Kosidou et al. (2012) showed that young non-European first-generation migrant women were overrepresented as suicide attempters compared to native Swedes. In a multicentre study with 11 participating centres in Europe, most of the migrant groups had suicide attempt rates in line with suicide rates in their home countries, that is, persons from low-risk countries had lower risk also in the new country. However, for almost all groups the risk of suicide attempt was higher than in the home country, and in some cases even higher than the risk of the population in the host country (Bursztein Lipsicas et al., 2012). The authors noted that the relative continuity in risk between country of birth and host country could be interpreted either as genetically or culturally determined but deemed the cultural hypothesis as the more probable one.

**Refugees and suicide.** As discussed in chapter 3.1, refugees have poorer mental health than the population in the countries to which they have moved. Yet, several studies show lower or equal risk of suicide. Norredam et al. (2013) compared mortality related to injury between refugees and family-reunited individuals and native Danes and found lower suicide rates for the male immigrants and refugees, and no consistent differences for the females.

Hollander, Pitman et al. (2020) compared refugees and non-refugees from the same countries with each other and with Swedish-born controls and found lower suicide risk in both immigrant groups, especially males, compared to the Swedish-born. After more than 20 years the immigrant groups in the study had the same suicide risk as Swedish-born but lower risk after adjusting for income.

In a register study, Amin, Helgesson et al. (2021) compared refugees and Swedish-born individuals and found that most refugee groups had significantly lower suicide rates than the Swedish-born, both totally and stratified for gender and age. Sociodemographic factors, earlier marginalization in the labour market and health factors had only marginal effect on the differences.

**Asylum seekers and suicide.** Asylum seekers are, as mentioned above, considered to be even more vulnerable than refugees in general (Kirmayer, Narasiah et al., 2011). There is a lack of studies of asylum seekers. In Sweden for instance, they have often been excluded from studies because they do not have personal identity numbers, and they are also more difficult to recruit because of their unstable housing situation. Some European studies have nonetheless shown an increased risk of completed suicide among asylum seekers with differences related to gender and region of origin (Cohen, 2008; Goosen et al., 2011; van Oostrum et al., 2011).

**Asylum seekers and suicide attempts.** Goosen et al. (2011) found that asylum seekers in The Netherlands of both sexes from Europe and from parts of Asia were more likely to be hospitalised after a suicide attempt than native Dutch people, whereas asylum seekers from major parts of Africa had a significantly lower likelihood of receiving such care. In the vast majority of the hospitalised cases, care records showed that the staff at the asylum centres had been aware of these individuals' mental health problems and that three quarters of all patients had received treatment before hospitalisation. However, the African asylum seekers had received less mental health treatment in the asylum centres. Similarly, Staehr & Munk-Andersen (2006) found an increased rate of suicide attempts leading to hospitalisation among 54 asylum seekers in Denmark in 2001-2003, compared to the general Danish population.

**Undocumented migrants and suicide.** Undocumented migrants are an under-researched group. In Sweden, they do not have personal identity numbers and they are not included in the Swedish Cause of Death Register. In many countries they have limited access to healthcare. In Sweden, since 2013, they have access to care that cannot wait, with the same criteria as asylum seekers, but in practice they may be fearful of approaching healthcare units and caregivers may be ignorant of their rights. The first study in Sweden to establish national figures of causes of death of undocumented migrants showed that external causes, including suicide, were the most common causes of death in this group, with a significantly increased risk for both women and men compared to Swedish residents (Wahlberg et al., 2014).

**Unaccompanied minors and suicide.** Unaccompanied minors are just as asylum seekers in general difficult to study since they do not have personal identity numbers and cannot be found in official death registers. In a study of suicide deaths in Sweden 2017, the researchers contacted different state agencies and NGOs to identify suicides in this group. They found that unaccompanied minors and youth (aged 10-21 years) had a much higher suicide rate than the general population in the same age span (Mittendorfer-Rutz et al., 2020).

**Female migrants and suicidality.** Spallek et al. (2015) found that young female immigrants from Turkey, East Africa and South Asia were a risk group for suicide both in their countries of origin and in the new countries. Other studies have demonstrated high rates of attempted suicide for some groups of female immigrants (Bhugra et al., 2011; Bhui et al., 2007; Bursztein Lipsicas et al., 2013; Kosidou et al., 2012; van Bergen et al., 2010). Conflicts with families, violence against women, poverty, and mental illness have been identified as risk

factors for suicidal behaviour of young immigrant women (van Bergen et al., 2021; Bhugra et al., 2011).

**Summary.** To summarise, the somewhat paradoxical findings are that migrants seem to bring the (often lower) suicide risk of their country of origin, even when they belong to groups that have been shown to have poorer mental health (such as refugees). By contrast, the risk of suicide attempts, at least in some subgroups, seems to be higher. Asylum seekers, undocumented migrants and unaccompanied minors are groups with higher risks of suicidality.

There are, however, methodological problems in this kind of research. The refugee concept is not used in the same way in all studies. Rates of attempted suicide are not registered in all countries and comparisons between pre- and postmigration risks use different measures of suicidality. Data on suicides from different parts of the world vary a lot in quality. As Amin, Helgesson et al. (2021) noted, if hospitalisation is used to measure a suicide attempt (in the absence of other measures), there is a risk of underreporting. Further, feared stigmatisation may stand in the way of seeking care after having attempted suicide.

### 3.2.4  Trauma and suicidality

Although there is consensus in suicide research that negative life events and traumatic events are related to suicidality (Hawton & van Heeringen, 2009), most studies show an association between posttraumatic stress disorder and suicidal behaviour (ideation, attempts) but not with completed suicide (Krysinska & Lester, 2010; Panagioti et al., 2012). Two Danish studies, however, showed that completed suicide was associated with stress disorders, including PTSD (Gradus et al., 2010, 2015).

Ferrada-Noli et al. (1998) found elevated rates of suicidal behaviour in asylum seekers and refugees with a PTSD diagnosis. In an interview study, traumatic experience, especially torture, was the pre- or postmigration stressor most strongly associated with suicidal thoughts (Ekblad & Shahnavaz, 2004). In a Danish study by Staehr and Munk-Andersen (2006), one third of the asylum seekers hospitalised after suicide attempts had served prison terms or been exposed to torture and/or war experiences.

### 3.2.5  Assessment and treatment of suicide-near migrants

As described above, there are barriers both in access to care, factors negatively influencing help-seeking, and in the clinical encounters that lead to unequal care for migrants. This is borne out by Bursztein Lipsicas et al. (2014), who in a multicentre study showed that, in Western European countries, immigrants from Eastern Europe and non-European immigrants are more likely than patients from the host country to be referred to less specialised care or no care at all after a suicide attempt. Amin, Rahman et al. (2021) found that refugees in Sweden received less specialised healthcare after a suicide attempt than Swedish-born persons. In a Dutch study of suicidal asylum seekers, the male African asylum seekers had a higher suicide

risk and the medical records showed that they had used the available mental health services prior to the suicide attempt to a lower degree (Goosen et al., 2011).

There may be particular challenges in the exploration of suicidality in the clinical encounter with refugees: cultural and language barriers related to the patient's difficulties of disclosing suicidal thoughts; patients' severe stress reactions, for example, cognitive impairment and shame related to experiences of torture and sexual violence; and handling legal aspects related to the migration process (Crumlish & Bracken, 2011; Kirmayer, Narasiah et al., 2011).

## 3.3   SOCIAL NETWORKS AND SOCIAL SUPPORT

It is well established that social isolation and loneliness are correlated with health problems. Social isolation is defined as an objective lack of social contacts; loneliness is defined as the subjective feeling of lacking a social network. A systematic review showed a correlation between social isolation and loneliness, respectively, and cardiovascular and mental disorders (Leigh-Hunt et al., 2017). There is, however, an ongoing discussion on the causality of these observations. Different theories have been advanced to explain the health effects of isolation and loneliness, ranging from deficiencies in protective hormones, stress effects, to the need of the human brain to receive stimuli (Leigh-Hunt et al., 2017; Bentall, 2003). Inversely, strong social bonds have been postulated to promote health and well-being. Several social science concepts have been developed to describe the way persons relate and affect each other's well-being. Tracy and Whittaker (1990, p. 462) described a social network as "the structure and quantity of a set of interconnected relationships", social support as the many ways in which people assist each other, and a social support network as "a set of relationships that provide nurturance and reinforcement for coping with life on daily basis".

### 3.3.1   History of social network studies and network therapy

The study of social networks has its roots in social anthropology and sociology. The British social anthropologist John Barnes (1954) was a pioneer, studying how inhabitants in a Norwegian fishing community related to each other. Network therapy developed in the 1960s as family therapists started to broaden the circle of persons involved in social work with afflicted persons beyond the family.

There has continued to be a strong connection between theoretical developments and the practice. In a scientific context, network analyses, which initially tended to focus on quantitative aspects, developed as anthropology shifted to an increased interest in aspects of meaning from the 1970s and onwards. Systems theory was formulated in the 70s with Bateson (1972) at the forefront. Bronfenbrenner (1979), who developed an ecological systems theory, studied how different levels of systems – from micro- to macrosystems, from the closest systems to societal values - affect individuals and their interaction with each other. This ecological view influenced the later development of the network map as a tool in research as well as in work with clients (Klefbeck, 2007a).

In the 1980s, network theory and therapy were influenced by the postmodernist and social constructivist emphasis on the need of exploring multiple perspectives to gain knowledge of the world. These influences led to a new or strengthened interest in how persons live and gain subjective meaning in the systems they form when they interact with other persons.

In yet a further development, a system-linguistic approach stemming from social constructivism was developed by Goolishian, Anderson, and other family therapists (Klefbeck, 2007b). These writers claimed that problems exist in language and not in structures or objective reality. In therapeutic work this led to a focus on the dialogue in the treatment encounter. Jaakko Seikkula (1996) developed system-linguistic theories into Open Dialogue, an approach facilitating and restoring dialogue in social networks, which was initially developed within mental health services for persons with severe mental illness. It is today implemented and studied in several countries, especially in the UK and the USA (Putman & Martindale, 2021).

### 3.3.2  Characteristics of social networks and support

The most common categorisations of social networks are in terms of structural (size, density, clusters), functional (providing different functions for the individual) and interactional characteristics (frequency, duration, direction, closeness, reciprocity). Marsella and Snyder (1981) described how the focus of network analysis has moved from mainly describing the structural to the functional and interactional characteristics. The critical function of the social network is to give support to the individual, including to help him or her to maintain his social identity and to make new social contacts (Walker et al., 1977). Llamas et al. (1981) described this function as providing necessary "psychosocial supplies" and a basis for individual growth and adaptation.

Hessle (1991) discussed the different origins and meanings of social networks and social support. Whereas the social network concept has been mainly used in sociology, social support has a tradition within social medicine and psychiatry. Hessle understood social support as the interactions we take for granted and that are fundamental elements of our identity. (That was also why he preferred the English term "social support" to its direct Swedish translation, "socialt stöd", which in his view indicates exchangeable support that is temporary in a social system.) Hessle stressed that social-network and social-support analyses have converged over time, and that social support can be seen as a subsystem within overarching network systems. We all have extensive networks, but not all of them are supportive.

Social support can be seen as part of the functional characteristics of the network. Other categorisations of social support are, for instance, as emotional, informational, concrete, and sometimes also as spiritual (Llamas et al., 1981; Tracy & Whittaker, 1990; Balboni et al., 2007). Israel (1985) categorised social support as emotional, appraisal support (feedback, affirmation), informational, and instrumental (money, labour, time). Wahlström (2013), in studies of survivors of a natural disaster, used a somewhat different categorisation,

distinguishing between formalised support from professional sources and support groups and social support from family, friends, co-workers, and neighbours. Wahlström also distinguished between perceived and actually received social support.

### 3.3.3 Role in health

Health effects of social support and social networks have been addressed in studies on, for example, transplant recipients (Cetingok et al., 2007), insomnia (Hanson & Östergren, 1987), deafness research (Hintermair, 2009), and nursing care to breastfeeding women (Souza et al., 2009).

There is a particular interest in the role of social networks in mental disorder, especially serious mental disorder such as psychosis and schizophrenia. Regarding schizophrenia, social isolation has been studied as a possible aetiological factor, a predisposing variable, a prognostic indicator, a residual symptom, or a consequence of the illness. Several studies have shown a particular reduction of social networks for persons diagnosed with schizophrenia (Pattison & Pattison, 1981; Lipton et al, 1981). Seikkula (1991, 1996) studied the social networks of patients referred to a psychiatric hospital, comparing those admitted for the first time to patients with recurrent disorder and patients with long-term disorder. He found differences in structural as well as interactional characteristics. The patients' networks seemed to diminish most in size and interaction in the first episode.

Meta-analyses of trauma studies showed that lack of social support after trauma predicts PTSD (Brewin et al., 2000; Ozer et al., 2003). Negative life events are often related to negative development of social support. "Stressful events can deplete social networks, that, in turn, increase PTSD symptoms" (Agaibi & Wilson, 2005, p. 205).

In a study of tsunami survivors in Sweden, Wahlström et al. (2013) showed that the family was the most common source of social support after the disaster. Psychological distress after the trauma was more related to dissatisfaction with the social support from family, friends, neighbours, and work colleagues than with the formal support from authorities. The authors argued that disaster victims reporting dissatisfaction with social support should be given special attention, given the increased risk of psychological distress.

### 3.3.4 Refugee studies on social networks and health

Social networks, which provide both emotional and practical support, are important for postmigration coping and resilience, for reestablishing a sense of identity, and for integration in the host country (Abraham et al., 2018; Beirens et al., 2007; Hassan et al., 2016; Kingsbury et al., 2018). Problems related to the social networks of refugees, such as separations, loss because of death, missing the family, loneliness, or lack of support from the person's ethnic community in the new country have been shown to be related to mental ill-health (Hauff & Vaglum, 1995; Porter & Haslam, 2005; Laban et al., 2005, 2008; Nickerson et al., 2010; Schweitzer et al., 2006). Other studies have shown that low social support for refugees affects

well-being and mental ill-health (Gorst-Unsworth & Goldenberg, 1998; Bogic et al., 2015; Tinghög et al., 2016).

Gender differences have been found. In a study in the USA of the social networks of resettled Bhutanese refugee women during pregnancy, Kingsbury et al. (2018) found that the refugee women often had dense social networks and found it difficult to make contact outside the group. A strong personal social network, nonetheless, contributed to stress mitigation and helped these women to maintain a sense of identity. In a study of family networks of first-generation adolescent migrants and the risk of developing psychosis, there was a gender difference with the presence of family networks being protective for the female migrants but not for the males (Dykxhoorn et al., 2019).

Silove (1999; 2013) developed the ADAPT (Adaptation and Development after Persecution and Trauma) model describing interpersonal bonds and social networks as one of the five essential psychosocial pillars in human societies threatened by mass conflict. The other pillars are safety and security, justice, roles and identities, and existential meaning.

### 3.3.5 Methods of studying social networks

Tracy and Whittaker (1990) developed the social network map as a way of measuring social support in a clinically meaningful way. They built on earlier use of so-called eco-maps and circle-mapping techniques by other social network researchers. The map was constructed for a single individual and listed members of the network from seven domains: household; family/relatives; friends; people from work or school; people from clubs, organisations, or religious groups; neighbours; and agencies or other formal service providers. The map and the accompanying questions were designed to provide information on both structure (size) and function (availability of support, closeness, stability, frequency).

Other research groups developed a social network map that visualizes an individual's relation to other persons in different walks of life and how they connect to each other. It comprises four sectors: household, relatives, work and school, and other relations (Klefbeck, 2007a). The last sector includes friends, neighbours and professional helpers. In a later development, the professional persons are often separated as a subsector (see figure 3). The focus of the network map is on the microsystems, that is, the part of the network with which the person is in direct interaction. In each sector there can be several microsystems and one microsystem can be represented in various sectors.

There are other types of network maps: the historic map, the geographic map, the biographic map, and the hypothetic map (Klefbeck, 2007a). The biographic network map can be compared to the rings of a tree, with the present time closest to the centre and the oldest period in life in the periphery. This map puts the focus on the changes in a person's network.
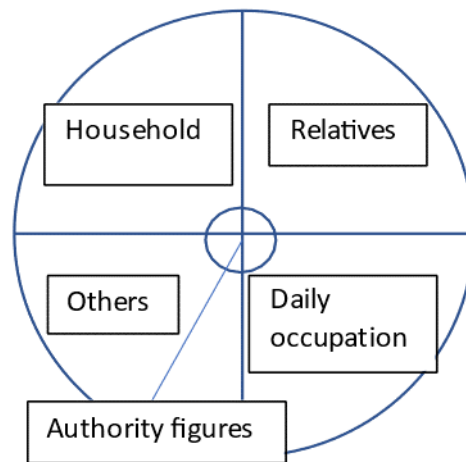
**Figure 3.** The social network map. Adapted from Klefbeck (2007a).

### 3.3.6  Resilience

In studies of the effects of individual trauma as well as of mass conflicts, there is a growing interest in resilience, defined as the ability to go through difficult experiences not only maintaining a level of mental health, but continuing to thrive and develop as a person. Resilience is a concept with roots in physics, but widely applied in different fields, including environmental studies. In psychology, it is commonly viewed as an individual trait (Kirmayer, Dandeneau et al., 2011). However, already when it was introduced in child psychology in the 1970s, the role of the social network was emphasised (Rutter, 1985). Social support is sometimes described as a resilience-strengthening factor, both in children and adults (Agaibi & Wilson, 2005).

Most studies on resilience have been on children who survive severe adversity or on war veterans. Refugee- and indigenous studies in recent years often include a focus on preventive family interventions in the service of well-being and mental health (Pejic et al., 2016), as well as a focus on community resilience (Xu, 2017), that is, collective adaptation after a major calamity. Kirmayer, Dandeneau et al. (2011) stressed that a person's resilience is an interpersonal resource strengthened by the person's community and cultural context.

Traditionally, migration has been seen as a definitive displacement and a permanent change that leads to assimilation in the new country and a distancing to the culture and social network of the country of origin. However, today it is well known that many migrants remain involved in their home countries and maintain social, economic, and political relations, and that these bonds may constitute a source of resilience. The maintenance of transnational families or transnational communities is facilitated by modern communication technologies and is reported to strengthen the migrants' self-image and to counteract experiences of discrimination and feelings of marginalisation (Eastmond & Åkesson, 2007).

## 3.4 CULTURE AND COMMUNICATION

### 3.4.1 The meanings of culture

There are innumerous definitions of culture. Here I will follow Öhlander's description (2010) of the historical roots, different uses of and debates round the concept. He described how the meaning of the word developed from the cultivating of plants and animals to the cultivation of the human soul, to societies having higher or lower cultural level. In the period of Enlightenment, Europe was defined as modernity, the more cultivated continent.

Öhlander (2010) described three main, interlinked meanings of the word "culture" today. It can be used as a description of an individual as "cultivated" which includes a value judgment and establishes a hierarchy. Culture can also be used in the aesthetical sense of the word as the exercising of artistic activities as well as the products of such activity – a field that is also value-laden. The third meaning, with most relevance for clinical research and practice is the anthropological meaning, defined by Öhlander as "a word summarising … lifestyle, typical behaviours, specific traditions, norms you adhere to, central ideals and values, [and] ways to perceive and interpret reality or ways of shaping and communicating something (for instance pain, anger or joy)" (p.21).

In my experience, both as a clinician and a researcher, "culture" can be a very sensitive concept, and is sometimes interpreted negatively. The third, anthropological meaning is not free of potential value judgments any more than the other two meanings. Öhlander claimed that whereas the use of culture can contribute to increased understanding and respect, it can also be part of "power processes" leading to categorisation of people into social hierarchies (p. 12). The idea of some societies having a higher cultural level has survived into our days, but there is also a culturally relativist position, claiming that cultures should be understood in their own contexts. On the other hand, cultural relativism has been questioned, for example in debates on so called honour violence. "Culture" can also be used as a static, reified category, reminding of the way the word "race" has been used through history. A common safeguard among contemporary anthropologists against such a static view of culture is to stress culture's continuously changing characteristics.

### 3.4.2 Culture in the history of psychiatry

Kirmayer and Minas (2000) described the development of cultural psychiatry in three phases. The first phase was linked to the colonisation of territories outside Europe. The research interest in local expressions of mental distress and disorder led to the identification of unique, culture-bound syndromes. Over the last century, as cultural psychiatry and anthropologists developed an increased understanding of the social context, many of those syndromes have been questioned (Kirmayer & Minas, 2000). As a result, in Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5), several conditions have been removed from the list which has also been renamed from "culture-bound" to "cultural" syndromes (American Psychiatric Association [APA], 2013).

As the colonies gained independence, large groups of their populations moved to the former colonists' homelands, where a social interest in understanding the migrants' health problems and how they could be helped emerged. This led to a second phase of cultural psychiatry with studies of illness comparing migrants with the native population and comparing different groups of migrants (Kirmayer & Minas, 2000). This research focus remains vital, and epidemiological studies of migrant health are abundant and increasing. In the third phase, cultural psychiatry has studied how cultural aspects affect psychiatric theory and practice. Cultural psychiatry in this sense was established in the late 1970s and 80s and included the collaboration of researchers in psychiatry and anthropology (Kirmayer & Minas, 2000). The view of culture as changing, hybrid, heterogenous, individually adapted, and worth studying not only as reflected in the observed person but also in the observer is expressed in the definition of culture included in the introduction to DSM-5 (APA, 2013).

Already the publication of DSM-IV (APA, 1994) marked a step forward for the inclusion of cultural perspectives into psychiatric assessments. In an appendix, an Outline for Cultural Formulation (OCF) was published. The outline presented a list of topics that the clinician could use to assess cultural aspects as part of his or her general diagnostic assessment. In some countries local interview guides concretising the topics of the OCF were produced. In Sweden, Bäärnhielm et al. (2007) formulated a manual with suggested areas to explore as well as concrete questions on cultural aspects.

In this project, especially in study III, we based our interviews on cultural aspects on the OCF and on the interview guide by Bäärnhielm et al. (2007). Since then, however, culture has received a more prominent place in the DSM system. In DSM-5 (APA, 2013) culture is addressed in the following ways: in the above-mentioned definition in the introduction, in comments regarding individual disorders, in a section on cultural concepts of distress, and in the form of a Cultural Formulation Interview (CFI) that is explicitly recommended in the initial assessment of all patients, not only those with a supposed "different" cultural background. The purpose is to enable the clinician to explore the role of culture and context in diagnostic assessment and to make more individually adapted treatment plans with patients (Lewis-Fernández et al., 2014).

### 3.4.3 Communication, culture, and idioms of distress

Good communication in medical encounters is essential for understanding, assessment, and treatment. When we as healthcare staff members reflect over our communication with patients with migration background, we often see linguistical difficulties as most important. The lack and role of interpreters are common causes of concern. We rarely consider barriers related to cultural aspects of language, including the language of the care culture. Other aspects of communication such as the asymmetric power relation in the clinical encounter, or differences in perceptions of illness and expectations of care are probably even more rarely taken into account (Fossum, 2019).

In DSM-5 (APA, 2013), three types of "cultural concepts of distress" are introduced: the already mentioned cultural syndromes, cultural idioms of distress, and cultural illness explanations.

Idioms of distress describe local ways of thinking. Lewis-Fernández and Kirmayer (2019) stressed the difference between psychiatric disorders and idioms of distress. Whereas the former most often have the character of syndromes with characteristic symptoms, course, dysfunction etc. the idioms are more fluid and flexible, expressing single symptoms, explanations, types of behaviour, and ranging from everyday problems to severe psychopathology. Lewis-Fernández and Kirmayer described the process of diagnosing psychiatric disorders as what is left after abstracting and decontextualising cultural concepts of distress, eliminating the narrative and the personal and social context.

### 3.4.4 Cultural perceptions of illness and cultural explanations

For a long time, anthropologists have been interested in how culture influences the way persons perceive and explain illness. Kleinman (1980), a psychiatrist trained in anthropology, developed the notion of explanatory models, and described them in the following way: "They [the explanatory models] offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness" (p. 105). In his view, explanatory models were coherent sets of ideas seeking to explain aetiology, time and onset of symptoms, pathophysiology, course of sickness, and treatment. Later, Kleinman and Benson (2006) noted that the explanatory models were often misused by clinicians and clinical students: "They materialize the models as a kind of substance or measurement (like hemoglobin, blood pressure, or X rays), and use it to end a conversation rather to start a conversation" (p. 1674).

Kirmayer and Sartorius (2007) noted that explanatory models may be difficult to explore in interviews, since they represent implicit knowledge based on social background knowledge that is taken for granted. Interview studies with Turkish immigrants in Sweden and Turkish-speaking, mainly Kurdish, immigrants in Britain indicate that patients often lack or have fragmented models of illness (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007). Various attempts have been made to construct interview guides for explanatory models: the McGill Narrative Interview (Groleau et al., 2006), the EMIC (Weiss, 1997), the SEMI (Lloyd et al., 1998), the Barts explanatory model inventory (Rüdell et al., 2009). They are mainly semi-structured interviews with the purpose of eliciting personal narratives.

### 3.4.5 Studies of cultural aspects in the care encounter

There are relatively few studies of the role of culture in the clinical encounter. Most often qualitative methods have been used in interview studies with patients and clinicians separately from each other. Bäärnhielm (2003) studied Swedish and Turkish-born women who had been assessed by caregivers as somatising. Initially the Turkish-born women presented their complaints mostly as bodily symptoms and found it difficult to accept the

psychological language offered to them by the caregiver. In a process of bridging the perspectives they approached a more psychological or psychiatric framework. The caregivers found it difficult to interpret the women's idioms of distress and thought they had little support from their organisation and few tools adapted to that interpretation. Hultsjö (2009) interviewed patients in psychosis outpatient care as well as their relatives and staff in psychiatric and somatic emergency services. The staff expressed difficulties and even distrust of the patients, when they were assessing the patients' needs in the asylum situation. The patients differed between themselves in their perceptions of illness and in their expectations of care interventions, contradicting stereotypical notions of cultural differences. Further, the families of the foreign-born patients did not expect the staff to know more about their cultural background, nor to offer adapted treatment. They did, however, wish that the staff would be interested in their situation and give time for them to develop mutual understanding.

Svenberg (2011) studied the patient-doctor encounter through interviews with Somali refugees about their experiences of health care and interviews with medical interns about their experiences meeting Somali patients. The Somali refugees felt rejected by the clinicians and lacked confidence in them. They perceived the primary care doctor as always saying "it's really nothing" about their problems, and often went abroad for medical care. The interns expressed insecurity and a cultural distance to the patients, whose expectations they found it difficult to satisfy. Svenberg stressed the importance of building trust through showing a genuine interest in the patient by offering thorough medical investigations and building a relationship over time.

Guregård and Seikkula (2014) analysed video-recordings of therapy sessions with Swedish-born therapists and refugee families in child- and adolescent psychiatry. Within the framework of the Open Dialogue approach (Seikkula, 1996), they investigated the dialogical quality of the meeting. They found that the therapists' lack of knowledge of the families' realities, differences in cultural perceptions, and family members being distressed by traumatisation constituted obstacles to the dialogue. The therapists seemed to find it difficult to empathise with the families.

### 3.4.6 Cultural competence

Training of students and clinicians in cultural competence is generally considered the path of choice towards handling clinical encounters when the patient and the clinician have different cultural backgrounds. In a guidance document the European Psychiatric Association (Schouler-Ocak et al., 2015) defined cultural competence as the ability to be aware of and handle cultural factors in all kinds of therapeutic interactions between clinicians and patients. The document also addressed the common criticism of the concept "cultural competence" as a technical skill that can be taught and learnt – essentially the same criticism as Kleinman's and Benson's views in the earlier mentioned article on explanatory models (2006).

The EPA document answered this criticism by emphasising the clinician's self-awareness, including of his or her own cultural identity and prejudices, as well as his or her ability to show empathy across cultures. It also stressed the role of professional values and non-discriminatory attitudes. Further, the document pre-empted a criticism that I have found very common in clinical practice – that cultural competence is impossible to achieve since we cannot learn everything about all the cultures in our settings. The guidance document stressed that:

> …cultural competency is not about learning the language or adopting the cultural values of a patient, but rather about respecting differences and making sure that these are bridgeable in order that they do not negatively impact upon the diagnostic and therapeutic process (Schouler-Ocak et al., 2015, p. 432).

Further, the document stressed that cultural competency is not only about training individuals but about accessible institutions, qualified interpreters, and culturally appropriate structures.

Several authors have noted the limitations of the actual training in cultural competence offered in various countries, and the risk of training reproducing stereotyped notions of the other (Bäärnhielm and Mösko, 2012; Kirmayer & Jarvis, 2019). Among alternative concepts that have been developed, *cultural humility* emphasises the importance of clinicians recognizing their own limited understanding of and being open to the patients' own perceptions. *Cultural safety*, a concept that was developed by Maori nurses in New Zealand from the point of departure that not only racism and discrimination but also caregivers' lack of knowledge of history and social conditions make healthcare institutions unsafe for minorities. The focus in this approach is on creating safe spaces through power sharing and dialogue (Kirmayer & Jarvis, 2019).

### 3.4.7 Acculturation for refugees

Acculturation is defined as the changes that occur when two cultures meet and influence each other. Most often, it is used to describe the individual migrant's process of adapting and adjusting to the new culture in the host country. It is a process with psychological, social and cultural dimensions, and the outcomes have been described as integration, assimilation, segregation, or marginalization (Berry & Kim, 1988). Rudmin (2009) stressed the importance of the reception in the new society, including discrimination, for acculturation.

Allen et al. (2006) suggested an integrated human rights conceptual framework for understanding refugee acculturation. Starting from the earlier mentioned ADAPT model (Silove, 1999, 2013) they described how reactions to trauma interact with refugees' acculturation experiences to destabilise the five essential psychosocial pillars in the ADAPT model (safety and security, interpersonal bonds and social networks, justice, roles and identities, and existential meaning). The refugee deals with acculturative processes at the same time as he or she tries to cope with experiences of trauma.

## 3.5 KNOWLEDGE GAPS

Even though the field of research on migrants and mental health is vast, there is a lack of studies on certain subgroups, on the clinical encounter in health care, and on person-centred perspectives. There is a lack of studies on the mental health of asylum seekers, including their suicidal behaviour. They are considered vulnerable to mental ill-health because of their potential recent traumatic experiences and their insecure situation, but their uncertain housing situation, their legal status and lack of personal ID numbers make them more difficult to study.

There is limited knowledge on how refugees' and asylum seekers' specific contexts affect their mental health, including suicidality. Further, there is limited knowledge of what happens in the encounter between the refugee and healthcare services. Knowledge is especially limited on suicide assessment and treatment of asylum seekers in mental health services.

There is a lack of knowledge on the social network of refugees and how refugees themselves experience changes in their social networks through the migration process. There is also a lack of knowledge of how refugees themselves perceive their social networks and social support linked to health and well-being.

# 4 RESEARCH AIMS

The overall aim was to study post-migration conditions for refugees and asylum seekers regarding their networks, and their encounter with health care when they had mental health problems, with a special focus on asylum seekers who have attempted suicide.

The four studies included in this dissertation had the following specific aims:

To increase our knowledge of clinicians' assessments of suicide risk in asylum seekers, both related to clinicians' reasoning and to the results of those assessments (Study I).

To study the communication between asylum-seeking female suicide attempters and clinicians, as documented in the medical records, and how it affects assessment and treatment (Study II).

To study how changes and challenges in social networks and social support are perceived by resettled Iraqi refugees and how these changes affect health and well-being (Study III).

To study social determinants of health, including social support, and resilience factors, including cultural perceptions of illness, that affect the health and acculturation of resettled Iraqi migrants (Study IV).

# 5 METHODOLOGICAL CONSIDERATIONS

## 5.1 CHOICE OF RESEARCH DESIGN

Two of the studies in this thesis are based on quantitative methods. One study uses qualitative methods, and one study mixed methods.

The choice of design is based on theoretical and epistemological considerations. Qualitative research has roots in sociology and is connected to the development of postmodernism and social constructivism. Its theoretical base can be described as a naturalist paradigm, developed as a critique of the positivist paradigm that traditionally dominates in medical research.

Lincoln and Guba (1985, p. 37) contrasted the naturalist paradigm and the positivist paradigm on the issues of ontology (view of the nature of reality), epistemology (what is the relation between the knower and the known), the possibility of generalisation, the possibility of causal linkages and the role of values. According to this conceptualisation the naturalist paradigm sees reality as multiple and holistic, the knower and the known as interconnected and dependent of each other, all hypotheses as dependent on time and context, causes as difficult to distinguish from effects, and inquiry as always value grounded.

There is a logical thread from this paradigm to research methods that explore the complex reality without generalising or attempting to establish causal links, focus on the subjects and their experiences, make the researchers' preunderstanding visible, and contextualise their results. Qualitative studies often consider the meanings of the phenomenon. The phenomena are studied in natural settings as opposed to experimental ones (Crowe et al., 2015).

Many researchers, however, combine quantitative and qualitative methods. Malterud (2011), in her introduction to qualitative methods in medical research, noted that the similarities between the methods are more important than the differences. Both need systematic scientific rigour, but their differences in procedure is due to differences in the research questions they set out to answer. Qualitative methods aim to understand rather than explain and describe rather than predict. Starrin et al. (1997) similarly advocated for the integration of the two research schools and claimed that they enrich each other.

Sometimes the role of qualitative studies is said to be to generate hypotheses for quantitative testing. In my view, that reduces the role of qualitative studies. They do not only yield knowledge that is more preliminary, less verified, than quantitative studies. They yield different knowledge – situated knowledge on complex realities - which cannot be found in quantitative studies.

In this thesis we applied the methodologies in the following way: In Study I we started with a quantitative study and went on to explore the finding that we found most intriguing in a qualitative study, Study II. In Study III we started with a mainly qualitative approach, and as this was developing used the preliminary results to formulate hypotheses and quantitative

measures for a quantitative survey study, Study IV. So, the four studies used mixed research approaches in different directions, quantitative - qualitative and qualitative - quantitative (see figure 4).
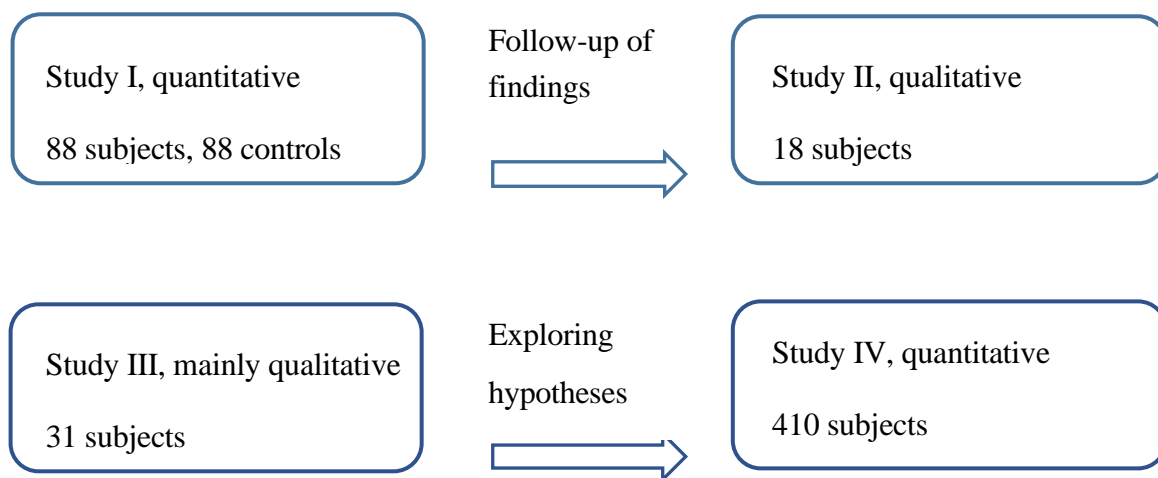
| Study I, quantitative 88 subjects, 88 controls | Follow-up of findings → | Study II, qualitative 18 subjects |
|---|---|---|
| Study III, mainly qualitative 31 subjects | Exploring hypotheses → | Study IV, quantitative 410 subjects |

**Figure 4.** The mixed method approach of the studies in this thesis.

Leech and Onwuegbuzie (2010) characterised mixed research designs according to three dimensions: level of mixing (whether the research is fully or partially mixed between qualitative and quantitative), time orientation (if the quantitative and qualitative phases occur at the same time or one phase before or after the other), and emphasis of approaches (the weight or priority put on the different phases in addressing the research questions/objectives). With those criteria, only Study III was a mixed-method study in the sense that we used qualitative and quantitative data collection and analysis methods with all participants with the purpose of answering a mixed research question.

## 5.2 OVERVIEW OF DESIGN IN STUDIES OF ASYLUM SEEKERS ASSESSED AFTER SUICIDE ATTEMPT (STUDIES I AND II)

### 5.2.1 Study I

**Subjects.** All asylum seekers registered for suicidal behavior in two time periods between 2005 and 2009 and assessed at the Central mental health emergency services of Stockholm County Council (located at a large hospital) were included in the study. The hospital had decided to register all suicides and suicide attempts in two separate initiatives in different time periods within this five-year period, and repeatedly informed all physicians making the initial assessment on how to make the registration. We received access to the medical records of all 186 patients in these registrations that were identified by a so-called reserve number. A reserve number is an ID number that is created at the healthcare unit and is given to persons without official residence in Sweden, and persons who arrive to the hospital without ID documents and in a state in which they cannot communicate their identity to the healthcare unit. Among those 186 patients, 130 persons were identified as asylum seekers. A logistic problem was that asylum seekers often were treated under different reserve numbers.

However, the birth date was always noted in the reception registration, which enabled safe identification.

After eliminating persons having more than one reserve number and persons doubly registered in the two registrations, 93 suicidal asylum seekers were identified. 88 of them were eligible for the study. The other five had been misclassified as suicide attempters. From the same registrations we created a control group of 88 patients, who were also suicide attempters, Swedish- or foreign-born, with or without Swedish citizenship (all with a Swedish personal identity number). We made this choice to be able to distinguish the impact of the particular conditions and life situation during asylum seeking. The controls were matched in gender, age (five-year age class), and year of registration of the suicide attempt.

**Data and instruments.** Our data were the digitalised medical records from the initial assessment carried out either in the emergency room or the hospital ward in the same hospital. In the same records we could also follow outpatient- and subsequent readmission data if the patient was treated within the same mental health services.

Medical records were written by all clinical professions (physicians, nurses, social workers, psychologists, mental health workers, occupational therapists, physiotherapists). The records were updated several times a day with added pieces of information about the staff's contacts with the patients, with their private networks, and with other professional agencies.

The formal suicide assessments were made by psychiatrists. Specific categories of suicidal behaviour were a recommended framework of reference, the use of which, however, was not mandatory at the time of the study. Information on suicidality could thus be found in different types of notations written by co-workers with different professional backgrounds.

For study I, I made a literature review of earlier research on risk factors for mental ill-health and suicide. Based on this review we constructed a standardised protocol with variables related to sociodemographic data, the migration process, family and network, traumatic events and other stressful situations before and after arriving in Sweden, earlier somatic and mental health and substance abuse, and the current care encounter from assessment to follow-up, including clinical picture, diagnosis, and treatment. We did not include such risk factors that, in our experience, are unlikely to be reported in medical records (e.g., socioeconomic conditions or sexual orientation).

I read through the more than 7,700 pages, applying the protocol to the text. This scrutiny involved a process of inference, beyond the mere observation. For example, symptoms that were noted in the patient history, or in the latest examination of the patient, were not always named as symptoms by the clinician. I would sometimes mark that the patient had "symptoms indicating posttraumatic stress syndrome or another serious stress reaction" even if the clinician had not used those concepts. In other instances, I would mark symptoms as psychotic (or both psychotic and posttraumatic) if the clinician had assessed them as such, even if my own assessment from the records were that they were dissociative. Diagnoses

were registered according to DSM-IV, ICD-10, or as tentative descriptive assessments. I made a special note if the clinician had documented his or her reasoning on diagnostics. Suicide methods were categorized as either self-injury or self-poisoning (Bergen et al., 2012).

Further, we applied the 15-items version of the Suicide Intent Scale, SIS (Beck et al., 1974), to the medical records. SIS assesses subjective intent as well as objective conditions, offering a possibility to study to what extent such questions were documented in the records. Also, it had been assessed as having high reliability especially concerning subjective intent (Freedenthal, 2008). Further, in a regional care program in Stockholm on the care of suicidal patients, the SIS was one of only three scales recommended, albeit with some reservations and as subordinate to the clinical assessments (Runeson, 2010). Later studies have shown that SIS – as well as most other scales – is insufficient for prediction (Lindh et al., 2019; Runeson et al., 2017).

**Data analysis.** We measured frequencies and proportions as well as means, medians, and the range when applicable. Variables were grouped together into meaningful categories for the bivariate analyses we conducted to compare the asylum seekers and the control group. We tested differences in proportions with the Chi-square test and Fisher's exact test, and differences in continuous variables with the Mann-Whitney U test. Data were also analysed genderwise, comparing male and female asylum seekers with their gender-matched controls.

The variables we had constructed from the Suicide Intent Scale were missing in the vast majority of cases, both for asylum seekers and controls. We could only find information on five of the fifteen variables in about 50 % or more of the sample (carrying out the suicide attempt with someone else present; purpose of suicide attempt being death; considering the act a serious attempt to end life; attitude towards living/dying; and degree of premeditation) and included only those five variables in the analysis. SPSS for Windows v. 22.0 (SPSS Inc.) was used for the analyses.

### 5.2.2 Study II

**Subjects.** Of the 88 asylum seekers included in Study I, all 18 women who had received compulsory care after a suicide attempt were selected.

**Data and data analysis.** I read the medical records of the 18 women and identified meaning units, which subsequently were coded line by line. Coding was discussed and consensually adjusted in discussions with another author. New codes were continuously introduced, others were rephrased, and all codes were grouped into preliminary categories. For each medical record, I wrote a memo summarizing important findings and reflections. Broader themes were identified from the categories and the memos. Codes deemed particularly relevant for each theme were further explored, and the themes refined. All authors read successive drafts of themes and in the end, consensus was reached on six themes.

## 5.3 OVERVIEW OF DESIGN IN STUDIES OF RESETTLED IRAQI REFUGEES AND THEIR SOCIAL NETWORKS (STUDIES III AND IV)

These two studies are part of a larger, mixed-methods project of studying mental health, meaning-seeking, and integration among Iraqi immigrants in Sweden, "Gilgamesh – Mental health, meaning-seeking, and integration processes among Iraqi immigrants in Södertälje, Stockholm, and Uppsala". The larger project had several, interdisciplinary foci ranging from acculturation, resilience, network resources and perceptions of illness, to trauma and mental health.

### 5.3.1 Study III

**Subjects.** The subjects were a convenience sample of Iraqi refugees with permanent residence in Sweden. Initially, we recruited only persons who had arrived in Sweden in 2003 or later. We chose this starting point since we considered the US invasion in Iraq and its aftermath as the important traumatic event, the effect of which we wanted to study.

Our subjects presented another image. When asked about war experiences they related experiences from 1980 (the beginning of the war against Iraq) and onwards, and in the end, we included three subjects who had arrived in Sweden a few years earlier than 2003.

We classified all respondents as refugees on the ground that they had been granted permanent residence in Sweden after having left a war-ridden country. They could have been granted residence either as "refugees" as defined in the Geneva Convention, that is, persons exposed to persecution in their home country, or on other grounds (e.g., needing protection or being relatives of permanent residents). We did not explore their individual grounds for residence.

We wanted to enhance diversity in our sample by recruiting study persons in two Swedish towns – one university city with an ethnically and religiously varied migrant population and one industrial town with a predominantly Christian migrant population from the Middle East – and by recruiting individuals treated in primary-care based mental health services and in psychiatry, as well as persons in non-clinical locations such as job centres, language schools, associations, churches, and voluntary organisations. We were assisted by key persons in the different arenas and partly used snowball sampling, in which one person at a time is recruited and further contacts are taken with persons in his or her network. We did not expect this procedure to lead to a fixed difference between "patients" and "non-patients", and it indeed turned out that persons in both groups had had recent contact with mental health services. Initially, we also approached mental health services in a third site, one area of Stockholm, to recruit persons with experiences as patients.

The recruitment period took longer time than expected. In one town we recruited only one patient (who later left the study) from specialised psychiatry in spite of our personal contacts and of having provided oral as well as written information about our study there. We finally managed to recruit persons with mental health care contacts through primary care. In the

Stockholm area, we also failed to recruit any patients from the mental health services we had approached.

Towards the end of the recruitment period an Arabic-speaking research assistant was included in the research team. He was helpful in recruiting study persons outside of healthcare. In all we interviewed 40 subjects, 31 of whom were included in the analysis after excluding those subjects who had not answered enough items in the health assessment scales to make an analysis meaningful.

**Data and instruments.** We constructed an interview guide in two parts with structured and open-ended questions that were based on selected items from the literature in the field. In the first part we included sociodemographic questions, scales on cultural and religious identity, open-ended questions on migration experiences, and a biographic network map. To our knowledge this project is the first time the network map has been used in refugee studies.

The social network map has the form of a circle, divided in sectors related to different arenas for network contacts. The study person is depicted in the middle of the circle and is asked to place important others (with both positive and negative influence) in the sectors. The distance to the central ego indicates how close these persons are felt to be, and different symbols are used to characterise the different relationships. The biographic map adds "period rings" for different periods in life from birth until the present time. We chose the biographic network map since it is appropriate for the exploration of the impact of changes in the network. For that purpose, we also adapted the map to our study population, choosing the period rings "childhood", "youth", "adulthood", and "today", the latter interpreted as the period passed in Sweden.

Further, we developed the map inspired by a life-history instrument, the 3-R approach, The Religion (Meaning-Making), Relational, and Ritual Functional Assessment Approach. It is an instrument with an object-relations perspective which has been used in research in the USA and Sweden (DeMarinis, 1998; Çetrez, 2005). The instrument explores a person's way of making meaning through interviews, client drawings and symbols about self-image, significant others, meaning-making systems, and rituals and symbols in different periods of life. In our study we added two sectors, "relationship to self" and "relationship to sources of existential meaning", to the biographic network map. We explored the relation of each of these sectors to different persons in the map, with the purpose of studying identity and meaning not only as the expression of individual traits but as relational phenomena.

The second part of the interview included both structured and open-ended questions on healthcare utilisation, perceptions of illness, and trauma questions. The questions on perceptions of illness were inspired by the Outline for Cultural Formulation in DSM-IV-TR (American Psychiatric Association, 2000) and by the Swedish manual on the cultural formulation developed by Bäärnhielm et al. (2007). We also included three scales on psychological-psychiatric health: a) Center for Epidemiologic Studies Depression Scale (CES-D-20), which identifies four factors of psychological well-being (depressive affect,

positive affect, somatic complaints, and interpersonal problems) (Radloff, 1977); (b) the Patient Health Questionnaire (PHQ-15) for somatisation, yielding four levels: "none", "mild", "moderate" and "severe" (Kocalevent et al., 2013); (c) the Mini International Neuropsychiatric Interview (MINI 5.0.0) screening for DSM-IV Axis I disorders, one Axis II disorder (antisocial personality disorder), and a suicidality module (Sheehan et al., 1998).

We pretested the first part of the interview with a voluntary test person. This trial also served as an opportunity to train using the map. Realising that the original interview took a long time, we shortened the list of questions. The first part of the interview was conducted by three of the researchers and later also by a research assistant. The second part, especially the section with the health-related scales, was administered by one of the two psychiatrists in the research team.

The interviews were carried out 2012-2013. The participants were generally interviewed in the healthcare unit where they were recruited, in municipal premises, at their workplace, or at home. Of the 39 interviews, 18 were performed in Arabic. Eleven of these interviews were done with the assistance of professional interpreters, the remaining seven interviews were interpreted by the Arabic-speaking research assistant. Each part of the interviews took 1½-2 hours to complete. The interviews were audiotaped and transcribed by external assistants.

**Data analysis.** My focus of the analysis was on the social networks of the study persons, relating changes in the networks to their migration experiences and mental health. Sociodemographic data was collated using descriptive statistics.

The analysis of the network maps was both visual and verbal: studying the maps, I moved between the graphic image, which gave a clear idea of the relative strengths of various sectors, of what relations remained or were lost after migration, and about the formation of new relations, and the transcription of the interviews giving more information on the nature of the network contacts.

I read and coded the 40 initial interviews, which were reduced to 31 in the final analysis due to the lack of quantitative data. We predefined codes related to sources of support (household, relatives, daily activities, authorities, other people, spiritual forces); time periods (childhood, youth, adulthood, today); functional, interactional, and structural characteristics of the network; and emotional, informational, concrete, and spiritual support.

The interviews were coded line by line. Following our research question, we had a focus on changes in support and challenges related to health status and migration. In the process new codes were formulated as subcodes of the initial codes. For instance, we added the code "spiritual source", after having noted in the first interviews, that some respondents reported the impact of spiritual forces as personal support.

Informal memos were written to capture noteworthy themes, and reflections on different aspects of the interviews. I wrote a summary for each individual, including social network characteristics and social support for each period. These summaries were compared between

interview persons. In the final analysis, we concentrated on post-migration challenges to social networks and social support and formulated three overriding themes and eleven subthemes.

We made use of the mixed method character of the study through a "thematic systematisation". I charted the qualitatively described data (subthemes) for each study person together with his or hers sociodemographic and quantitative data (health outcomes). In that way I was free to move between the subthemes and quantitative information, noting patterns and analysing observations without attempting to draw statistical conclusions. The interpretation of the network maps, the coding, and the thematic systematisation were discussed and refined continuously with the other authors.

Following the earlier mentioned three-dimensional typology of mixed research designs developed by Leech and Onwuegbuzie (2010), we had a high level of mixing, and the time orientation was concurrent (we collected qualitative and quantitative data at the same time). However, regarding the third dimension, the emphasis of approach, we put more emphasis on the qualitative than on quantitative data.

### 5.3.2 Study IV

**Subjects.** We recruited a convenience sample with the inclusion criteria of being Iraqi, having moved to Sweden between 2000 and 2012, and residing in one of three towns. With the aid of the Arabic-speaking research assistant we approached municipal stake holders, associations, churches, and university departments. We presented written information material about the study, made personal contacts, presented ourselves to membership meetings of associations and used snowball sampling. In total 410 persons were recruited in 2012 and 2013 and included in the analysis.

**Data and instruments.** We constructed a survey with 54 questions, based on the initial findings from the earlier interview study and with four areas of exploration derived from our theoretical model of public mental health in migration: *social determinants of health*, including social networks and social support (Çetrez et al., 2020; Hynie, 2018; Kirmayer, 2012); *resilience* including perceptions of illness (with selected items from the Explanatory Model Interview Catalogue, EMIC, Weiss, 1997), and the Connor-Davidson Resilience Scale, CD-RISC2 (Vaishnavi et al., 2007); *mental health outcomes* (items on self-perceived health, the PC-PTSD screen (Prins et al., 2003)); *acculturation* through items on identity (Çetrez, 2005) and questions about conditions in Iraq compared to Sweden.

The questionnaire was pretested and refined with twelve voluntary men and women from different religious denominations. Surveys (using the final version of the questionnaire) were conducted in Arabic, English or Swedish, depending on the participant's preference. It took on the average 30-40 minutes to complete the survey, but up to 1½ hours for individuals who needed help with reading and writing. Although designed as self-administered, the questionnaire was typically filled out in the presence of an Arabic-speaking research assistant

(who provided language support). The setting for filling in the questionnaire was at the choice of the study person.

**Data analysis.** The survey study data were analysed with descriptive statistics, using SPSS v.27.0 (SPSS Inc.).

Analysing social support, frequencies and percentages were given for the different types of support related to the different sources. Chi-square was used to test gender differences. Other questions in the survey gave additional information on social support. For those items, Chi-square tests were used for gender and country differences.

Analysing perceptions of illness for mental health problems, we clustered the items in the instrument as social-situational, emotional-developmental, medical-biological, or religious-spiritual (Estroff et al., 1991). Frequencies and percentages were calculated for each cluster. Gender differences were tested with Chi-square.

We attempted to study perceptions of illness by asking where the participant would recommend a friend with mental health problems to seek help and by asking them about their actual healthcare experiences. However, there were indications of misunderstandings of these questions and the response rate was lower at the end of the lengthy questionnaire, so we could not analyse them.

## 5.4   COMMENTS ON THE USE OF CONTENT ANALYSIS (STUDIES II AND III)

Studies II and III were mainly qualitative in character. Study II used qualitative analysis of the medical records, whereas study III included several dimensions: descriptive statistics of sociodemographic and health data, an analysis of the network maps focusing on the relation between sectors and the changes over time, and a qualitative analysis of all audiotaped and transcribed material (including all material except for about half of the health scales).

There are various traditions of qualitative analysis, for example Grounded Theory, phenomenology, case studies (Creswell, 1998). We chose to apply content analysis, defined by Krippendorf (2004) as "a research technique for making valid and replicable inferences from texts (or other meaningful matter) to the contexts of their use" (p. 18). He adhered to a definition of content analysis as emerging in the process of a particular researcher that analyses a text relating it to a particular context. Texts do not have objective qualities or single meanings. Meanings relate to something outside of the text, within a particular context. Krippendorf also noted that a context is always somebody's construction. Content analysis has developed from quantitative approaches to an approach within the qualitative paradigm (Graneheim et al., 2017; Rivas, 2012), even though it retains elements of quantification (Hsieh & Shannon, 2005).

**Qualitative content analysis or thematic content analysis**. The name of the procedure as such can be called "qualitative content analysis" as we did in study II or "thematic content analysis" (Rivas, 2012) as we did in study III. Crowe et al. (2015) claimed that thematic

content analysis is more inductive and content analysis more deductive (which could be seen as the opposite of our design) but the procedure is also described as a continuum that can change during the analytical process (Crowe et al., 2015; Krippendorf, 2004). In our case the similarities between the methods are more important than the differences.

**Inductive, deductive, abductive analysis.** Following Graneheim et al. (2017) an inductive approach starts from and initially stays close to the text, including the concrete and "local" expressions described in the text. Its next step is to look for similarities and differences between codes and thus move from the concrete to the more abstract. That is the model we used in study II.

A deductive approach starts from a theoretical model and predefines codes before the analysis. It moves from those theoretically motivated codes to the data, a move from the more abstract to the more concrete. Deductive analysis was described by Graneheim et al. (2017) as a way of testing existing theories. We did not use it in that way in study III, but rather as Krippendorf (2004) described it, as a way of adding new dimensions to a model – in our case to deepen the understanding of the importance of social networks and social support for refugees.

Abduction was described by Graneheim et al. (2017) as "a movement back and forth between inductive and deductive approaches" (p. 31). Another description of an abductive approach is a "back-and-forth movement between the empirical material… and any emerging theoretical interpretations of these" (Lindqvist, 2016, p. 60). We did not use the concept abduction, but our analysis did oscillate between the inductive and deductive approaches and between empirical material and emerging theoretical interpretations. One example was when we moved from codes relating to the subjectively reported meanings of suicide in the interviews, to theories about suicide, which in turn enriched the understanding of the patterns in the interviews. In study III we moved from deductive, preformulated codes to experience-near subcodes as we discovered more nuances of the material, and these subcodes in turn influenced the formulation of the deductive codes and the themes.

**Categories and themes**. The distinction between categories and themes is often confusing and the concepts are sometimes used interchangeably (Graneheim et al., 2017). Categories are sorting data and group codes with common characteristics. They answer the question "what?" on a manifest level. Categories can be used to generate broader themes that constitute a red thread that recurs in the categories. Such themes are of two kinds: either descriptive, answering the question "what happens here?", or themes of meaning, answering the question "what is the meaning of the stories told?".

In study II, we grouped codes into categories, and then went on to formulate themes. In study III, one could say that the preformulated codes served as categories, since the analysis mainly meant adding subcodes. Through the thematic systematisation we could identify the most important of those codes/categories and go on to formulate themes.

**Manifest and latent content.** Graneheim et al. (2017) described the manifest content of the text as descriptive, close to the text, whereas the latent content is on a more interpretative level. These authors, however, also stressed that the difference is not always very sharp, and that both levels of content imply some interpretation.

In study II, we focused on the communication between patients and clinicians, but since we used such an indirect source as the medical records, we were obviously oriented towards an inferred, latent level. Our ambition was to try to understand what was happening in the communication between the patient and the clinician, often based on quite scarce information. This process involved interpretation. At the same time, we had a real interest in and scrutinised the records for signs of manifest content, in the form of the patient's and the clinician's own words.

In study III, one of our primary aims was to give voice to the subjective experiences of the interviewed refugees. We were interested in the manifest level and concerned not to distance our analysis too far from the voices of the study persons. At the same time, the themes we formulated implied interpretation and expressed a latent narrative.

As an aid in the qualitative analysis, we used software programmes in both studies, N'Vivo v.9 (Bazeley & Jackson, 2013) for study II and Atlas.ti 8 (Friese, 2019) for study III.

## 5.5 ETHICAL CONSIDERATIONS

In studies I and II, the main ethical consideration was the fact that the participants could not be asked to give informed consent, since the studies were based on medical records documented several years before the research project, in the context of a clinical registration of suicide attempts. The asylum seekers did not have Swedish ID numbers, and their individual so-called reserve numbers were often changed. Further, asylum seekers lack permanent addresses and are often very difficult to reach. A few years after the registration we would not have been able to establish whether they had been deported, were living as undocumented migrants, or even if they had died. So, demanding informed consent retrospectively would mean that a large part of the asylum seekers would be lost for the study.

The studies were not deemed to expose the study persons to risk, since the records were stripped of personal information before the data was analysed and the results were presented at a group level. Ethical approval for study I and II was given by the Regional Ethical Review Board of Stockholm (number 2010/3:6 and 2012/982-32).

In studies III and IV, the participants received written and oral information on the study and gave informed consent. The main ethical consideration was whether the interview or the survey would cause mental distress.  All study persons were offered to contact one of the clinical units for further advice and referral if they experienced distress. On the other hand, being offered the opportunity to reflect on your mental health problems with a trusted listener could also have a potential beneficial impact for the participants.

Another consideration is whether a study of mental ill-health could be stigmatising in a migrant group that already runs the risk of being discriminated against. Our study was, however, not focused on studying the prevalence or incidence of mental ill-health in one particular group, but to increase knowledge of protective- and risk factors for and experiences of mental ill-health in the migration situation.

Against the background of the intense conflicts in Iraqi society both at the time of the participants' flight and at the time of the investigation, the political allegiances of the researchers were a sensitive issue. The Arabic-speaking research assistant's main role was to support the participants, but we could not assume that even he, as a person from the same region with cultural knowledge, would stand above suspicion in the conflictual climate. We all approached this ethical challenge guided by and manifesting our ambition to explore the experiences of all kinds of experiences, independently of real or imagined ideological positions, and maintaining a stance of cultural openness and sensibility throughout the process.

Ethical approval was given by the Regional Ethical Review Board of Uppsala (number 2011/394).

# 6 RESULTS

## 6.1 THE ENCOUNTER BETWEEN SUICIDAL ASYLUM SEEKERS AND CLINICIANS IN MENTAL HEALTHCARE (STUDIES I AND II)

### 6.1.1 Study I

As noted above, we studied 88 asylum seekers who were assessed at emergency mental health services after a suicide attempt, as well as 88 age class-, gender- and time-matched suicide attempters in a control group. I scrutinised the medical records applying a protocol consisting of sociodemographic data and known risk factors for suicide, including the Suicide Intent Scale. We calculated descriptive statistics (frequencies, means, medians, Chi-square, Fisher's exact test, the Mann-Whitney U-test) and also made a gender-separated comparison between asylum seekers and controls.

**Sociodemographic data.** Forty-seven of the 88 asylum seekers who had made a suicide attempt were men and 41 were women. They were between 18 and 54 years of age, with a median age of 29. About half of these persons had lived in Sweden for two years or less. In the control group, 22 persons were documented as foreign-born, four of whom were adopted in Sweden in childhood.

The asylum seekers came from 26 different countries, the most common being Bangladesh, Iraq, Iran, and Azerbaijan. For women, Bangladesh was the most common country of birth, for men it was Iraq. The distribution does not entirely correspond to the rank order of nationalities of asylum seekers in Sweden during this period, which in the period 2002-2009 was Iraq, Afghanistan, Somalia, Bosnia, and Federal Republic of Yugoslavia (in 2003 renamed State Union of Serbia and Montenegro; Swedish Migration Agency, 2021d).

We also studied the statistics from the Swedish Migration Agency on percentage of rejected asylum applications and the length of the asylum period for individuals from different countries, to see if the nationalities in our sample in some way differed from the average of all asylum seekers. The percentage of rejected applications for asylum seekers from Azerbaijan and Bangladesh were above average for all asylum applications every year in the period from 2004 to 2009, and the time to reach a decision on the application was above average all years for applicants from Iran, Azerbaijan, and Bangladesh (Migration Agency, 2015). However, the relatively small sample and the lack of statistics on the regional distribution of asylum seekers preclude any conclusions on the distribution of nationalities.

The asylum seekers and the controls were matched in gender, five-year age class and year of registration for suicide attempt. In other sociodemographic data, they differed. The asylum-seeking women were more often married or had a partner and more often had children than did the female controls. The controls of both sexes more often lived alone.

**Comparison between asylum seekers and the control group.** We found many similarities between the two groups: Regarding *earlier health,* the documented earlier somatic or mental

health problems, previous suicide attempts, and the proportion of individuals assessed as suicidal after previous self-destructive behaviour were similar in the two groups. The *formal assessment* made by the mental health services did not differ either. The most common recorded *diagnosis* was mood disorder in both groups, and in both groups the *documentation of suicidal intent* was scarce. As mentioned above, we applied the SIS scale to the medical records but could only find sufficient information on a few items.

But there were also important differences: The two groups differed in *social stressors*. The registered suicide attempt was made after a recent rejection of their application for political asylum in 39.1% of the cases, more often for the female asylum seekers than for the males. On the other hand, about a quarter of the asylum seekers made the attempt already in the first period of asylum seeking before the official decision. Asylum seekers were significantly more often recorded to have been exposed to potentially traumatic events, whereas the controls' records more often contained information on other social stressors than trauma, such as alcohol and substance abuse in parents, relational conflicts (including recent separation), and socio-economic stress.

The controls had received *earlier specialised psychiatric care* more often than the asylum seekers. The controls also significantly more often had documented alcohol and substance abuse in their medical history. The female controls significantly more often had documented earlier violent behaviour than the asylum-seeking women.

There was a *lack of information*, especially in the records of the asylum-seeking men, on their social context, on previous suicide attempts and on suicide in the family. For all asylum seekers, there was a lack of information on whether interpreters had been used or not during the psychiatric care episode.

There were differences in *clinical pictures and diagnoses* given at the time of the assessment: PTSD-related symptoms, psychosis-like symptoms and symptoms related to psychosocial stress were significantly more often described in the group of asylum-seeking women, and asylum seekers (both men and women) more often received the diagnosis PTSD than did the controls. Among the 20 asylum seekers who were exposed to torture, 7 received a diagnosis of PTSD. Symptoms and diagnoses related to abuse of alcohol or other drugs and personality disorder diagnoses were more often recorded for the controls of both sexes.

Regarding *suicidal intent*, more asylum seekers reported death as the purpose of the suicide attempt and considered the act as a serious attempt to end life, whereas the controls more often carried out their suicide attempts without anyone else present. The female asylum seekers more often used suicide methods categorised as self-injury and considered more lethal than the female controls who more often used self-poisoning.

There were differences in *treatment and follow-up*: More asylum seekers than controls were hospitalised after the psychiatric assessment. The difference was significant for the women but not for the men. Of the asylum seekers who could be followed in the medical records

because they were hospitalised at the same hospital as that where they had received the emergency room assessment after the suicide attempt, more female asylum-seekers than female controls were treated in compulsory care. Asylum-seeking women also received a greater variation of types of psychotropic medication and had longer periods of hospitalisation than the female controls. The asylum-seekers and the controls received talking interventions (including psychotherapy) in the same proportion, about 10%. More controls were referred for follow-up in specialised psychiatric care.

**Concluding remarks.** One of the findings that stood out in this study was how the situation for the asylum-seeking women differed. The documentation of their earlier health, including suicidality, and of the current suicide attempt and the treatment they received in hospital suggest severe health conditions for which the healthcare system had difficulties finding adequate treatment. Yet, asylum seekers of both sexes were referred to specialised follow-up less often than patients with permanent residence.

Another finding was the lack of information and the differences in information recorded. There was, for instance, little information on background, life before arriving in Sweden, trauma, and suicide in the family. The lack of information on the subjective intent of the suicide attempt was more surprising. We also noted that the asylum-seeking men were more anonymous than both the controls and the asylum-seeking women in the medical records. One possible interpretation of this finding of anonymity is that the asylum-seeking women as a group had more complex clinical pictures and were more difficult to treat. It would be natural that more information on the person was explored in a lengthy, complicated treatment process.

Another piece of information that was often missing was if an interpreter had been present at the care meeting. The reason for this omission might be that an interpreter was always present, although that is contradicted by our own experiences of difficulties of finding interpreters in clinical work.

## 6.1.2  Study II

The results of Study I made us want to explore the situation of the asylum-seeking women further. Could we get a deeper understanding of why they seemed to have more difficult life stories and poorer health conditions, which were more difficult to treat, yet – like the asylum-seeking men - were followed up at a less specialised level than the controls? Could a closer study of what actually happened in the communication between the patients and the clinicians help us in this endeavour?

We made a qualitative content analysis of the medical records of the 18 asylum-seeking women who were treated in compulsory care, with a focus on how the communication between the staff and the patients was documented. Our chosen focus was on what happened between the patient and the clinicians, rather than within any one of them.

**The sample.** The studied patients were 19–43 years old, 11 were younger than 30. Seven patients were born in Bangladesh, two in Jordan, two in Azerbaijan, and one in each of Uzbekistan, Iran, Afghanistan, Iraq, Pakistan, and Congo. They had resided in Sweden between a few months and more than five years, but in the majority of cases for less than two and a half years. One of the women was sent directly to a hospital in another county after the initial psychiatric assessment. The others were hospitalised for between 5 and 197 days, the majority for less than two months. Of the 18 patients, 4 were followed up in primary care and 12 in specialized mental health services; in two cases follow-up was not documented.

**Content analysis.** In the analysis we identified six overarching themes: unbearable realities, decoding languages of distress, elusive trauma, meanings of suicide and communication of meaning, challenges of combining perspectives, and shared powerlessness.

**Unbearable realities** referred to the documented communication between patients and staff about extremely difficult external realities in the asylum-seeking women's lives.

The women reported a whole range of stress factors related to the asylum process. The stress that the clinicians communicated related to the difficulty of assessing the mental state in the asylum situation and to other pressing external factors, that they saw as unrelated to medical considerations.

In addition, there were aspects of being a woman that were described as unbearable. Several women had experienced oppressive conditions in their life including domestic violence. Nine women had been sexually abused, five of them as part of torture in prison in their home country. The women communicated to the clinicians that the sexual abuse was a cultural disaster, leading to broken relations and threats from close ones who condemned them. These women described intense inner psychological suffering including a sense of losing their identity. Another unbearable situation was being a mother and not being able to safeguard your children in the asylum situation.

The clinicians struggled to understand the extent of the women's distress and there were even indications that clinicians found it difficult to believe their stories. There were few examples of women being offered support in the handling of their unbearable realities. However, when children were involved, more attention was given to their situation and more resources were used to help them.

The second theme, **decoding languages of distress,** referred to the documented mutual difficulties in communication: the patients' difficulties in communicating distress and life circumstances, and the clinicians' difficulties in making sense of their expressions and circumstances.

We identified four categories within this theme: difficulties of contact and verbal communication, unfamiliar behaviour and symptoms, unfamiliar forms of expression, and unfamiliar life circumstances.

*Difficulties of contact and verbal communication* ranged from the patient being totally silent or incoherent to having language difficulties. The records only documented fragmented explanations given by the women themselves: painful feelings, language difficulties, memory problems, and the assumption that the staff would not understand. The clinicians would interpret this as avoidance or lack of compliance but also sometimes as reflecting difficulties in communicating about trauma. The clinicians seldom seemed to consider how the immediate context including the participation of family members might affect the communication.

*Unfamiliar behaviours and symptoms.* Some women showed unfamiliar psychomotor activity rather than unfamiliar verbal expressions. Clinicians rarely explored the meanings of these symptoms and when patients refused to eat and drink, this was interpreted either as a sign of depression, a crisis symptom, or as a conscious protest. Concepts like "hysteria" and "dissociation" were used without clear criteria, and trauma that could explain the behaviour was rarely explored. Tactile perceptions, visions, and voices were categorised as symptoms of psychosis.

*Unfamiliar forms of expression* were difficult to understand for the clinicians. One example was when a woman used the expression that "the whole body is burning and aching" and this was understood as incapacity to verbalise instead of as a possible cultural idiom of distress. Another example was when a woman saying that she had "blood on her hands" was described as hysterical instead of possibly expressing guilt feelings.

The category *unfamiliar life circumstances* refers to the difficulty of clinicians to understand, and sometimes believe, the patients' stories about their social realities. The most striking example was when a woman's fear that her relatives in the home country would reject her – a fear that was later confirmed – was characterised as a "depressive delusion".

We called the next theme **elusive trauma** since it was often mentioned in the medical records that a woman had been traumatised – but that the trauma subsequently seemed to vanish from the clinical process. Even in cases in which an outpatient clinician had first diagnosed and treated a trauma-related condition, it was unusual that a hospital clinician had documented contacts with that colleague. Nor was the traumatic background generally explored in dialogue with the patient.

Further, whereas the women described an association between the horrifying memory content and her suicidal behaviour, the clinicians focused on other aspects of suicidality such as suicide intent, degree of depression, hopelessness, and attitude to care. When psychotherapy in rare instances was considered, it was generally not regarded as an option. The reason given was that asylum seekers had restricted access to care.

The theme **meanings of suicide and communication of meaning** refers to how the patient's subjective meaning of the suicide attempt was documented and taken account of.

The clinicians sometimes assessed the patient's suicidality with the help of a suicide risk assessment scale, but rarely documented the patient's own thoughts about not wanting to live. Among the comments on the meaning of having attempted suicide that we could discern, we noted suicide as a way out of an unsolvable dilemma (linked to the asylum situation or to the continued pain of the trauma); a way of protecting one's children; a way of getting rid of immediate pain related to intrusive memories of trauma; and a way of being united with dead relatives.

Dialogues between the staff and the patient about existential questions were rarely documented. Practical support for religious activities was sometimes given.

**Challenges of combining perspectives** refers to how clinicians and patients communicated on different perspectives on the patient's situation and health state.

We noted many documented instances of the clinicians perceiving it as challenging to grasp multiple perspectives. The patients' perspectives, on the other hand, were not usually explicitly documented, but could be discerned from their questions and complaints.

The women came to healthcare with a narrative about their whole life situation. They gave existential and social explanations of their suffering. They seemed to expect understanding, being listened to, and receiving help with the entire situation, and when their situation did not improve, they expressed frustration and hopelessness.

The clinicians met the women with the tools of their profession, checklists, and other diagnostic instruments for understanding mental illness. They understood the suffering in biomedical terms, applying diagnostic criteria. In the records, they often asked, with an assumption of *either–or*: "Is this merely a crisis reaction or a diagnosis proper?" When the clinician was uncertain about the answer to this question, suicide risk was often described as low, which indicates that suicidality was seen as linked to mental illness rather than to social factors. The treatment offered almost always consisted of medication and other medical interventions. When the interventions failed, the clinicians expressed frustration and hopelessness.

The last theme **shared powerlessness**, which refers to the documented expressions of powerlessness in the patient as well as the clinicians, can at least in part be seen as an effect of the failure to combine perspectives described above.

Setbacks in the asylum process seemed to provoke feelings of powerlessness in both patients and clinicians. The women expressed their powerlessness in words but also frequently in self-destructive behaviour. Clinicians expressed their feeling of powerlessness in the medical records with comments implying that the situation was beyond their medical expertise and control. "This is not psychiatry", was one such comment.

When mothers rejected their children or considered extended suicide, or when patients starved themselves or refused medication, the clinicians' reactions were sometimes to

distance themselves from the patient by using value judgments or action that according to the records did not seem warranted (electroconvulsive therapy as a last resort, "activation" as a measure against self-starvation).

**Concluding remarks.** The women struggled to express their suffering and the clinicians struggled to understand it and to find ways of helping. However, the clinicians seemed to lack tools for this explorative work. Partly the lack of tools could be ascribed to what was generally known in psychiatry at the time of the study, especially regarding trauma and cultural aspects.

Today, several of the clinical pictures described in the medical records would probably be identified as posttraumatic symptoms by most clinicians. This is especially true for dissociative features, such as swift changes in mood, behaviour and consciousness, fragmentation, hearing voices, extreme difficulties of establishing contact, etc.

Posttraumatic stress disorder (PTSD) was included in the DSM-III in 1980 and classified as an anxiety disorder (APA, 1980). In DSM-III-R (APA, 1987) a criterion for PTSD was dissociative flashbacks (memories experienced as reliving the event). In the WHO's (1980) *International classification of diseases* (9th rev., clinical modification; ICD-9-CM), used in official Swedish health registers 1987-1996, PTSD was a subcode of adjustment disorders. A separate diagnostic group included dissociative disorders together with hysteria and conversion disorders. Yet, in the medical records of Study II, the concepts of "PTSD" and "dissociation" were used without clear criteria or documentation of diagnostic considerations. There was also an apparent lack of expertise on trauma within the mental health services. On the rare occasions when psychotherapy was considered, the clinician referred the patient to an external agency.

Cultural aspects affecting languages of distress and the encounter with clinicians were introduced on a broader scale in DSM-IV (APA, 1994) -  in the introduction to the manual, as cultural considerations for specific diagnoses, as guidelines for a cultural formulation, and as a glossary of culture-bound syndromes and idioms of distress (Mezzich et al, 1999). The guidelines for the cultural formulation that most directly addressed the needs in the clinical encounter were however only published in an appendix (APA, 1994). In Sweden, as in several other countries, work started to transform the guidelines into a more practical interview guide. A manual was published 2007 locally within Stockholm County Council (Bäärnhielm et al., 2007) but has not been widely used in psychiatry.

Finally, another obstacle was the narrow interpretation of the access to healthcare for asylum seekers. Normally a suicide attempt is regarded as reflecting a serious condition that requires attention by a specialist, but the asylum-seeking women and men in the material for Studies I and II were more often referred to primary care than to specialist psychiatry. One might think that the reason was legal, since the law on the right for asylum seekers of healthcare that cannot wait was not passed until 2008 (Swedish Code of Statutes [SFS] 2008:344). However, already long before the study period official guidelines emphasised the need of thoroughly

assessing anxiety, depression, or torture-related problems without delaying care (National Board of Health and Welfare, 1995).

Apart from these examples of lack of knowledge, partly reflecting historical developments, it also appeared that the medical framework within which clinicians viewed suicidal processes was not sufficiently helpful. The focus on symptoms, diagnoses, and the dichotomy "crisis or depression" sometimes seemed to hinder rather than help in the efforts to understand the asylum-seeking women. The clinicians did not generally find a way of combining their medical-psychiatric perspective with the perspective of the patients' lived experiences. They did not in general explore the subjective meanings of the suicidal behaviour for their patients, apparently not seeing such work as meaningful.

## 6.2 CHALLENGES AND CHANGES IN SOCIAL NETWORKS AND SOCIAL SUPPORT FOR IRAQI REFUGEES IN THE POST-MIGRATION SITUATION (STUDIES III AND IV)

### 6.2.1 Study III

In this study, we interviewed 40 Iraqi refugees in two towns, with a semi-structured interview guide within a broader, multidisciplinary project. My focus in the study was on social networks and perceptions of illness. We used a biographic network map, structured and open questions on health consumption, and open questions on perceptions of illness. We assessed mental health with the measures CES-D 20, PHQ-15, and the MINI 5.0.0. The material was analysed with descriptive statistics and with content analysis of the transcribed interviews. Of the 40 interviewed persons, the 31 who had completed a sufficient proportion of the health assessments were included.

**Sociodemographic data**. Of the interviewed 31 Iraqi refugees in two Swedish towns, 55% were men, their median age was 48 (range 23-71), and median length of stay in Sweden was five years (range 2-13). The group had many resources that normally affect health positively: most of them had high education and were married. They belonged to different religious communities: Islam (n=13), Christianity (n=11), Mandaeism (n=6), and with one person self-identifying as an atheist. Their sense of religious belonging and belonging to their original culture was strong, whereas the belonging to Swedish culture was much weaker. Nonetheless, they often expressed satisfaction with life in Sweden, especially with the safety they had found there. Almost half of the studied persons rated their command of Swedish as fairly or very good.

**The network map.** A common feature of the network map analysis was the emphasis on the closest social network (usually the close family) as a provider of different kinds of social support in all periods of life, before and after migration. There were however some exceptions related to family conflicts, cases of abuse within the family, and oppressive or restrictive conditions for girls and women.
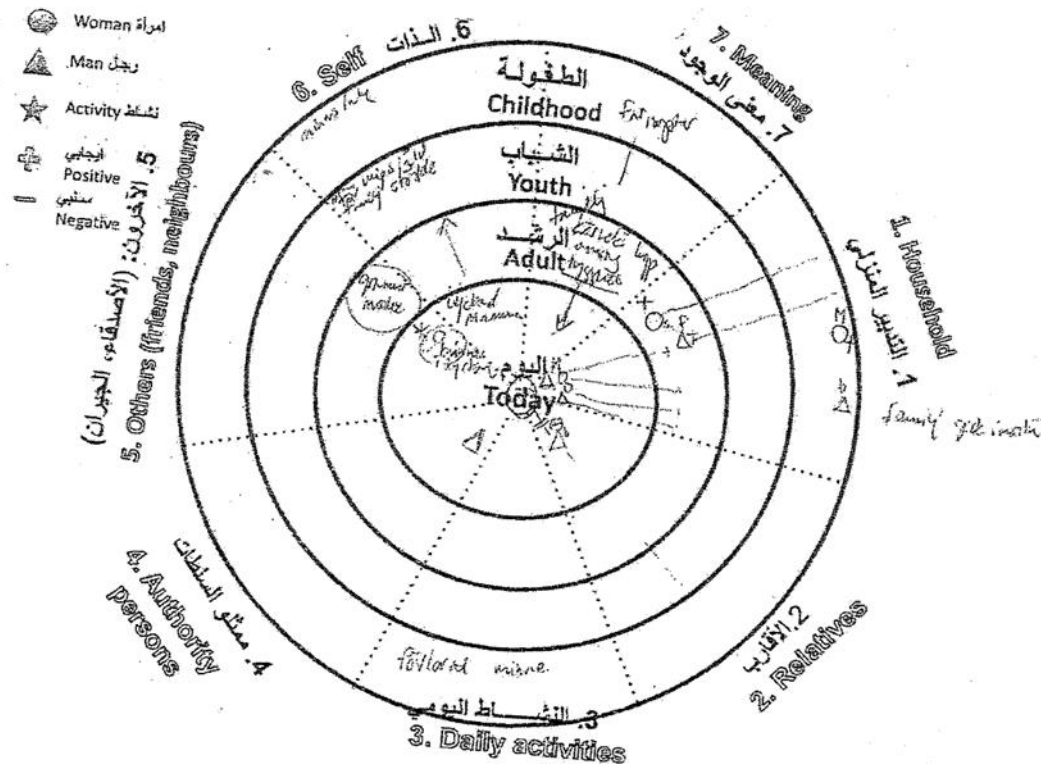
Postmigration, the most common feature was that supportive relations outside of the close family had shrunk and that the social networks in general were weakened. There was also a lack of new relations formed in Sweden. Another conspicuous change was the entrance of authority persons whose counterparts were largely absent – or actively avoided – in Iraq, but who were now introduced into the map and played a big role in the study persons' lives.

Figures 5 and 6 show the contrasting networks of two study persons, a young man, and a middle-aged woman.



**Figure 5.** A 23-year old man with a large social network, mainly based in the household (mother, father and four siblings) and peers whom he has met in daily activities, and in church. All the 12 friends from childhood with whom he is still in intense contact are living in other countries. In his self-image there is a yin and yang symbol and a cross, indicating the importance of religion.

**Figure 6.** A 44-year old woman with somatic and psychic traumatisation during the war. She left school at the age of 12 and after that had few contacts outside of the family. She misses her sister who remains in Iraq but gets support from her marital family with husband and three children. Her GP is noted as an important person. Her father and sister gave meaning in life earlier, and her marital family today.

**Thematic content analysis.** Analysing the interviews in terms of migration-related personal challenges, we identified three recurring themes: (1) weakened social networks; (2) barriers to integration; and (3) challenges to cultural and religious belonging. (For an overview of themes and subthemes, see Table 1.)

*Weakened social networks* related to separation and loss as well as to becoming less socially active in the new country. The participants explained this social inactivity as a result of the stress of the migration experience, personal problems, and the cold climate. To a degree, the weakening of earlier networks was balanced by regular, active contacts via many channels and on many forums with the transnational network, mainly on the internet. The efforts necessary to integrate into Swedish society made these contacts more difficult to maintain and added to the feeling of loneliness.

A particularly painful experience was when the participants could not reunite with family members or others left behind, and they often worried intensely about their absent close ones.

Family patterns changed in exile and participants sometimes reported that this led to conflicts in the close networks.

| Theme | Weakened social networks | Barriers to integration in Sweden | Challenges to cultural or religious belonging |
|---|---|---|---|
| **Subthemes** | Reduced network in Sweden *(27)* | Difficulty in learning the new language *(26)* | Challenges to religious belonging *(11)* |
| | Failed reunion and worrying about relatives *(22)* | Failure to find employment or meaningful activities *(20)* | Acquiring a new cultural belonging *(23)* |
| | Conflicts in close networks *(12)* | Negative contacts with authorities *(24)* | Preserving and developing the culture of origin *(13)* |
| | | Discrimination *(19)* | |
| | | Cold climate in Sweden *(16)* | |

**Table 1**. **Challenges related to changes in social networks in migration.** Themes and subthemes emerging from the thematic analysis. The number of participants reporting each subtheme in italics within parenthesis. (Adapted from Sundvall et al., 2018).

The strongest of the perceived *barriers to integration* was the difficulty in learning the new language, especially for the older participants. Language problems were seen as the main obstacle to finding employment and forming new social relationships, but also as contributing to bullying and discrimination.

Many of the study persons reported negative contacts with authorities. Several participants described how they had lost control of their lives and become dependent on authority persons. One man described the situation as living in "a cage of gold". The loss of personal freedom was exacerbated by some authority persons being described as unhelpful but also as discriminating and humiliating. Some persons linked incidents with authority persons directly to their mental ill-health.

*Challenges to cultural and religious belonging* involved both maintaining the original religious belonging, acquiring a new cultural belonging, and preserving and developing the culture of origin. The difficulties in maintaining religious activity which were reported by a minority of the participants were described as due to the stress and difficulties of integration.

The participants perceived that the main obstacle to acquiring a new cultural belonging was the almost total lack of personal contacts with Swedes, which they attributed to language problems, segregation, xenophobia on part of the Swedish population but also to a general lack of social bonds they perceived in Swedish society. Several participants described Swedes as cold and distant, even within the family.

The attitude to the culture of origin varied, from participants fearing the loss of their identity and others wanting to combine the two cultures. Women described that they had gained new independence, but this also led to new conflicts and emotional dilemmas: husbands not wanting to share domestic work, authorities demanding that they do, and divorce as a feared consequence of the new challenges. One Muslim woman felt doubly harassed, by her own community, which restricted her freedom, and by Swedes who attacked her for wearing a veil.

**Thematic systematisation of health outcomes and challenges in migration.** The participants scored high on measures of psychological distress and somatisation and screened positively for mental health problems to a high degree. Twenty-eight participants (90%) reported traumatic experiences in the MINI interview. Eighteen of the participants had had recent healthcare contacts for mental health problems.

We made a thematic systematisation, linking challenges in migration (represented by the subthemes identified in the qualitative analysis) to the health outcomes for each one of the participants. Sixty-one percent of all participants reported major depression, PTSD, or suicide risk; a high figure which is not surprising since we consciously recruited part of the sample through health services. An even higher level of mental health problems was documented among those who reported failure of family reunion or worrying about relatives (82%) or conflicts in their close networks (83%). Participants who reported barriers to integration presented mental health problems to a lesser extent (44-65%). My understanding is that this reflects that the healthier persons were more capable of participating in integration activities, and also had higher demands from others and themselves to do so, than persons with serious mental health problems.

**Concluding remarks.** The ruptured social networks and social support were sometimes counterbalanced by network resources in the transnational network, a resource of which I personally had been less aware. Yet, although the transnational contacts were prominent in the network maps and reported as valuable sources of social support, they did not compensate for real-life separations and losses, nor for the social isolation in the new country.

Women seemed to be more exposed to stressful challenges regarding their social networks. Already in childhood in Iraq some women had experienced a restricted and sometimes isolated life. In Sweden they found themselves in a radically changed situation with authorities demanding their active participation in integration processes with the goal of finding a job. Some welcomed new opportunities, whereas others described an increased burden of everyday life, struggling to combine domestic work and participation in courses and preparatory work placements.

The study gives an in-depth image of the participants' social networks and social support as well as indications of their mental health status. By itself, the small convenience sample, however, does not allow for conclusions about causal associations between network, social support, and mental health. We did nonetheless note that mental health problems were most

common in persons reporting problems related to the close network, including failures of family reunion. Other types of material and methods would be needed to explore such associations further.

### 6.2.2 Study IV

We proceeded from the interviews with 40 Iraqis to a survey with 410 Iraqi refugees in Södertälje, Uppsala, and Stockholm. The aim of this study was to systematically explore factors affecting acculturation and health in a larger sample of Iraqi refugees, who arrived in Sweden after the year 2000. As noted above, the survey included four fields of exploration: social determinants of health, including social networks and social support; resilience, including cultural perceptions of illness; mental health; and acculturation. We combined existing assessment scales with questions we constructed based on preliminary findings regarding all research questions in the project.

**Sociodemographic data.** Like the participants in study III, most of the participants in this study were married or living in partnership, highly educated, and evaluated their Swedish language proficiency as good. They identified themselves as belonging to religious communities in about the same proportion as the participants in the interview study (39.7% Muslims, 33.2% Christian, 26.8% Mandaean). Another similarity was that the level of unemployment was relatively high despite a long stay in Sweden, with 75% in employment including unpaid work.

**Social networks and social support.** We studied the role and functioning of the participants' social networks from several different angles. Viewing social support as a social determinant of health, we explored both the sources and types of support (divided into emotional, concrete, informational, or spiritual support). The most important sources of all types of support were parents and siblings, followed by partner and children. Men, however, significantly more often also had concrete and informational support from sources outside of the family.

The important role of the closest family was apparent also in answers to other questions in the survey. Almost everyone assessed the influence of the family in Iraq as "positive" or "very positive", with only a small decrease in Sweden. The family was also assessed as the most important factor to help give life meaning and to help in coping in difficult situations in both Iraq and Sweden. For women, however, the family's importance in meaning and coping decreased in Sweden, whereas work and school increased as a help for coping. Worries for the family had been very common in Iraq but were significantly reduced after migration.

Having no support at all, of any type, was reported by 16.4% of the participants and having no concrete support was reported by 14.1%. The level of perceived support from authorities was even lower, ranging from 1.5% for emotional support to 6,1% for informational support.

**Resilience factors and trauma.** Further, we studied different assessments of social and personal resilience factors and their changes from Iraq to Sweden. Measuring resilience with

the instrument CD-RISC, the median level was low, but the picture was more nuanced when we explored different dimensions of resilience. The study persons assessed their capacity to socialise with others and their network support as substantially deteriorated in Sweden compared to Iraq. They described themselves as less successful in Sweden than in Iraq, but at the same time as more goal-oriented and capable of adapting to new situations. This difference was significant for the women.

Asked about religious belonging, a large majority answered that they belonged to a religious denomination and described themselves as "very religious". Likewise, a vast majority of the women fasted and prayed privately sometimes or often with significantly lower figures for the men.

A little less than a third of the participants, more men than women, had traumatic experiences, most often war-related. In our interview study, where we had consciously recruited persons who had sought help in healthcare for mental health problems, the corresponding figure was 90%. Of the participants in the survey, 75% assessed their general health as high.

**Perceptions of mental illness.** We studied perceptions of mental illness as a cultural aspect of resilience. Possible explanations were clustered as either social-situational, emotional-developmental, medical-biological, or religious-spiritual (Estroff et al. 1991).

Social and situational problems, especially financial difficulties and unemployment were the most commonly given explanations of mental ill-health, whereas difficulties directly related to being a refugee were less common. Emotional and developmental explanations were almost as common, with death and separation as the predominant explanations for women (significantly higher than for men). Medical and biological explanations were also common, and about a fifth of the participants believed that religious or spiritual factors could cause mental illness. Women significantly more often supported biochemical explanations as well as religious or spiritual explanations. Only 11.1% of the participants gave only one category of explanations as an answer.

**Acculturation.** Regarding acculturation, the majority of the respondents felt that they had a dual belonging -  to their original culture and to Swedish culture and society. About 50% expressed that this was an integrated and relatively conflict-free experience. Yet, about half of the study persons reported that they had been unfairly treated due to their ethnic background or language skills.

**Concluding remarks.** The findings from Study III on the strong role of the closest family before and after exile, the weakening of the social network in general and the lack of support from Swedish society were confirmed in this study. However, the participants in Study IV assessed their health as positive to a higher degree and described themselves as capable of adjusting to new situations to a higher degree than that found in Study III. The proportion of respondents who experienced a dual belonging both to their original culture and Swedish

culture was considerably higher. These differences could probably be at least partly explained by the more vulnerable health situation of the interview persons in the previous study.

As in Study III, there was a gender difference but along somewhat different lines. Whereas in Study III some women described oppressive conditions leading to isolation in early life in Iraq and sometimes to increased conflicts and burdens in the post-migration situation, women in Study IV seemed to cope better in the new country, sometimes, also, better than the men, notwithstanding that men had more social support from sources outside the family. In the questions on meaning and coping, women also assessed the family's importance as diminishing, whereas work and school had become more important as a source of social support strengthening their coping. When we assessed resilience with CD-RISC, women had a lower resilience level than men. But in qualities that are included in a wider spectrum of resilience, the women self-assessed as more goal-oriented and capable of adapting to new situations to a significantly higher degree than the men. They also, more often than the men, used religious practices for coping. In short, resilience is a multi-factorial concept that is determined by societal, network-, psychological, and cultural factors. Our study did not enable us to disentangle the role of these different aspects of resilience.

As to the employed health measures, the women screened lower on self-assessed health. Even though the men more often reported traumatic experiences, men and women had about the same level of PTSD symptoms.

It is warranted to caution against conclusions about women's apparent higher adaptability. Even though being able to acquire a hard-working lifestyle may be socially desirable, for example, when you participate in official integration programmes, the subjective experience may be less positive. In the preceding interview study, women often complained about feeling forced by authorities to work hard, and described this as an additional burden in their lives, actually adding to the challenges against well-being and health.

Expecting reported perceptions of illness to reflect the study persons' personal experiences to some extent, we noted that causes related to the post-migration situation ranked higher than causes related to having had to flee your country. That the vast majority presented multiple explanations of mental illness, ranging from religious and spiritual to medical and biochemical ones, is in line with other studies and should instruct clinicians to avoid having stereotypical views of their patients' cultural perceptions.

# 7 DISCUSSION

## 7.1 UNDERSTANDING SUICIDE

*"Suicidology has disproportionately focused on explaining suicide rather than understanding it"* (O'Connor et al., 2011, as cited in Michel et al., 2017).

In Study II we saw that the female patients and the clinicians seemed to have very different views of the situation and its challenges, leading to frustration and a sense of powerlessness on both sides. The clinicians appeared to be occupied with diagnostic assessment and issues such as "is this a crisis or a depression?" or "this is not psychiatry".

The clinicians' expressions of powerlessness can be seen as reflecting a lack of tools, the feeling that "there is nothing I can do", confronted with an overwhelming reality. But their concerns can also be seen as reflecting a medical model of suicide. As described in chapter 3.2 this model is predominant in individual-based suicide prevention, but, in recent decades, it has also been questioned. The principal argument against the medical model is that suicide is not a disease, even if mental health disorders are important risk factors for suicide. Authors have put forward alternative views to what has been called the "biologification" of suicide (Hjelmeland, 2011, p. 61), approaches that should have a greater focus on the psychology of suicide (Michel, 2021; Panagioti et al., 2009), and on the impact of stressful life events (Howarth et al, 2020).

One of the most consistent efforts to give a coherent alternative to the disease model is the work by Michel, Valach and others to develop an "action theoretical concept of suicide" (Michel & Valach, 1997, p. 214). If suicide is not a disease, the suicidal person is not primarily a patient with a diagnosis but an agent in his own life, who is assumed to be guided by goal-directed processes, and who should not be "*objectified* in terms of sign and symptoms" (Michel et al., 2004, p. 204, italics in the original).

Another type of criticism addresses an alleged absence of coherent models of suicide, for example in the concepts of risk factors for suicide. Just as the development of statistics in the 19th century led to a turn toward sociology in suicide studies (from Durkheim and onward), so has the development of more sophisticated statistical methods for testing associations between a large number of risk factors and suicide influenced the idea of what suicide is. Mäkinen (1997b) and Michel et al. (2017) observed that the risk factor approach might create a fragmented understanding of suicide. Michel et al. claimed that risk factors cannot account for the psychological experience of suicidality and that they cannot be translated into treatment models. In clinical suicide prevention, risk factors are insufficient.

We nonetheless found the identification of risk factors in Study I to be a useful tool for mapping similarities and differences in the suicidal process between the asylum seekers and the control group. However, we also found it necessary to continue with a qualitative study to deepen the understanding of these findings.

Further, in Study II we saw that clinicians tended to view suicidal behaviour triggered by non-medical factors – such as the asylum processes – as less serious than if they assessed the suicide attempts to be caused by mental disorder. If the answer to the "crisis-or-depression"-question was "crisis", this answer seemed to influence the view of the health state and of what intervention was needed. I understand this attitude to the patient's suffering as an expression of the medical model, albeit that other factors also seemed to come into play in the physician's mind, the most frequent being legal issues in the asylum process.

An important finding in Study I was that there were many similarities between the asylum seekers and the controls with regard to earlier mental health and suicidality. The asylum-seeking women had used suicide methods that are considered more lethal, compared to the women in the control group. These findings contradict the assumption that suicide attempts during the asylum process generally represent an allegedly not so serious "cry for help".

It is conceivable that the interpretation of suicide intent influenced the clinicians' perceptions of the seriousness of a given case. As we reported there was a general lack of information on suicide intent in all medical records. Since suicide intent is one of the few items that register the patient's subjective view of his or her suicidality, this lack could by itself be interpreted as an effect of the medical model in which the clinician is the expert and the patient a passive object of the investigation. The few findings on suicide intent that could be analysed statistically pointed in different directions. Although subjects in the control group more often had made their suicide attempt alone, which by itself may indicate a high level of intent, two subjective indicators, the purpose of their suicide attempt being death and the act being a serious attempt to end life, were more often documented for the asylum seekers.

Subjective indicators are generally rated higher in studies using the Suicide Intent Scale. In a review, Freedenthal (2008) discussed if this discrepancy could be a sign of suicide attempters exaggerating their intent. In our study, it would be conceivable that the legal context could incentivise asylum seekers to exaggerate. Freedenthal, however, thought that there may be other conclusions related to the structure of the scale and recommended more qualitative research.

There were no differences between the groups regarding premeditation. Nonetheless, in Study II we noted that some clinicians assessed impulsive suicide attempts as less serious. This is at least partly in line with the logic of the Suicide Intent Scale and other similar measures. However, Freedenthal (2008) warned against overinterpreting planning versus impulsiveness as measures of suicide intent and recommended further investigation of this indicator. This in turn points in the direction of an alternative model of suicide, Schneidman's psychache (1993) with its emphasis on rapid-changing "perturbation" and "lethality", that is, the probability of the suicidal behaviour having a lethal outcome, as tools to assess suicidality.

## 7.2    A CRITIQUE OF PSYCHIATRY IN GENERAL

A similar criticism of medical models in psychiatry in general was provided by Kirmayer (2015a), who summarized the three predominant views of psychopathology of the last century: a view of the person as a biological organism, a view centering on the psychological self, and a view where social contexts and the environment shape and constrain psychopathology.

Kirmayer quoted a statement about psychiatric disorders being brain disorders and described this as "an expression of faith, not a judgment grounded in evidence" (2015a, p. 628). However, he did not claim that one perspective was truer than another. Nor did he see them as mutually exclusive since they all offer a partial truth. The criticism of the biological model is primarily based on its dominance over other perspectives over a long period of time.

Further, Kirmayer (2015a) emphasised that the balance between the different perspectives does not depend only on scientific advances "but on the social, cultural, political, and economic contexts of psychiatry as an evolving field of inquiry, profession, and social institution" (p. 622). He claimed that psychiatry is shrinking to a discipline focused on diagnosis and medication prescription and that this development has occurred "in conjunction with the corporatisation and globalisation of health care" (p. 644). However, he made an even sharper analysis of the causes of this shrinking. It could not only be explained by economic interests of influence of new technology - but there is also a "*resistance* [emphasis added] to addressing social-structural, political, and economic determinants of mental health" (p. 644).

This idea of psychiatry's resistance to social perspectives resonated in my head during the reading and analysing of the medical records in studies I and II. The challenges of combining perspectives that we observed in that material sometimes seemed so deep-rooted that the word resistance was appropriate.

In Study II we interpreted this as reflecting a lack of tools: the clinicians struggled to help their patients but were not equipped to do so. What might be the answer to this problem? Kirmayer's (2015a) vision is one of an ecosocial renaissance in psychiatry in which different perspectives are integrated in more self-aware and self-critical modes of practice.

I would add that to realise such a vision, psychiatry needs a more concrete approach: what, for example, is that "social" thing that should be integrated into biomedical thinking? This question is not only about our views of aetiology and disease but about the view we have of human experiences.

## 7.3    SOCIAL SUFFERING

Kleinman et al. (1997) introduced the concept social suffering in the following way: "Social suffering... brings into a single space an assemblage of human problems that have their origins and consequences in the devastating injuries that social force can inflict on human experience" (p. ix). So far it could be interpreted as one of many statements about the social causation of suffering and mental ill-health. But the authors mean something more: "For

example, the trauma, pain, and disorders to which atrocity gives rise are health conditions; yet they are also political and cultural matters" (p. ix). Health is a social process. Further, suffering is a social experience in two ways: We are taught and learn collective modes of perceptions and expressions of suffering and ill-health; social interactions (as between patients and their caring families) are part of an illness experience (Kleinman & Kleinman, 1997).

The issue is not to underestimate the importance of the psychiatric understanding of trauma or pain but to reflect on the medicalisation of the patient's suffering as a means of reducing human experience – and on the fact that, as we observed in Study II, this reduction risks making the encounter in health care less helpful. In studies of the encounter between therapists in psychiatry and female migrant patients, Lindqvist (2016) saw social suffering as a concept that addresses both the patient's suffering and the compassion of the therapist enabling him or her to open up to the suffering of the person.

Our way of understanding health and challenges to health in studies III and IV can also be elaborated from the point of view of social suffering. We explored self-assessed health items with quantitative measures, but our studies did not enable us to draw conclusions about causal relations between variables. We systematically explored health as subjective experiences of health and challenges to health. The result of those studies was a phenomenological understanding of health, an understanding in which subjective experiences of health as well as the recognition that suffering is linked to the social context are essential (Lindqvist, 2016).

But how should you as a medical researcher approach a person's social suffering? To Kleinman & Kleinman (1991) "social suffering" refers to human, subjective experience as well as the social meaning of the illness. Lindqvist (2016, p. 12), referring to Gunaratnam (2012), noted that "social pain" is mediated by intersubjective (social) relationships. I will develop these different perspectives and their possible contribution to understanding social suffering in the following sections.

## 7.4   SUBJECTIVITY

The American psychiatrist John Strauss is one of the forerunners in psychiatry of a continued emphasis on the exploration of the subjective level. He claimed that the subjective level is data, just as much as more medical information about the disorder. He wrote:

> "Subjectivity is a major part of our field and we know so incredibly little about it…. We can't assume that it needs to be reduced, as though on some procrustean bed, to those mental experiences that can be viewed in fragments and easily rated with reliable scales" (Strauss, 1996, p. 206).

His research shows how the exploration of subjective experiences could be of help in clinical work. When I worked in an outpatient psychosis unit we were inspired by Strauss' descriptions of the patients' own regulatory mechanisms, such as the low turning-point,

woodshedding, and the meaning of negative symptoms (Rakfeldt & Strauss, 1989; Strauss, 1989).

Strauss recommended the study of autobiographical and first-person accounts as well as developing interview methods that allow for persons' stories to be told. In a period when structured questionnaires had become the norm in research he developed semi-structured interviews with a high degree of openness to experiences, feelings, and spontaneity (Strauss, 1989).

In Study II, we found that clinicians rarely explored the subjective experiences of the asylum seekers. In some cases, the clinicians appeared not so empathetic with their patients. Empathy is a word that is often used as a value-judgment about personal qualities of the clinician. Kirmayer (2015b), however, discussed empathy as a source of knowledge in the clinical encounter. He described three sources of knowledge – empathy or *Einfühlung* (knowledge of the other based on emotions), *Verstehen* (understanding human action by taking the other's perspective), and *Erklären* (causal explanations of behaviour in terms of underlying mechanisms). Applying this categorisation to our findings in Study II, I contend that the studied clinicians were mostly engaged in *Erklären*, as in the preoccupation with diagnostic assessments.

If empathy needs to be expanded, then we also need to understand its limits. When people are more difficult to understand, they may be more difficult to empathise with. This is a challenge in psychiatry, when the patients' symptoms represent reactions that are unfamiliar to the clinicians. Kirmayer (2015b) described several aspects that might further limit empathy in the intercultural clinical work – linguistic differences, cultural differences, divergent life experiences, the patient's lack of trust in the clinical setting, or patients' limited awareness of their own social and cultural context. In another context, he described how different life experiences may lead to failures of imagination on the part of the clinician (Kirmayer, 2010).

In Study II, we addressed this challenge in the theme "Decoding languages of distress", where we described both difficulties in contact and communication, decoding unfamiliar expressions and behaviour, and unfamiliar life circumstances. The findings of this study as well as those of Study III suggest that there was a lack of attention to the refugee patient's subjective experiences in their encounters with authority figures, including both health care staff (documented in Study II), and representatives of agencies responsible for integration in Swedish society (documented in Study III).

## 7.5   SOCIAL RELATIONSHIPS AND SOCIAL NETWORKS

In Study III we explored the relation between changes in social networks and social support during the migration process, and social suffering. First, in the content analysis, we discerned themes expressing "challenges related to changes in social network". In a further step, we combined the quantitative health measures with the important challenges (expressed by the subthemes in the content analysis) for each individual. This allowed a deeper understanding of the psychological and social context of health.

Issues related to social networks and social support appeared to be related to social suffering in studies III and IV – but also as protective against suffering. For the participants in both studies there were indications of a protective network continuity as well as network crisis. In the interviews in study III, the interpersonal aspect of resilience was apparent in the participants' descriptions of impact of changes in their social networks.

Network continuity was represented by the close family, which, despite separation and loss, continued to be the most important provider of different kinds of social support. Also, the transnational network was an important continuous resource for the participants in Study III. Further, participants in both studies maintained continuity in their religious belonging notwithstanding that they reported difficulties in maintaining religious practices.

In Study III, the weakening of social networks was manifest in four forms: through separation in exile and loss; increased conflicts and disappointment with important members of the network; pressure from the peripheral network in Sweden, especially authorities; and the overwhelming difficulty of building new networks. In Study IV, a general deterioration of the social networks and of social support outside of the close family was salient.

Even though we did not have access to any systematic exploration of the social networks of the asylum-seeking women in Study II, notations in the medical records showed that their suffering was also a network crisis. The inner psychological suffering related to their unbearable life situation and earlier traumatic experiences seemed exacerbated by the loss of support from their family network – due to the exile but in some cases also to rejection by the family. Lacking network support seemed to exacerbate the helplessness they felt when they could not protect their children.

## 7.6 MEANING OF SUICIDE

When alternatives to the biomedical disease model are put forward, particularly concerning suicidality, the concept of "meaning" often comes to the fore. My own first consideration of meaning in suicide assessment, was triggered by reading a work by the historian Arne Jarrick, *Hamlets fråga. En svensk självmordshistoria* [Hamlet's question. A Swedish history of suicide] (2000). Jarrick described how Swedish tribunals from the 16th to the 19th century meticulously investigated suspected suicides. The important question was "why did the person want to die?" The tribunal searched for evidence concerning the person's state of mind, analysed his or her behaviour, and interviewed relatives. Should the deceased person be granted a burial in consecrated ground or not? A proper burial might be allowed if the suicide could be proved to be the result of mental disturbance. But if the suicide expressed some kind of evil inclination, a conscious destruction of life as God's gift, the corpse would be buried outside the churchyard.

This historical account illustrates two different aspects of meaning related to suicide. There was a genuine interest in the meaning of the suicide to the deceased person him- or herself. But suicide also had a clear social meaning: a sign of madness or a sin, depending on the

deceased person's intent and state of mind, and on the predominant (Lutheran) religious traditions as adjudicated by the clergy.

In Study II we found a lack of documentation of the meanings that the patients attributed to suicide and suicide attempts. In the few cases where patients' meanings were documented, suicide was seen as a solution to an unsolvable dilemma (often the failed asylum process), a way of giving their children a better future, a way of getting rid of unbearable traumatic memories, or a way of reuniting with dead relatives.

Social meanings, in this case in the social context of the culture of healthcare, were also found in the documentation. They related to the suicide attempts being seen as the expression of a psychiatric diagnosis (mainly "depression"), as a less serious psychological state ("crisis"), or even as an intentional act ("acting out", "protest"). Resounding of the history of the tribunals assessing suicide in old times, these distinctions often seemed to have the function of establishing boundaries: "This is not psychiatry" was a quite common statement in the records. Staff repeatedly explained to patients that their (the patients') situation was the responsibility not of healthcare but of the migration authorities.

Meanings attached to suicide have been hypothesised to vary between cultures (Colucci, 2013). This idea has been motivated by the well-known differences in suicidal epidemiology between countries as well as between men and women. Some researchers have focused on how cultures may affect the incidence of psychopathology, whereas others have pointed to the need of a more contextualised understanding of how culture affects meaning. Strauss and Quinn (1997) defined meaning as "the interpretation evoked in a person by an object or event at a given time" and a cultural meaning as "the typical… interpretation of some type of object or event evoked in people as a result of their similar life experiences" (p. 6).

Good and Good (1982) described the networks of meaning of an illness in a culture as "the metaphors associated with a disease, the ethnomedical theories, the basic values and conceptual forms, and the care patterns that shape the experience of the illness as well as the social reactions of the sufferer" (as cited in Colucci, 2013, p. 31). Examples of different sociocultural meanings of suicide were given by Boldt (1988) who listed suicide being seen as an unforgivable sin, as a human right, as a ritual obligation, and as an unthinkable act. Meng (2002) saw suicide as a symbolic act of rebellion and revenge for some Chinese women. In an interview study with young immigrant women in The Netherlands, van Bergen et al. (2011) interpreted the meaning of these women's suicidal behaviour as related to struggles over life choices in which they experienced a lack of autonomy.

In the medical records we studied in studies I and II, however, cultural aspects of meaning were rarely noted. My hypothesis is that expressions of meaning were not expected by the clinicians and therefore not explored.

## 7.7   STUDYING ASYLUM SEEKERS AND REFUGEES

**The importance of trust**. There are obvious methodological difficulties in studying asylum seekers and refugees, starting with the difficulty of obtaining data. Since I had earlier experiences of problems recruiting research subjects (in a pilot study on cultural aspects of psychosis in a migrant population), I was particularly attentive to this issue over the years. The difficulties in both the thwarted pilot study and in Study III was the difficulty of recruiting persons who were patients in mental health services. This led to the tentative conclusion that these difficulties were related to the stigma of mental health problems. I would however like to express it in more general terms as a question of trust.

Nickerson et al. (2019) showed that refugees' low interpersonal trust in persons they met in the new country was associated with lower subsequent engagement in the host community, which I assume also might include the willingness to be engaged in research. In Study III, the participants emphasised the low trust they experienced from the host community as a barrier to integration – also a factor that may diminish the wish to participate in research. There were differences in this regard between the two sites in Study III. In one of the towns there were no problems recruiting research subjects through the psychiatric units with which the potential participants had contact, whereas, in the other town, recruitment of psychiatric patients failed totally. The difference may reflect that the clinician who asked persons to participate in the "successful" location was the same clinician that they had met in earlier care encounters, not so in the other one. It is sometimes said that you should not carry out research on your own patients, and there are certainly ethical complications that need to be considered. Research subjects must, for example, be informed that they cannot expect a preferential access to treatment for complying with "their" doctor's request to participate in a research project.

Nonetheless, previously established trust is an important asset in a context where trust is difficult to build. That might be the case with the Iraqi refugees in Study III, many of whom experienced Swedes as distant and authorities in Sweden as less helpful. Trust might be even more difficult to achieve because of language problems and lack of knowledge of Swedish society as well as of research practices. Building the prerequisites for seeing the vulnerable person and hearing his or her voice is also an important ethical issue in this type of research. The positive impact on the recruitment efforts of the Arabic-speaking research assistant in studies III and IV should also be recognised. His beneficial role adds to our understanding of the importance of creating trust.

**Trustworthiness of observations.** Another difficulty that I have reflected on is that of handling individuals with unfamiliar experiences and life circumstances. I believe that researchers often find themselves in a situation that is similar to that of the clinician in this respect. In Study II, for example, we noted that clinicians sometimes perceived the person as a mere asylum seeker, thus overlooking other aspects of his or her experience. Scrutinising the medical records in Study I with our protocol, I realised that I initially registered more external, stressful situations other than trauma (especially economic and work- or study-related problems) among the controls compared to the asylum seekers. Was that difference

really plausible? I reread the first records and found that I had indeed sometimes missed information about everyday stress in the asylum seekers' lives. My interpretation was that I was so overwhelmed by the history of trauma and the asylum process that I occasionally missed more "mundane" information. Although differences in this regard remained noticeable, if to a lower degree than before my reevaluation, this experience was a reminder that the observer's unconscious biases can negatively affect the validity of qualitative results.

It is conceivable that the trustworthiness of my observations in Studies I and II would have been strengthened, had I interviewed asylum seekers instead of studying their medical records; I would at least have been able to stick to a protocol and ask probing questions. However, the results of the interviews carried out in Study III also suggested that the interviewers had different ideas about the challenges of migration, leading them to different pathways of exploration of the participants' experiences. All interview situations include aspects of social interaction that might influence which facts are revealed and which facts are noted.

**Other lessons learned.** Exploring trauma is another challenge when you study vulnerable groups. There is an interesting difference between Studies III and IV in this regard. Even though the participants in these studies came from the same country during the same period, a much higher proportion of the participants in the interview study (Study III) reported traumatic experiences. Apart from the circumstance that the participants in this study were partly recruited through healthcare, this discrepancy may reflect that in this study, experienced psychiatrists posed the questions from the MINI about traumatic experiences and could both clarify the applied concepts and ask probing questions after the patient's initial response. Also, the personal narrative related to the network map that was created in the interview most likely contributed to establishing a trustful collaboration with the interviewer, making it possible to divulge personal and potentially sensitive information.

Another lesson from Studies III and IV was the need to adapt instruments to the linguistic and other challenges. I have become increasingly aware of the risk of creating long and complicated instruments to satisfy different interests of the engaged researchers. It is important not to underestimate the increased time and effort needed because of language problems, not only for those persons needing an interpreter. In Study III, several participants did not complete the assessment instruments, probably because of language problems and the length of the procedure; in Study IV, wishing to maximise the yield of our questions, we formulated some of them in language that was too complex and difficult to understand. As a result, the response rate to the survey's final questions was lower than for the questions in the beginning of the instrument.

We also found that participants in Study III sometimes expected us to fulfill a more concrete helping role in their lives. Indeed, most lay persons probably have vague ideas about what participation in research implies. With the asylum seekers, however, we also found that for some of them we seemed to be among the very few Swedes they had actually talked to, apart from the authority figures with whom they were obliged to interact. Consequently, it

appeared that some of them hoped that the interview would be a longed-for opportunity to speak with Swedish persons about problems they had encountered in Sweden. One person, for example, even was frustrated when he realized that we could not provide a solution to his situation.

## 7.8   USING MEDICAL RECORDS AS A SOURCE

Medical records are rich sources of information. But information on what? The ethnologist Lars-Eric Jönsson, in a dissertation on "room and body in Swedish psychiatric asylum care 1850-1970" (1998), described the medical records as "a documentation of a human being's life as a patient". He noted:

> In other words, the case record does not only contain information on the examined and described person. It is also a rich source of information about the documenting person, the examiner, that is, the author of the case record. In this respect, patient and psychiatrist can hardly be separated from each other. The patient does not exist without the psychiatrist. The psychiatrist does not exist without the patient (Jönsson, 1998, p. 53).

Psychiatric case records were also discussed by the literary scholar Petter Aaslestad in his book *The patient as text: The role of the narrator in psychiatric notes, 1890-1990* (2009). His main ambition was to study the storyteller's, that is, the psychiatrist's, role in the records and especially how the storyteller allows the patient to be heard and seen. The object of the investigation was the text, and Aaslestad stressed the difference between a history and a story, where the history is the content to which the story refers. The history, in this case the patient's illness and life history, cannot be totally reconstructed from the story.

Aaslestad's investigation showed that the patients' voices were rarely heard in the records. He analysed the different forms that are used to quote a person and found that even though the text seemed to be presenting the patient's own speech it often turned out to be the writer's speech. His comment was that the choice of forms of discourse has a meaning beyond the linguistic one. In his conclusions he referred to Rita Charon (2006), a well-known author in narrative medicine, stressing the need of the patient's life world to be more strongly represented in the written documentation.

Our findings in Study II coincided with both Jönsson's and Aaslestad's findings. In our material, there was of course abundant information on the patient and his or her mental state. It was, however, also apparent that the patient as a person was not heard in the records, not in the way recommended by Charon (2006) or in Swedish guidelines for person-centred care (Centre for Person-centred Care, 2021). In Study II, we systematically scrutinised the records to lay bare the patients' own voices but found few examples of direct quotes or indirect recapitulations of the narrative.

As Jönsson described, information about the author of a given notation was also discernable. This information did not only include the professional assessment and formal decisions and

evaluations, but also information on the clinician's knowledge and perceptions of how suicidality is assessed, including his or her insecurity, view of his or her role in the assessment and treatment process, and emotional reactions to the patient and the patient's life stressors.

Aaslestad similarly noted that the psychiatric case record is influenced by factors that far from always are medical or scientific. He found that historical circumstances, modes of thinking and ideological currents of the times readily left their marks in the form and content of the psychiatric case record. In Studies I and II we too found that the impact of external factors on the medical record was salient, albeit not always explicitly formulated. The most obvious societal factor that was reflected in the individual medical records was the asylum process, manifest in clinicians' comments, for example, on the role of other authorities, the burden of assessing asylum seekers in psychiatry, the difficulty of assessing the mental state during the asylum process, and on the veracity of the patient's story against the background of the unresolved asylum application. Organisational issues in the mental health services were sometimes also reflected in the records, for instance the emphasis on diagnostic procedures, perceptions of causes of mental disorders, opinions about which treatments were considered appropriate, the reactions of colleagues in the care unit to unfamiliar clinical pictures, the role of senior persons in the unit in determining the boundaries of psychiatry, and the collaboration with the private social network and with social agencies.

In studies I and II, the medical records were the only way of getting knowledge on this group of persons, who would not have been easily accessible for interviews after the care episode, and on their encounter with healthcare. However, studying the records also gave us access to information on many matters that might be more difficult to explore in an interview. The drawbacks were also noticeable. For instance, if a sought-for item in our protocol was not found in the record we could not know if it had not been explored or if it just was not documented. There was often a lack of information on issues that we considered important, like suicidal intent. In such cases, I still found it fruitful to reflect on the absence as a finding in its own right, but of course such a procedure included a high degree of inference.

In short, I think that even more knowledge on the different perspectives would be gained if studies of medical records could be combined with interviews with patients whose voices are underrepresented in the records.

## 7.9   USING THE NETWORK MAP AS A TOOL

*"This is nice, you take me back to the childhood period and it is so nice. Yes, you took me back to the old days when I played marbles as a child".* (Comment during the charting of the network map by an elderly man who had earlier interrupted an interview session because of an intense attack of anxiety.)

It might seem bold to add the biographical network map to the already extensive set of instruments of the Gilgamesh project, of which Study III forms part. Charting a network map is always time-consuming and requires extensive reflection in order to be meaningful. Using

a biographical network map with its added time layers, as we chose to do, is even more demanding.

However, having used the map earlier in clinical work, I was confident that it could be useful. One advantage of the network map is that it starts with questions about everyday life that are usually not intimidating, such as "Who are the most important persons in your household?", which invite a continued narrative to be developed. It starts with concrete questions but to my experience is not perceived as questioning. The focus is understandable across languages.

Klefbeck (2007a) described drawing a network map with a client as if the person is looking into a mirror, discovering things about him- or herself, eliciting reflections on the image he meets. He claimed that the mutual emotions that a counsellor and a client experience while making a network map strengthen their cooperation and contribute to building of trust. There is a resemblance with the comment made by the elderly man quoted above, even though the research context is different from the care relation Klefbeck referred to.

We chose the biographical network map because it helps to see changes in the past. We had a research focus on the changes and challenges of migration, and the network map yielded rich information on that topic. The graphical images and the narratives that were spun around the emerging map, helped the study person visualise the impact of the migration process.

Adding the two sectors "relationship to self" and "relationship to sources of existential meaning" made it possible for us to explore the mutual relationship between social networks, and self-image and existential meaning. This expansion of the instrument yielded a deeper understanding of different network persons' influence on the studied person's meaning systems and self-image. In a few cases, we also discovered spiritual forces that were seen as personified members of the social network, with roles comparable to family and relatives.

In summary, my confidence in the network map was vindicated in this study. I see it as a fruitful method in qualitative interviews in general, and certainly in interview studies with migrants. Given space and time and with a researcher following up with probing questions, it will yield rich narratives.

## 7.10  TRUSTWORTHINESS OF THE RESULTS

I have earlier mentioned the question of the trustworthiness of my observations related to the context of studying traumatised persons. In the following I will shortly summarise how trustworthiness criteria apply to the studies in general.

### 7.10.1 Quantitative studies: Studies I and IV

In Study I, asylum seekers were compared to controls that were matched for gender, five-year age class, and year of registration of the suicide attempt. The validity was strengthened by the fact that the studied group included all asylum seekers assessed for suicide attempts at the central mental health emergency services in the period in question were included - there was no selection bias. We were informed that the emergency mental health services had made

repeated efforts to remind the clinicians of the registration as part of the clinical documentation. But there is no way of assuring that some clinicians did not miss out on this instruction. Yet, it is unlikely that this should lead to a systematic exclusion of asylum-seeking patients.

Earlier, I have mentioned other threats to trustworthiness in Study I – the fact that we could not interpret the non-documentation in the medical records of items in our protocol, and the realisation that my own reading of the case notes was sometimes affected by their content. The ways I handled these threats arising in the data analysis were to proceed with increased rigour, checking the findings repeatedly, and discussing all steps and interpretative choices in the analysis with my cowriters, with maximal transparency.

Unable to claim that our results are generalisable to asylum seekers in general, we have strived to describe the context of the results as thoroughly as possible. I consider that this contextualisation combined with the close description of our procedure strengthens the trustworthiness of our results. Our findings made it possible to compare with other studies on asylum seekers and suicidality, while keeping the differences in populations, legal aspects, and organisational settings in mind.

In Study IV, the main threat to the validity was the sampling procedure. The convenience sample was not representative, and the results did not permit generalisation to refugees at large. That the participants were highly educated, had stable living conditions and better self-assessed health status than refugees in other studies could be ascribed to a selection bias. However, the studied sample was fairly large and diverse, and the trustworthiness of our results was strengthened by the fact that we managed to reach out to non-Muslim groups, younger persons, and women to a relatively high degree.

As mentioned earlier, the survey was too time-consuming and complicated, which could be seen as a threat to its reliability. This led us to eliminate some questions from analysis.

In summary, the trustworthiness of Study IV builds on its rich information and contextualisation of a certain population from a certain background during a certain period: refugees from different religious groups who arrived in Sweden from the year 2000 to 2010. Our approach generated results that can be used by migration researchers in other contexts and areas.

### 7.10.2 Qualitative studies: Studies II and III

Qualitative research does not - and cannot - aspire to statistical generalisability. Still, in order to be useful, it needs to show that it is trustworthy and meaningful. Different strategies have been used to achieve trustworthiness in qualitative research. Some qualitative researchers follow and adapt the traditional validity criteria more closely, and even try to generate mathematical expressions of validity and reliability, whereas others suggest a different view. In the following brief reflections on my studies, I will mainly follow the criteria suggested by Lincoln and Guba (1985).

*Transferability,* according to Lincoln and Guba (1985), corresponds to external validity and generalisability and refers to the possibility of transferring the findings to another context. Transferability depends on the similarity between the original and the receiving contexts. The task of the researcher is to give a thorough description of the context of the exploration. This makes it possible for the person reading the study to compare and make inferences about differences and similarities in his or her context.

Our approach to enhancing transferability in both Study II and III was to give as rich a description of the subjects, the context in time and place, our role as investigators etc. as possible. When we described individual patients in Study II, we were limited by the need to protect their confidentiality, which was especially important since we could not get informed consent from them. In Study III, we had a similarly cautious approach to avoid identification, even though the participants had given informed consent. Consequently, our choice in both studies was to describe their background on a group level with demographical data. In Study II, we found it important to describe the legal and organisational context of the migration process and the healthcare system extensively enough to make it understandable to a reader in another setting. In Study IV, we similarly gave a description of the context, in this case the Swedish reception system for refugees. In both studies we explored the subjective experiences in some detail with (depersonified) descriptions of situations and quotes from the records in Study II and descriptions of challenging circumstances and quotes from the interviews in Study III. In my assessment, this approach enhanced transferability.

*Credibility* is described by Lincoln and Guba (1985) as "the naturalist's substitute for the conventionalist's internal validity" and refers to the tasks of carrying out the inquiry in a way that increases the probability of getting credible findings, and of demonstrating the credibility of the findings by having them approved "by the constructors of the multiple realities being studied" (p 296). Consequently, credibility depends both on the quality of the methods used and the quality of the interpretation of the findings. Among the methods recommended by Lincoln and Guba to achieve credibility are prolonged, persistent observation, triangulation in which different sources, methods, investigators, and theories are used, and member checks. This latter is the process in which data and conclusions are tested with the persons from whom the data were collected.

Since Study II was a study of medical records, we did not have access to the "constructors of the multiple realities" directly. So, the credibility depended on my thorough reading of the records, our step-by-step data analysis with coding, grouping into categories, formulation of themes, refinement, and discussion in every step within the research group. Reflections captured in memos and collective reasoning around alternative interpretations were used to increase the credibility and sharpen the analysis. In the end, credibility depended on our capacity to describe the process and the findings in a way to make them trustworthy and credible in the eyes of the readers-to-be.

The credibility in Study III, which was an interview study, was in my assessment increased by the triangulation of sources and methods. Our sample was fairly large for an interview

study and diverse regarding age, sex, religious and ethnic belonging. We also interviewed persons from different settings ranging from municipal activities to healthcare units. We combined structured instruments with open-ended questions and the charting of a biographical network map. The network maps were analysed graphically as images, and the transcribed interviews were analysed as texts with content analysis.

The contextualisation of the study, solid descriptions of the methods and of the process of discovering the findings, and (structured, individual, and collective) reflection on the results a well as including the subjective voices of the study persons, to the extent it is possible, also contributes to the trustworthiness of the studies.

Finally, I want to refer to Malterud (2011) who suggests another not so often used but valuable criterion of scientific knowledge – relevance. This is not just about transferability of findings, but about their usefulness and originality. It has been my ambition with these studies to find relevant knowledge on hitherto understudied themes or groups, not the least the social network of refugees and the communication between clinicians and asylum-seeking patients, and to give voice to the subjective experiences of persons not often heard.

## 7.11 IMPLICATIONS OF THE STUDIES

### 7.11.1 Implications for research

The quest for health equity – or "closing the gap" in WHO's words (CSDH, 2008) - is a giant task and a strong argument for continuing and developing research on health conditions, social determinants of health, and helpful interventions for underprivileged groups, such as refugees and asylum seekers. This thesis contributes to a deepened understanding of aspects of mental health promotion for the studied groups. It contributes to an understanding of how social networks and social support, resilience, and other social determinants affect health and well-being for refugees and asylum seekers. It also addresses the encounter between refugees and asylum seekers and the healthcare system, and how the context of this encounter affects both patients and clinicians. As lessons learnt from the included studies, some recommendations for further research can be given:

The need of exploring subjective experiences is an argument for qualitative studies. I found the qualitative approach particularly fruitful in the study of subgroups of migrants. When you study individuals of whose living conditions and perceptions you lack knowledge, or whose language or culture is foreign to you as an observer (beyond the otherness of any human being placed in the position of research subject), it becomes even more important to give room for the subject's narrative.

In future studies of refugees and asylum seekers, open or semi-structured interviews would enhance the exploration and understanding of idioms of distress, meaning of suicidality, social network resources, resilience factors, etc. To further focus on the personal encounter in the care system, it would be even more relevant to interview both parties in the communicative process, the clinician as well as the patient. This does not preclude the study

of medical records, which I found informative on many aspects of the encounter (e.g., the impact of the organisation, the meaning of what is not documented or explored, perceptions that may not be verbalised in an interview). Similar approaches could be used in studies of refugees and asylum seekers' encounters with other agencies in society. Studies of the encounters in different arenas might contribute to improved reception of migrants and to increased equality in healthcare.

Further, I would recommend researchers to address linguistic and cultural aspects of the research process. To have good interpreters is vital, but there is also a need of adapting the length and the complexity of research instruments when persons are interviewed in a foreign language or with the help of interpreters. Fostering trust is always essential with study persons, but especially important when researchers approach persons with prior negative experiences of authorities in Sweden and deficient knowledge of research institutions' independence of other, potentially more repressive, social agencies.

The network map proved to be a valuable instrument, capable of stimulating a narrative – provided that there was time for the subject to reflect and the researcher to follow up with probing questions. To enable this in future research, I would consider using the map as the primary interview tool.

Especially in Studies III and IV, we had the conscious intention of exploring not only problematic conditions but also the subjects' strengths and resilience. It took some effort, since there were so many life stories about dire conditions and negative experiences, which we obviously needed to explore. However, the focus on resilience remains important since it might influence a more "egalitarian" and open-minded approach to the study subjects, seeing them as agents in their own lives and not only as victims. In this respect, too, I think that the narrative approach is valuable. As Study IV indicated, resilience is a multifactorial concept with cultural and individual variations, and consequently not easy to standardise. Understanding resilience and using it in clinical as well as in social work underlines the need of exploring the narrative.

I see an important role for multidisciplinary studies in research on refugees and asylum seekers, both due to their diverse social, medical, and psychological needs and due to language and cultural issues. In the studies of this thesis, we formed multidisciplinary teams with psychologists, sociologists, psychiatrists, and statisticians. Including anthropologists, linguists, or literary scientists would further broaden the scope of knowledge you could retrieve.

Finally, there is definitely a case for collaboration between quantitative and qualitative research. To move between new data from quantitative studies of large samples and a deeper understanding of selected aspects of those data through qualitative methods produces valuable, new knowledge.

## 7.11.2 Implications for clinicians

It may seem surprising that my emphasis in this text to such a high degree has been on the lack of attention to the suffering person's subjective experiences and to the failure of "combining perspectives", as in Study II. After all, the concept person-centred care is often invoked in contemporary healthcare. However, all too often the person-centred perspective is used as a catchword without committing to a deeper exploration of its implications. To my knowledge, the most systematic effort in Sweden to develop person-centred care, including training and research, is found at the Centre for person-centred care, GPCC, at Gothenburg University. On the centre's webpage three components of person-centred care are defined: (1) viewing the clinical encounter as a partnership between two experts, one of whom is the patient, who is seen as an active and responsible partner; (2) listening to the patient's narrative to understand the meaning of his or her symptoms, needs and resources; and (3) documenting the patient's narrative in a written health plan that is accessible to the patient (Centre for Person-centred Care, 2021). Involving the patient is his or her care is also the aim of so-called shared decision-making, implemented in guidelines for mental healthcare in Sweden (National Board of Health and Welfare, 2018).

The narrative, emphasised in person-centred care, is a recurring theme in different approaches in psychiatry. For example, the international so called Aeschi group of suicidologists that describes itself as "a movement for improving the therapeutic approach to the suicidal person" (www. aeschiconference.unibe.ch) stressed the importance of the narrative as a way of strengthening the therapeutic relationship with the patient. Michel et al. (2017) have developed a therapeutic intervention, called ASSIP (Attempted Suicide Short Intervention Program), based on the patient's narrative.

Exploring the narrative together with the patient is also the aim of the Cultural Formulation Interview in the DSM-5, recommended in the assessment of all patients independent of cultural background. It enables the clinician to explore how the patient him- or herself perceives the problem, what helps and what hinders in the solving of the problem and what help he or she has sought or expects (APA, 2013; Lewis-Fernández et al, 2014). The Cultural Formulation Interview also addresses social and relational aspects of the person's life world, aspects that the results of Studies I and II suggest that clinicians rarely explore.

Clinicians also need to be attentive to contextual factors apart from the cultural idioms of distress that affect the clinical encounter. The fact that it was rarely noted in the medical records whether an interpreter was present or not indicates that the importance of the interpreter as a tool and of the presence of a third person in the room was not acknowledged.

However, I do not think that any tool by itself will guarantee good healthcare for refugees and asylum seekers. Clinicians need time to create trust and build relationships; they also need empowerment from the healthcare managers, and a mandate to take the time necessary to understand their patients. As Study II showed, clinicians may lack knowledge and need training. Educational programmes should transmit factual knowledge about laws and

international conventions, social determinants of health, the effects of trauma, the living conditions for migrants, as well as include training in addressing cultural issues, working with families and other network members, paying attention to resilience factors and the subjectivity of their patients and their close ones (Bäärnhielm & Sundvall, 2018). Guidelines for cultural competence training have been published by the European Psychiatric Association (Schouler-Ocak et al., 2015), and practical guidelines for training in transcultural psychiatry have been published by the Swedish Psychiatric Association (Sundvall, 2018).

Meeting the cruellest aspects of the world in the care encounter has strong emotional effects on clinicians. They need the possibility for self-reflection on cultural issues and support to handle their countertransference reactions, as well as opportunities to reflect on ethical dilemmas. Supervision and cultural consultation can be ways of providing for that.

# 8 CONCLUSIONS

The studies of the asylum-seeking suicide attempters contradict the assumption that suicidal behaviour in asylum seekers is only a "cry for help". The results, especially the less specialised follow-up after a suicide attempt, indicate a lack of health equity. The analysis of the communication between clinicians and asylum-seeking women suggests that clinicians would be helped by addressing cultural languages of distress and by increasing their awareness of the living conditions of asylum seekers. They would also benefit from combining diagnostic concerns with broader views of the suicidal process, exploring the role of traumatic experiences and trauma-related symptoms, as well as the subjective meaning of the suicide attempts for their patients.

The studies of the resettled Iraqi refugees give voice to the subjective experiences of the interview persons, describing the challenges of disruptions in their earlier social networks and the difficulties of building new networks. The results suggest that the importance of the close family as provider of all types of social support is strong in migration, possibly explaining why family issues (failed reunion with family members, worrying about family members, conflicts with members of the close family) are perceived as especially challenging and as strongly related to mental health problems. The results also underscore the importance of facilitating the building of new social networks for refugees, and the importance for authorities to build trust with the newcomers.

A common conclusion from the studies is the need and value of adopting a broader view of health as a social process, and for professional helpers to address subjective experiences of the persons they want to help. This would be helpful both for the clinicians meeting suicidal patients and authorities supporting refugees in the integration process. Also, our analysis of the resilience of the Iraqi refugees suggests that a focus on their own descriptions of how they move forward in life after disruptive experiences gives a deeper understanding than applying standardised measures. In clinical contexts, such an approach would mean applying but also concretising and integrating the concept of person-centred care with a focus on persons' narratives. In this effort, clinicians might find certain tools helpful – like the Cultural Formulation Interview for the understanding of cultural languages of distress, or the social network map for a joint exploration helping the person to formulate his or her narrative about their life world. However, clinicians would also need time and empowerment to follow this path, training providing both knowledge and experiential learning to approach the subjective aspect, and support in this hard emotional work.

Health care systems, managers as well as politicians deciding on rules and resources, need to confront the challenge of achieving health equity for refugees and asylum seekers. This includes being attentive to issues of discrimination and racism in health care. In a resolution on refugees and migrants, the World Medical Association (2016) stated as principles, that physicians have a duty to provide medical care on the basis of medical need alone, that physicians should be allowed adequate time and sufficient resources for adequate

assessments of the health conditions of asylum seekers, and that physicians and their professional organisations should speak out against legislation and practices that are against this fundamental right.

# 9 ACKNOWLEDGEMENTS

# 10 REFERENCES

Aliens Act [*Utlänningslagen*]. (SFS 2005:716). (2005).
http://www.riksdagen.se/sv/dokument-lagar/dokument/ svensk-
forfattningssamling/utlanningslag-2005716_sfs2005-716

Aaslestad, P., Skuggevik, E. & Dawkin, D. (2009). *The patient as text: The role of the
narrator in psychiatric notes, 1890-1990.* Radcliffe Publishing. (Original work
published 2007.)

Abraham, R., Lien, L., & Hanssen, I. (2018). Coping, resilience and posttraumatic growth
among Eritrean female refugees living in Norwegian asylum reception centres: A
qualitative study. *International Journal of Social Psychiatry, 64*(4), 359-366.
https://doi.org/10.1177/0020764018765237.

Agaibi, C. E., & Wilson, J. P. (2005). Trauma, PTSD, and resilience. A review of the
literature. *Trauma, Violence & Abuse, 6*(3), 195-216.
https://doi.org/10.1177/1524838005277438.

Allen, J. A., Vaage, A. B., & Hauff, E. (2006). Refugees and asylum seekers in societies. In
D. L. Sam & J. W. Berry (Eds.), *Cambridge Handbook of Acculturation Psychology*
(1st ed., pp. 198-217). Cambridge University Press.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental
disorders* (3d ed.).

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental
disorders.* (3d ed., rev.)

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental
disorders: DSM-IV: prepared by the Task Force on DSM-IV.* (4th ed).

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental
disorders: DSM-IV-TR.* (4th ed., text revision.).

American Psychiatric Association. DSM-5 Task Force. (2013). *Diagnostic and statistical
manual of mental disorders: DSM-5* (5th ed.).

Amin, R., Helgesson, M., Runeson, B., Tinghög, P., Mehlum, L., Qin, P., Holmes, E. A., &
Mittendorfer-Rutz, E. (2021). Suicide attempt and suicide in refugees in Sweden – a
nationwide population-based cohort study. *Psychological Medicine, 51*(2), 254-263.
https://doi.org/ 10.1017/S0033291719003167

Amin, R., Rahman, S., Tinghög, P., Helgesson, M., Runeson, B., Björkenstam, E., Qin, P.,
Mehlum, L., Holmes, E. A., & Mittendorfer Rutz, E. (2021). Healthcare use before
and after suicide attempt in refugees and Swedish born individuals. *Social Psychiatry*

*and Psychiatric Epidemiology, 56*(2), 325-338. https://doi.org/10.1007/s00127-020-01902-z.

Andersson, L. M. C., Hjern, A., & Ascher, H. (2018). Undocumented adult migrants in Sweden: mental health and associated factors. *BMC Public Health, 18*(1), 1369. https://doi.org/10.1186/s12889-018-6294-8.

Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, E., Lathan, C. S., Peteet, J. R., & Prigerson, H. G. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology, 25*(5), 555-60. https://doi.org/10.1200/JCO.2006.07.9046.

Bateson, G. (1972). *Steps to an ecology of mind.* Ballantine books.

Barnes, J. A. (1954). Class and committees in a Norwegian island parish. *Human Relations, 7*(1), 39-58. https://doi-org.proxy.kib.ki.se/10.1177/001872675400700102

Bazeley, P., & Jackson, K. (2013). *Qualitative data analysis with Nvivo* (2nd ed.). Sage Publications.

Beck, R. W., Morris, J. B., & Beck, A. T. (1974). Cross-validation of the suicidal intent scale. *Psychological Reports, 34,* 445–446

Beck-Friis, J. (2005). *När Orfeus vände sig om – en bok om depression och självaktning.* [When Orpheus looked back: A book about depression and self-regard]. Natur & Kultur.

Beirens, H., Hughes, N., Hek, R., & Spicer, N. (2007). Preventing social exclusion of refugee and asylum-seeking children: Building new networks. *Social Policy & Society, 6*(2), 219–229. https://doi.org/10.1017/S1474746406003484

Bentall, R. P. (2003). *Madness explained: Psychosis and human nature.* Penguin Books.

Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S., & Kapur, N. (2012). How do methods of non-fatal self-harm relate to eventual suicide? *Journal of Affective Disorders, 136*(3), 526–33. https://doi.org/10.1016/j.jad.2011.10.036.

Berry, J. W. & Kim, U. (1988). Acculturation and mental health. In J. Dasen, J. W. Berry, & N. Sartorius (Eds.), *Health and cross-cultural psychology towards application* (pp. 207-235). Sage Publications.

Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J. D., Kirkbride, J., Moussaoui, D., Nazroo, J., Qureshi, A., Stompe, T., & Tribe, R. (2011). WPA guidance on mental health and mental health care in migrants. *World Psychiatry, 10*(1), 2-10. https://doi.org/10.1002/j.2051-5545.2011.tb00002.x.

Bhui, K., McKenzie, K. & Rasul, F. (2007). Rates, risk factors & methods of self harm among minority ethnic groups in the UK: a systematic review. *BMC Public Health, 7,* 336. https://doi.org/ 10.1186/1471-2458-7-336

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights, 15,* 29. https://doi. org/10.1186/s12914-015-0064-9

Boldt. M. (1988). The meaning of suicide: Implications for research. *Crisis, 9*(2), 93–108.

Bosqui, T. J., Hoy, K., & Shannon, C. (2014). A systematic review and meta-analysis of the ethnic density effect in psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology, 49*(4), 519–529. https://doi.org/10.1007/s00127-013-0773-0.

Bourque, F., van der Ven, E., Fusar-Poli, P., & Malla, A. (2011). A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants. *Psychological Medicine, 41*(5), 897-910. https://doi.org/10.1017/S0033291710001406.

Boydell, J., van Os, J., McKenzie, K., Allardyce, J., Goel, R., McCreadie, R. G., & Murray, R. M. (2001). Incidence of schizophrenia in ethnic minorities in London: ecological study into interactions with environment. *British Medical Journal, 323*(7325), 1336-8. https://doi.org/10.1136/bmj.323.7325.1336.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of consulting and clinical psychology, 68*(5), 748-766. https://doi.org/10.1037//0022-006x.68.5.748.

Bronfenbrenner, U. (1979). *The experimental ecology of human development.* Harvard University Press.

Bursztein Lipsicas, C., Mäkinen, I. H., Apter, A., De Leo, D., Kerkhof, A., Lönnqvist, J., Michel, K., Salander Renberg, E., Sayil, I., Schmidtke, A., van Heeringen, C., Värnik, A., & Wasserman, D. (2012). Attempted suicide among immigrants in European countries: an international perspective. *Social Psychiatry and Psychiatric Epidemiology, 47*, 241–251. https://doi.org/10.1007/s00127-010-0336-6

Bursztein Lipsicas, C., Mäkinen, I. H., Wasserman, D., Apter, A., Bobes, J., Kerkhof, A., Michel, K., Salander Renberg, E., van Heeringen, K., Värnik, A., & Schmidtke, A. (2014). Immigration and recommended care after a suicide attempt in Europe: equity or bias? *European Journal of Public Health, 24*(1), 63-65. https://doi.org/10.1093/eurpub/ckt090

Bursztein Lipsicas, C., Mäkinen, I. H., Wasserman, D., Apter, A., Kerkhof, A., Michel, K., Salander Renberg, E., van Heeringen, K., Värnik, A., & Schmidtke, A. (2013). Gender distribution of suicide attempts among immigrant groups in European countries—an

international perspective. *European Journal of Public Health, 23*(2), 279-84. https://doi.org/10.1093/eurpub/cks029.

Byström, M. (2012). Från fattigt utvandrarland till rikt invandrarland. [From poor emigration country to rich immigration country.] In Y. Hirdman, J. Björkman, & U. Lundberg (Eds.), *Sveriges historia 1920-1965* (pp. 418-425]. Norstedt.

Bäärnhielm, S. (2003). *Clinical encounters with different illness realities. Qualitative studies of illness meaning and restructuring of illness meaning among two cultural groups of female patients in a multicultural area of Stockholm* [Doctoral dissertation, Karolinska institutet].

Bäärnhielm, S. & Ekblad, S. (2000). Turkish migrant women encountering health care in Stockholm: a qualitative study of somatization and illness meaning. *Culture, Medicine and Psychiatry, 24*(4), 431-452. https://doi.org/10.1023/a:1005671732703.

Bäärnhielm, S. & Mösko, M. (2012). Cross-cultural training in mental health care--challenges and experiences from Sweden and Germany. *European Psychiatry, 27*(Suppl 2):70-5. https://doi.org/10.1016/S0924-9338(12)75711-5.

Bäärnhielm, S., Scarpinato Rosso, M., & Pattyi, L. (2007). *Kultur, kontext och psykiatrisk diagnostik. Manual för intervju enligt kulturformuleringen i DSM-IV* [Culture, context and psychiatric diagnostics. Manual for interviewing according to the cultural formulation in the DSM-IV]. Transcultural Centre, Stockholm County Council.

Bäärnhielm, S. & Sundvall, M. (2018). Clinical challenges in cultural psychiatry – searching for meaning, searching for methods. *Nordic Journal of Psychiatry, 72*(sup1), S9-S12. https://doi.org/10.1080/08039488.2018.1525648.

Cantor-Graae, E. P. & Selten, J. P. (2005). Schizophrenia and migration: a meta-analysis and review. *American Journal of Psychiatry, 162*(1), 12-24. https://doi.org/10.1176/appi.ajp.162.1.12.

Carta, M. G., Bernal, M., Hardoy, M. C., Haro-Abad, J. M. and the "Report on the Mental Health in Europe" working group. (2005). Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1). Report on the Mental Health in Europe Working Group. *Clinical Practice and Epidemiology in Mental Health, 1,* 13. https://doi.org/10.1186/1745-0179-1-13.

Centre for Person-centred Care. (2021, September 27). *About person-centred care.* https://gu.se/en/gpcc

Cetingok, M., Hathaway, D., & Winsett, R. (2007). Contribution of post-transplant social support to the quality of life of transplant recipients. *Social Work in Health Care, 45*(3), 39-56. https://doi.org/10.1300/J010v45n03_03

Çetrez, Ö. (2005). *Meaning-Making Variations in Acculturation and Ritualization: A multi-generational study of Suroyo migrants in Sweden* [Doctoral dissertation, Uppsala University].

Çetrez, Ö., DeMarinis, V., Pettersson, J., & Shakra, M. (2020). *Integration: Policies, Practices, and Experiences, Sweden Country Report. Working papers Global Migration: Consequences and Responses,* Paper 2018/10, Uppsala University. http://doi.org/10.5281/zenodo.3951714

Charon, R. (2006). *Narrative medicine. Honoring the stories of illness.* Oxford University Press.

Cohen, J. (2008). Safe in our hands?: A study of suicide and self-harm in asylum seekers. *Journal of Forensic and Legal Medicine, 15*(4), 235-244. https://doi.org/10.1016/j.jflm.2007.11.001.

Colucci, E. (2013). Culture, cultural meaning(s) and suicide. In E. Colucci, D. Lester, H. Hjelmeland, & B. C. B. Park (Eds.), *Suicide and culture: understanding the context* (pp. 25-46). Hogrefe Publishing.

Commission on Social Determinants of Health [CSDH]. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report.* World Health Organisation.

Compton, M. T. & Shim, R. S. (Eds.) (2015). *The social determinants of mental health.* American Psychiatric Publishing.

*The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.* (1984). Retrieved from https://cti2024.org 2021, October 21.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Sage Publications.

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: Thematic and content analyses. *Australian & New Zealand Journal of Psychiatry, 49*(7), 616-623. https://doi.org/10.1177/0004867415582053.

Crumlish, N., & Bracken, P. (2011). Mental health and the asylum process. Irish Journal of *Psychological Medicine, 28*(2), 57–60. https://doi.org/10.1017/S0790966700011447

Dahlgren, G., & Whitehead, M. (1991). P*olicies and strategies to promote social equity in health.* Institute for Futures Studies. Adapted and accessible in Dahlgren, G., & Whitehead, M. (2007). *European strategies for tackling social inequities in health: Levelling up Part 2.* WHO Regional office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

Dahlgren, G., & Whitehead, M. (2021). The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows. *Public Health, 199,* 20-24. https://doi.org/10.1016/j.puhe.2021.08.009

DeMarinis, V. (1998). Religious ritual-hunger and the quest for religious ritual-sustenance: A psycho-cultural investigation of New Age participants in Berkeley, California. In E. Barker & M. Warburg (Eds.), *New Religions and New Religiosity* (pp. 108-132). Aarhus University Press.

Di Thiene, D., Alexanderson, K., Tinghög, P., La Torre, G., & Mittendorfer-Rutz, E. J. (2015). Suicide among first-generation and second-generation immigrants in Sweden: association with labour market marginalisation and morbidity. *Journal of Epidemiological Community Health, 69*(5), 467-73. https://doi.org/10.1136/jech-2014-204648.

Duggal, A. K., Kirkbride, J. B., Dalman, C. & Hollander, A. C. (2020). Risk of non-affective psychotic disorder and post-traumatic stress disorder by refugee status in Sweden. *Journal of Epidemiology and Community Health, 74*(3), 276–282. https://doi.org/10.1136/jech-2019-212798

Durkheim, E., & Simpson, G. (2002). *Suicide: A study in sociology.* (J.A. Spaulding, Trans.; G. Simpson, Ed.) Routledge. (Original work published 1897).

Dykxhoorn, J., Hollander, A. C., Lewis, G., Dalman, C. & Kirkbride, J. B. (2019). Family networks during migration and risk of non-affective psychosis: A population-based cohort study. *Schizophrenia Research, 208,* 268-275. https://doi.org/10.1016/j.schres.2019.01.044.

Eastmond, M. & Åkesson, L. (2007.) Introduktion. [Introduction.] In M. Eastmond. & L. Åkesson (Eds.), *Globala familjer. Transnationell migration och släktskap* [Global families. Transnational migration and kinship]. (pp. 7-43).

Ekblad, S., & Shahnavaz, S. (2004). Trauma, postmigrationsstress och suicidala tankar hos asylsökande. [Trauma, postmigration stress, and suicidal thoughts in asylum seekers.] *Suicidologi, 9,* (1), 19-31. https://doi.org/10.5617/suicidologi.1867

Estroff, S. E., Lachicotte, S. W., Illingworth, L. C., & Johnston, A. (1991). Everybody's got a little mental illness: accounts of illness and self among people with severe, persistent mental illnesses. *Medical Anthropology Quarterly, 5*(4), 331–369. https://doi.org/10.1525/maq.1991.5.4.02a00030

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365*(9467), 1309-14. https://doi.org/10.1016/S0140-6736(05)61027-6.

Ferrada-Noli, M. (1997). A cross-cultural breakdown of Swedish suicide. *Acta Psychiatrica Scandinavica, 96*(2), 108–16. https://doi.org/10.1111/j.1600-0447.1997.tb09914.x.

Ferrada,-Noli, M., Åsberg, M., Ormstad, K., Lundin, T., & Sundbom, E. (1998). Suicidal behavior after severe trauma. Part 1: PTSD diagnoses, psychiatric comorbidity, and assessments of suicidal behavior. *Journal of Traumatic Stress, 11*(1), 103-12. https://doi.org/10.1023/A:1024461216994.

Ferrada-Noli, M., Åsberg, M., Ormstad, K., Nordström, P. (1995). Definite and undetermined forensic diagnoses of suicide among immigrants in Sweden. *Acta Psychiatrica Scandinavica, 91*(2),130-5. https://doi.org/10.1111/j.1600-0447.1995.tb09753.x

Foo, S. Q., Tam, W. W., Ho, C. S., Tran, B. X., Nguyen, L. H., McIntyre, R. S., & Ho, R. C. (2018). Prevalence of depression among migrants: A systematic review and meta-analysis. *International Journal of Environmental Research and Public Health, 15*(9), 1986. https://doi.org/10.3390/ijerph15091986.

Fossum, B. (Ed.) (2019). *Kommunikation: samtal och bemötande i vården* (Tredje upplagan) [Communication: conversations and encounters in care. 3d ed.]. Studentlitteratur.

Freedenthal, S. (2008). Assessing the wish to die: a 30-year review of the Suicide Intent Scale. *Archives of Suicide Research, 12*(4), 277-98. https://doi.org/10.1080/13811110802324698.

Freud, S. (1914). On narcissism: An introduction. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 67-102). Hogarth.

Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 237-260). Hogarth.

Friese, S. (2019). *Qualitative data analysis with Atlas.ti* (3rd ed.). Sage Publications.

Gerritsen, A. A. M., Bramsen, I., Devillé, W., van Willigen, L. H., Hovens, J. E., & van der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 41*(1), 18-26. https://doi.org/ 10.1007/s00127-005-0003-5.

*Gilgamesheposet: "han som såg djupet"* (L. Warring, & T. Kantola, Trans.). (2001). Natur & Kultur.

Gilliver, S. C., Sundquist, J., Li, X., & Sundquist, K. (2014). Recent research on the mental health of immigrants to Sweden: a literature review. *European Journal of Public Health, 24*(Suppl. 1), 72-79. https://doi.org/10.1093/eurpub/cku101.

Goosen, S., Kunst, A. E., Stronks, K., van Oostrum, I. E., Uitenbroek, D. G., & Kerkhof, A. J. (2011). Suicide death and hospital-treated suicidal behaviour in asylum seekers in the Netherlands: a national registry-based study. *BMC Public Health, 11,* 484. htpps://doi.org/10.1186/1471-2458-11-484.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq: Trauma-related factors compared with social factors in exile. *British Journal of Psychiatry, 172,* 90–94. https://doi.org/10.1192/bjp.172.1.90

Gradus, J. L., Qin, P., Lincoln, A. K., Miller, M., Lawler, E., Sørensen, H. T., Lash, T. L. (2010). Posttraumatic stress disorder and completed suicide. *American Journal of Epidemiology, 171*(6), 721–727. https://doi.org/10.1093/aje/kwp456.

Gradus, J. L., Antonsen, S., Svensson, E., Lash, T. L., Resick, P. A., & Hansen, J. G. (2015). Trauma, comorbidity, and mortality following diagnoses of severe stress and adjustment disorders: A nationwide cohort study. *American Journal of Epidemiology, 182*(5), 451–458. https://doi.org/10.1093/aje/kwv066.

Gramaglia, C., Gambaro, E., Delicato, C., Di Marco, S. Di Tullio, E., Vecchi, C., Bert, F., Castello, L. M., Siliguini, R., Avanzi, G., & Zeppegno, P. (2019). Pathways to and results of psychiatric consultation for patients referred from the emergency department. Are there differences between migrant and native Patients? *Transcultural Psychiatry, 56*(1), 167-186. https://doi.org/10.1177/1363461518798844.

Graneheim, U. H., Lindgren, B. M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse education today, 56,* 29-34. https://doi.org/10.1016/j.nedt.2017.06.002.

Groleau, D., Young, A., & & Kirmayer, L. J. (2006). The McGill Illness Narrative Interview: An interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry, 43*(4), 671–691. https://doi.org/10.1177/1363461506070796.

Guregård, S. & Seikkula, J. (2014). Establishing therapeutic dialogue with refugee families. *Contemporary Family Therapy, 36,* 41–57 https://doi.org/10.1007/s10591-013-9263-5

Hanson, B., & Östergren, P. O. (1987). Different social network and social support characteristics, nervous problems and insomnia: Theoretical and methodological aspects and some results from the population study "Men born in 1914". *Social Science & Medicine, 25*(7), 849-859. https://doi.org/10.1016/0277-9536(87)90043-8

Hassan, G., Ventevogel, P., Jefee-Bahloul, H., Barkil-Oteo, A., & Kirmayer, L. J. (2016). Mental health and psychosocial wellbeing of Syrians affected by armed conflict. *Epidemiology and Psychiatric Sciences, 25*(2), 129–141. https://doi.org/10.1017/S2045796016000044

Hauff, E. & Vaglum, P. (1995). Organised violence and the stress of exile predictors of mental health in a community cohort of Vietnamese refugees. *British Journal of Psychiatry, 166,* 360–367. https://doi.org/10.1192/bjp.166.3.360.

Hawton, K., & van Heeringen, K. (2009). Suicide. *Lancet, 373*(9672), 1372-81. https://doi.org/10.1016/S0140-6736(09)60372-X.

Hessle, S. (1991). Social support och sociala nätverk. Några tankar om dagsläget och frågeställningar i nätverksforskningen [Social support and social networks. Some considerations on the current situation and issues in network research]. In B. Bergsten, A. Bjerkman. H. E. Hermansson, & J. Israel. (Eds.), *Etik, solidaritet, välfärd.* Daidalos.

Hintermair, M. (2009). The social network map as an instrument for identifying social relations in deaf research and practice. *American Annals of the Deaf, 154*(3), pp. 300-310. https://doi.org/10.1353/aad.0.0100.

Hjelmeland, H. (2011). Cultural context is crucial in suicide research and prevention. *Crisis. 32*(2), 61–64. https://doi.org/10.1027/0227-5910/a000097.

Hjern, A., & Allebeck, P. (2002). Suicide in first- and second-generation immigrants in Sweden: A comparative study. *Social Psychiatry and Psychiatric Epidemiology, 37*(9), 423-429. https://doi.org/10.1007/s00127-002-0564-5

Hjern, A., Palacios, J., Vinnerljung, B., Manhica, H., & Lindblad, F. (2020). Increased risk of suicidal behaviour in non-European international adoptees decreases with age - A Swedish national cohort study. *EClinicalMedicine, 29-30,* 100643. https://doi.org/10.1016/j.eclinm.2020.100643.

Hollander, A. C., Bruce, D., Burström, B., & Ekblad, S. (2013). The association between immigrant subgroup and poor mental health: a population-based register study. *Journal of Nervous and Mental Disease, 201*(8), 645-52. https://doi.org/10.1097/NMD.0b013e31829dbd64.

Hollander, A. C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden. *British Medical Journal, 352,* i1030. https://doi.org/10.1136/bmj.i1030.

Hollander, A. C., Mackay, E., Sjöqvist, H., Kirkbride, J. B., Bäärnhielm, S., & Dalman, C. (2020). Psychiatric care use among migrants to Sweden compared with Swedish-born residents: a longitudinal cohort study of 5 150 753 people. *BMJ Global Health, 5*(9), e002471. https://doi.org/10.1136/bmjgh-2020-002471.

Hollander, A. C., Pitman, A., Sjöqvist, H., Lewis, G., Magnusson, C., Kirkbride, J. B. & Dalman, C. (2020). Suicide risk among refugees compared with non-refugee migrants

and the Swedish-born majority population. *British Journal of Psychiatry, 217*(6), 686–692. https://doi.org/10.1192/bjp.2019.220

Howarth, E. J., O'Connor, D. B., Panagioti, M., Hodkinson, A., Wilding, S., & Johnson, J. (2020). Are stressful life events prospectively associated with increased suicidal ideation and behaviour? A systematic review and meta-analysis. *Journal of Affective Disorders, 266,* 731-742. https://doi.org/10.1016/j.jad.2020.01.171

Hsieh, H. F. & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research, 15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687.

Hultsjö, S. (2009). *Caring for foreign-born persons with psychosis and their families: Perceptions of psychosis care* [Doctoral dissertation, Linköping University].

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: a critical review. *Canadian Journal of Psychiatry, 63,* 297–303. https://doi.org/10.1177/0706743717746666

International Organization for Migration. (2019). *Glossary on Migration.* Retrieved from https://www.iom.int 2021, October 21.

Israel, B. A. (1985). Social networks and social support: Implications for natural helper and community level interventions. *Health Education Quarterly, 12*(1), 65-80. https://doi.org/10.1177/109019818501200106.

Jarrick, A. (2000). *Hamlets gåta. En svensk självmordshistoria* [Hamlet's question. A Swedish history of suicide]. Norstedts.

Johansson, L. M., Sundquist, J., Johansson, S. E., Bergman, B., Qvist, J., & Träskman-Bendz, L. (1997). Suicide among foreign-born minorities and native Swedes: An epidemiological follow-up study of a defined population. *Social Science & Medicine, 44*(2), 181-187. https://doi.org/10.1016/S0277-9536(96)00142-6

Juarez, S. P., Honkaniemi, H., Dunlavy, A. C., Alridge, R. W., Barreto, M .L., Katikireddi, S. V., & Rostila, M. (2019). Effects of non-health-targeted policies on migrant health: A systematic review and meta-analysis. *Lancet Global Health, 7*(4), e420-e435. https://doi.org/10.1016/S2214-109X(18)30560-6.

Jönsson, L. E. (1998). *Det terapeutiska rummet. Rum och kropp i svensk sinnessjukvård 1850-1970* [The therapeutic room. Of room and body in Swedish psychiatric asylum care 1850-1970; Doctoral dissertation, Umeå University].

Katsampa, D., Akhter, S. F., Hollander, A. C., Dal, H., Dalman, C., & Kirkbride, J. B. (2021). Inequalities in psychiatric service use and mortality by migrant status following a first diagnosis of psychotic disorder: A Swedish cohort study of 1.3M people.

*Schizophrenia Bulletin Open, 2*(1), sgab009.
https://doi.org/10.1093/schizbullopen/sgab009.

Kingsbury, D. M., Bhatta, M. P., Castellani, B., Khanal, A., Jefferis, E., & Hallam, J. S.
(2018). The personal social networks of resettled Bhutanese refugees during
pregnancy in the United States: A social network analysis. *Journal of Community
Health, 43,* 1028–1036. https://doi.org/10.1007/s10900-018-0518-9

Kirkbride, J. B., Fearon, P., Morgan, C., Dazzan, P., Morgan, K., Murray, R. M., & Jones, P.
B. (2007). Neighbourhood variation in the incidence of psychotic disorders in
Southeast London. *Social Psychiatry and Psychiatric Epidemiology, 42*(6), 438-45.
https://doi.org/10.1007/s00127-007-0193-0.

Kirmayer, L. J. (2010). Failures of imagination: The refugee's narrative in psychiatry.
*Anthropology & Medicine, 10*(2), 167-185.
https://doi.org/10.1080/1364847032000122843

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry, 49*(2),
149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J. (2015a). Re-visioning psychiatry. Toward an ecology of mind in health and
illness. In L. J. Kirmayer, R. Lemelson, & C. A. Cummings (Eds.), *Re-visioning
psychiatry. Cultural phenomenology, critical neuroscience, and global mental health*
(pp. 622-660). Cambridge University Press.

Kirmayer, L. J. (2015b). Empathy and alterity in psychiatry. In L. J. Kirmayer, R. Lemelson,
& C. A. Cummings (Eds.), *Re-visioning psychiatry. Cultural phenomenology, critical
neuroscience, and global mental health* (pp. 141-167). Cambridge University Press.

Kirmayer, L. J., Dandeneau, S., Marshall, E., Phillips, M. K., & Williamson, K. J. (2011).
Rethinking resilience from indigenous perspectives. *Canadian Journal of Psychiatry,
56*(2), 84–91. https://doi.org/10.1177/070674371105600203

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally responsive services as a path to equity in
mental healthcare. *Healthcare Papers, 18*(2), 11-23.
https://doi.org/10.12927/hcpap.2019.25925

Kirmayer, L. J. & Minas, H. (2000). The future of cultural psychiatry: an international
perspective. *Canadian Journal of Psychiatry, 45*(5)-438-46.
https://doi.org/10.1177/070674370004500503.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G.,
Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants
and refugees: General approach in primary care. *Canadian Medical Association
Journal, 183*(12), E959–967. https://doi.org/10.1503/cmaj.090292

Kirmayer, L. J., & Sartorius, N. (2007). Cultural models and somatic syndromes. *Psychosomatic Medicine, 69*(9), 832-840. https://doi.org/10.1097/PSY.0b013e31815b002c.

Klefbeck, J. (2007a). Network maps and analysis of the social environment. In B. Holmberg & S. Trygged (Eds.), *Social networking with Russian families in crisis* (pp. 34-50). Department of Social Work, Stockholm University.

Klefbeck, J. (2007b). Theoretical foundations of work with the social network. In B. Holmberg & S. Trygged (Eds.), *Social networking with Russian families in crisis* (pp. 15-28). Department of Social Work, Stockholm University.

Kleinman, A. J. (1980). *Patients and Healers in the Context of Culture.* University of California Press.

Kleinman, A. & Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS Medicine, 3*(10), 1673-1676. https://doi.org/10.1371/journal.pmed.0030294.

Kleinman, A., Das, V., & Lock, M. (1997). Introduction. In A. Kleinman, V. Das, & M., Lock (Eds.), *Social suffering* (pp. ix-xxvii). University of California Press.

Kleinman, A., & Kleinman, J. (1991). Suffering and its professional transformation: toward an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry, 15*(3), 275-301. https://doi.org/10.1007/BF00046540.

Kleinman, A., & Kleinman, J. (1997). The appeal of experiences; the dismay of images; cultural appropriations of suffering in our times. In A. Kleinman, V. Das, & M., Lock (Eds.), *Social suffering* (pp. 1-24). University of California Press.

Kocalevent, R. D., Hinz, A., & Brähler, E. (2013). Standardization of a screening instrument (PHQ-15) for somatization syndromes in the general population. *BMC Psychiatry, 13,* 91. https://doi.org/10.1186/1471-244X-13-91

Kosidou, K., Hellner-Gumpert, C., Fredlund, P., Dalman, C., Hallqvist, J., Isacsson, G., & Magnusson, C. (2012) Immigration, transition into adult life and social adversity in relation to psychological distress and suicide attempts among young adults. *PLoS One, 7*(10): e46284. https://doi.org/10.1371/journal.pone.0046284.

Krippendorff, K. (2004). *Content analysis: An introduction to its methodology* (2nd ed.). Sage Publications.

Krysinska, K., & Lester, D. (2010). Post-traumatic stress disorder and suicide risk: a systematic review. *Archives of Suicide Research, 14*(1), 1-23. https://doi.org/10.1080/13811110903478997

Laban C. J., Gernaat, H. B., Komproe, I. H., van der Tweel I., & de Jong J. T. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease, 193*(12), 825–32. https://doi.org/10.1097/01.nmd.0000188977.44657.1d.

Laban C. J., Komproe I. H., Gernaat, H. B., & de Jong J. T. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 43*(7), 507–15. https://doi.org/10.1007/s00127-008-0333-1.

Lawrence, R. E., Oquendo, M. A., & Stanley, B. (2016). Religion and Suicide Risk: A Systematic Review. *Archives of Suicide Research, 20*(1), 1–21. https://doi.org/10.1080/13811118.2015.1004494

Leavey, G., Guvenir, T., Haase-Casanovas, S., & Dein, S. (2007). Finding help: Turkish-speaking refugees and migrants with a history of psychosis. *Transcultural Psychiatry, 44*(2), 258-274. https://doi.org/ 10.1177/1363461507077725.

Leech, N. L., & Onwuegbuzie, A. J. (2010). Guidelines for conducting and reporting Mixed Research in the field of counselling and beyond. *Journal of Counseling and development, 88*(1), 61-69. https://doi-org.proxy.kib.ki.se/10.1002/j.1556-6678.2010.tb00151.x

Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., & Caan, W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health, 152,* 157-171. https://doi.org/10.1016/j.puhe.2017.07.035.

Lewis-Fernández, R., Aggarwal, N. K., Bäärnhielm, S., Rohlof, H., Kirmayer, L. J., Weiss, M. G., Jadhav, S., Hinton, L., Alarcón, R. D., Bhugra, D., Groen, S., van Dijk, R., Qureshi, A., Collazos, F., Rousseau, C., Caballero, L., Ramos, M. & Lu, F. (2014). Culture and psychiatric evaluation: Operationalizing cultural formulation for DSM-5. *Psychiatry, 77*(2), 130-54. https://doi.org/10.1521/psyc.2014.77.2.130.

Lewis-Fernández, R. & Kirmayer, L. J. (2019). Cultural concepts of distress and psychiatric disorders: Understanding symptom experience and expression in context. *Transcultural Psychiatry, 56*(4):786-803. https://doi.org/10.1177/1363461519861795.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Sage Publications.

Lindh, Å. (2019). *Predicting suicide attempt and suicide – the role of standardised instruments in a psychiatric cohort* [Doctoral dissertation, Karolinska institutet].

Lindqvist, M. (2016). *Speaking about social suffering? Subjective understandings and lived experiences of migrant women and therapists* [Doctoral dissertation, Karlstad University].

Lindqvist, S. (2009/1978). *Gräv där du står.* [Dig where you stand.] [New edition.] Atlas Vintage.

Lipton, F., Cohen, C., Fischer, E., & Katz, S. (1981). Schizophrenia: A network crisis. *Schizophrenia Bulletin, 7*(1), 144-151. https://doi.org/10.1093/schbul/7.1.144.

Llamas, R., Pattison, E. M. & Hurd, G. (1981). Social networks: A link between psychiatric epidemiology and community mental health. *International Journal of Family Therapy, 3,* 180-192.

Lloyd, K. R., Jacob, K. S., Patel, V., St Louis, D., Bhugra, D., & Mann, A. H. (1998). The development of the Short Explanatory Model Interview (SEMI) and its use among primary-care attenders with common mental disorders. *Psychological Medicine, 28*(5), 1231-1237. https://doi.org/10.1017/s0033291798007065.

Maier,T., Schmidt, M., & Mueller, J. (2010). Mental health and healthcare utilisation in adult asylum seekers. *Swiss Medical Weekly, 140,* p.w.13110 https://doi.org/10.4414/smw.2010.13110

Malterud, K. (2011). *Kvalitative metoder i medicinsk forskning. En innføring* (3. utgave). [Qualitative methods in medical research, 3d ed.] Universitetsforlaget.

Maltsberger, J. T. & Buie, D. H. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry, 30*(5), 625-33. https://doi.org/10.1001/archpsyc.1974.01760110049005.

Mann, J. J. (2002). A current perspective of suicide and attempted suicide. *Annals of Internal Medicine, 136*(4), 302–311. https:// doi.org/10.7326/0003-4819-136-4-200202190-00010

Marmot, M. G., Adelstein, A. M., & Bulusu, L. (1984). Lessons from the study of immigrant mortality. *Lancet, 1*(8392), 1455-7. https://doi.org/10.1016/s0140-6736(84)91943-3.

Marsella, A. & Snyder, K. (1981). Stress, social supports and schizophrenic disorders: Toward an interactional model. *Schizophrenia Bulletin, 7*(1), 152-163. https://doi.org/10.1093/schbul/7.1.152.

Meng, L. (2002). Rebellion and revenge: the meaning of suicide of women in rural China. *International Journal of Social Welfare, 11*(4), 300-309. https://doi-org.proxy.kib.ki.se/10.1111/1468-2397.00239

Mezzich, J. E., Kirmayer, L. J., Kleinman, A., Fabrega, H., Parron, D. L., Good, B., Lin, K. M., & Manson, S. (1999). The place of culture in DSM-IV. *Journal of Nervous & Mental Disease, 187*(8): 457-464. https://doi.org/10.1097/00005053-199908000-00001.

Michel, K. (2021). Suicide models and treatment models are separate entities. What does it mean for clinical suicide prevention? *International Journal of Environmental Research and Public Health, 18,* 5301. https://doi.org/10.3390/ ijerph18105301

Michel, K., Dey, P., Stadler, K., & Valach, L. (2004). Therapist sensitivity towards emotional life-career issues and the working alliance with suicide attempters. *Archives of Suicide Research, 8*(3), 203-213. https://doi.org/10.1080/13811110490436792

Michel, K., & Valach, L. (1997). Suicide as goal-directed action. *Archives of Suicide Research, 3*(3), 213-221. https://doi.org/10.1080/13811119708258273

Michel, K., Valach, L., & Gysin-Maillart, A. (2017). A novel therapy for people who attempt suicide and why we need new models of suicide. *International Journal of Environmental Research and Public Health, 14*(3), 243. https://doi.org/10.3390/ijerph14030243.

Mittendorfer-Rutz, E., Hagström, A., & Hollander, A. C. (2020). High suicide rates among unaccompanied minors/youth seeking asylum in Sweden. *Crisis 41*(4), 314–317. https://doi.org/10.1027/0227-5910/a000636.

Morgan, C., Knowles, G., & Hutchinson, G. (2019). Migration, ethnicity and psychoses: evidence, models and future directions. *World Psychiatry, 18*(3), 247-258. https://doi.org/10.1002/wps.20655.

Mulder, C. L., Koopmans, C. L., & Selten, J. P. (2006). Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands. *British Journal of Psychiatry, 188,* 386-91. https://doi.org/10.1192/bjp.188.4.386.

Mäkinen, I. H. (1997a). Are there social correlates to suicide? *Social Science and Medicine, 44*(12), 1919-1929. https://doi.org/10.1016/s0277-9536(97)00016-6.

Mäkinen, I. H. (1997b). *On suicide in European countries: some theoretical, legal and historical views on suicide mortality and its concomitants* [Doctoral dissertation. Stockholm University].

Mäkinen, I. H. & Wasserman, D. (2001). Some social dimensions of suicide. In D. Wasserman (Ed.), *Suicide – an unnecessary death* (pp. 101-108). Martin Dunitz.

National board of health and welfare [Socialstyrelsen]. (1995). *Health care for asylum seekers and refugees. General advice 1995:4.* [Hälso- och sjukvård åt asylsökande och flyktingar. Allmänna råd 1995:4].

National Board of Health and Welfare. (2009). *Public Health Report 2009*, ch.13.

National Board of Health and Welfare. (2018*). Nationella riktlinjer för vård och stöd vid schizofreni och schizofreniliknande tillstånd.* [National guidelines for care and support in schizophrenia and similar conditions.]

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of psychiatric research, 44*(4), 229-35. https://doi.org/10.1016/j.jpsychires.2009.08.006.

Nickerson, A., Liddell, B. J., Keegan, D., Edwards, B., Felmingham, K. L., Forbes, D., Hadzi-Pavlovic, D., McFarlane, A., O'Donnell, M., Silove, D., Steel, Z., van Hooff, M., & Bryant, R. A. (2019). Longitudinal association between trust, psychological symptoms and community engagement in resettled refugees. *Psychological Medicine, 49*(10), 1661-1669. https://doi.org/10.1017/S0033291718002246.

Norredam, M., Olsbjerg, M., Petersen, J. H., Laursen, B., & Krasnik, A. (2013). Are there differences in injury mortality among refugees and immigrants compared with native-born? *Injury Prevention, 19*(2), 100–105. https://doi.org/10.1136/injuryprev-2012-040336

O'Connor, R. C., & Nock, M. K. (2014). The psychology of suicidal behaviour. *Lancet Psychiatry, 1*(1), 73-85. https://doi.org/10.1016/S2215-0366(14)70222-6.

Ozer, E. J, Best, S. R, Lipsey, T. L, & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychological Bulletin, 129*(1), 52-73. https://doi.org/10.1037/0033-2909.129.1.52.

Panagioti, M., Gooding, P., & Tarrier, N. (2009). Post-traumatic stress disorder and suicidal behavior: A narrative review. *Clinical Psychology Review, 29*(6), 471–482. https://doi.org/10.1016/j.cpr.2009.05.001.

Panagioti, M., Gooding, P. A., & Tarrier, N. (2012). A meta-analysis of the association between posttraumatic stress disorder and suicidality: the role of comorbid depression. *Comprehensive Psychiatry, 53*(7), 915-930. https://doi.org/10.1016/j.comppsych.2012.02.009.

Pattison, E. M., & Pattison, M. (1981). Analysis of a schizophrenic social network. *Schizophrenia Bulletin, 7*(1), 135–143. https://doi.org/10.1093/schbul/7.1.135

Pejic, V., Hess, R. S., Miller, G. E., & Wille, A. (2016). Family first: Community-based supports for refugees. *American Journal of Orthopsychiatry, 86*(4), 409-14. https://doi.org/10.1037/ort0000189.

Phillips, M. R., Yang, G., Zhang, Y., Wang, L., Ji, H., & Zhou, M. (2002). Risk factors for suicide in China: A national case-control psychological autopsy study. *Lancet, 360*(9347), 1728–1736. https://doi.org/10.1016/S0140-6736(02)11681-3

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. A meta-analysis. *Journal of the American Medical Association, 294*(5), 602–612. https://doi.org/10.1001/jama.294.5.602

Posselt, M., McIntyre, H., Ngcanga, M., Lines, T., & Procter, N. (2020). The mental health status of asylum seekers in middle- to high-income countries: a synthesis of current global evidence. *British Medical Bulletin, 134*(1), 4-20. https://doi.org/10.1093/bmb/ldaa010.

Priebe, S., Giacco, D., & El-Nagib, R. (2016). *Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region [Internet].* WHO Health Evidence Network Synthesis Reports. WHO Regional Office for Europe.

Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F. D., & Sheikh, J. I. (2003). The Primary Care PTSD Screen (PC-PTSD): development and operating characteristics. *Primary Care Psychiatry, 9*(1), 9–14. https://doi.org/10.1185/135525703125002360

Putman, N., & Martindale, B. (Eds). (2021). *Open dialogue for psychosis. Organising mental health services to prioritise dialogue, relationship and meaning.* Routledge.

Radhakrishnan, R., & Andrade, C. (2012). Suicide: An Indian perspective. *Indian Journal of Psychiatry, 54*(4), 304–319. https:// doi.org/10.4103/0019-5545.104793

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385–401. https://doi. org/10.1177/014662167700100306

Rakfeldt, J., & Strauss, J. S. (1989). The low turning point. A control mechanism in the course of mental disorder. *Journal of Nervous and Mental Disease, 177*(1), 32-37. https://doi.org/10.1097/00005053-198901000-00005

Ratkowska, K. A., & DeLeo, D. (2013). Suicide in Immigrants: An Overview. *Open Journal of Medical Psychology, 2,* 124-133. http://dx.doi.org/10.4236/ojmp.2013.23019 Published Online July 2013.

Rosen, G. (1971). History in the study of suicide. *Psychological Medicine, 1*(4), 267-85. doi: 10.1017/s0033291700042239.

Rivas, C. (2012.) Coding and analysing qualitative data. In C. Seale (Ed.) *Researching society and culture* (3d ed.). Sage Publications.

Rüdell, K., Bhui, K. & Priebe, S. (2009). Concept, development and application of a new mixed method assessment of cultural variations in illness perceptions: Barts explanatory model inventory. *Journal of health psychology, 14*(2), 336-347.https://doi.org/ 10.1177/1359105308100218.

Rudmin, F. (2009). Constructs, measurements, and models of acculturation and acculturative stress. *International Journal of Intercultural Relations, 33*(2), 106-123. https://doi.org/10.1016/j.ijintrel.2008.12.001

Runeson, B. (2010). *Regionalt vårdprogram. Suicidnära patienter* [Regional care programme. Suicidal patients]. Stockholm County Council.

Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Jildevik Adamsson, I., & Waern, M. (2017). Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. *PLoS One, 12*(7), e0180292. https://doi.org/10.1371/journal.pone.0180292.

Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147,* 598-611. https://doi.org/10.1192/bjp.147.6.598.

Salander Renberg. E. (1998). *Perspectives on the suicide problem – from attitudes to completed suicide* [Doctoral dissertation, Umeå University].

Schneidman, E. (1993). *Suicide as psychache. A clinical approach to self-destructive behavior.* Jason Aronson Inc.

Schouler-Ocak, M., Graef-Calliess, I. T., Tarricone, I., Qureshi, A., Kastrup, M. C., & Bhugra, D. (2015). EPA guidance on cultural competence training. *European Psychiatry, 30*(3), 431–440. https://doi.org/10.1016/j.eurpsy.2015.01.012

Schweitzer, R., Melville, F. Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179–187. https://doi.org/10.1080/j.1440-1614.2006.01766.x.

Seikkula, J. (1991). *Perheen ja sairaalan rajasysteemi potilaan sosiaalisessa verkostossa* [The family-hospital boundary system in the social network] [Doctoral dissertation, Jyväskylä University].

Seikkula, J. (1996). *Öppna samtal: från monolog till levande dialog i sociala nätverk.* Bokförlaget Mareld.

Selten, J. P., Cantor-Graae, E., Slaets J., & Kahn, R. S. (2002). Odegaard's selection hypothesis revisited: schizophrenia in Surinamese immigrants to The Netherlands. *American Journal of Psychiatry, 159*(4), 669-71. https://doi-org.proxy.kib.ki.se/10.1176/appi.ajp.159.4.669

Selten, J. P., van der Ven, E., & Termorshuizen, F. (2020). Migration and psychosis: a meta-analysis of incidence studies. *Psychological Medicine, 50*(2), 303–313. https://doi.org/10.1017/S0033291719000035

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G. M. (1998). The Mini-international neuropsychiatric interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry, 59*(suppl. 20), 22–33.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations and refugee trauma: towards an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4), 200-207. https://doi.org/10.1097/00005053-199904000-00002.

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention : international journal of mental health, psychosocial work, and counselling in areas of armed conflict, 11*(3), 237 - 248. https://doi.org/10.1097/WTF.0000000000000005

Simpson, G. (2002). Editor's introduction. The aetiology of suicide. In E. Durkheim & G. Simpson, *Suicide: A study in sociology* (pp. xiii-xxxii). Routledge. (Original work published 1897).

Souza, M. H. N., Souza, I. E. O, & Tocantins, F. R. (2009). The use of social network methodological framework in nursing care to breastfeeding women. *Revista Latino-Americana de Enfermagem, 17* (3), 354–60.  https://doi.org/10.1590/S0104-11692009000300012

Spallek, J., Reeske, A., Norredam, M., Smith Nielsen, S., Lehnhardt, J., & Razum, O. (2015). Suicide among immigrants in Europe – a systematic literature review. *European Journal of Public Health, 25*(1), 63-71. https://doi.org/10.1093/eurpub/cku121.

Staehr, M. A., & Munk-Andersen, E. (2006). Selvmord og selvmordsadfærd blandt asylansøgere i Danmark i perioden 2001–2003. En retrospektiv undersøgelse. [Suicide and suicidal behavior among asylum seekers in Denmark during the period 2001-2003. A retrospective study]. *Ugeskrift Laeger, 168*(17), 1650-1653.

Starrin, B., Dahlgren, L., Larsson, G., & Styrborn, S. (1997). *Along the path of discovery. Qualitative methods and Grounded Theory.* Studentlitteratur.

Statistics Sweden [Statistiska Centralbyrån]. (2016). *From Finland to Afghanistan – immigration and emigration since 1970 for persons born in different countries.* Demographic reports. Report 2016:1.

Statistics Sweden. (2021). *Foreign-born persons by country of birth and year.* PxWeb (scb.se)  Retrieved on 2 September 2021 from the website www.statistikdatabasen.scb.se

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Journal of the American Medical Association, 302*(5), 537-49. https://doi.org/ 10.1001/jama.2009.1132.

Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science & Medicine, 72*(7), 1149-56. https://doi.org/10.1016/j.socscimed.2011.02.007.

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health and temporary protection on the mental health of refugees. *British Journal of Psychiatry, 188,* 58-64. https://doi.org/10.1192/bjp.bp.104.007864.

Straiton, M., Corbett, K., Hollander, A. C., & Hauge, L. J. (2014). Immigrants' use of primary health care services for mental health problems. *BMC Health Services Research, 14,* 341. https://doi.org/10.1186/1472-6963-14-341.

Straiton, M., Corbett, K., Hollander, A. C., & Hauge, L. J. (2019).  Outpatient mental healthcare service use among women with migrant background in Norway: a national register study. *BMC Health Services Research 19*(1), 944. https://doi.org/10.1186/s12913-019-4788-4.

Strauss, C., & Quinn, N. (1997). *A cognitive theory of cultural meaning.* Cambridge University Press.

Strauss, J. (1989). Subjective experiences of schizophrenia: Toward a new dynamic psychiatry—II. *Schizophrenia Bulletin, 15*(2), 179–187. https://doi-org.proxy.kib.ki.se/10.1093/schbul/15.2.179

Strauss, J. (1996). Subjectivity. *Journal of nervous and mental disease, 184*(4), 205-212.

Sundvall, M. (2011). "Familjen kan aldrig släppa taget" – erfarenheter från familjearbete i ett psykosteam i mångkulturell miljö ["The family can never let go" - experiences from family work in a psychosis team in a multicultural setting]. *Fokus på familien, 39*(3), 196–209. https://doi.org/10.18261/ISSN0807-7487-2011-03-04

Sundvall, M. (2018). Utbildning och vidareutbildning av personal [Training and further training of personnel]. In Svenska psykiatriska föreningen [Swedish Psychiatric Association] *Transkulturell psykiatri. Kliniska riktlinjer och behandling* [Transcultural psychiatry. Clinical guidelines and treatment], (pp. 241-46). Gothia Fortbildning AB.

Svenberg, K. (2011). *Mötet mellan patienten och läkaren - erfarenheter hos somaliska flyktingar och läkare under utbildning* [The meeting between the patient and the doctor - experiences among Somali refugees and medical trainees] [Doctoral dissertation, Gothenburg University].

Swedish Code of Statutes [Svensk författningssamling, SFS] 2008:344. *Lag om hälso- och sjukvård åt asylsökande m.fl.* [Act on Healthcare for Asylum Seekers and others.]

Swedish Migration Agency [Migrationsverket]. (2015). *Statistics retrieved from the Central foreigner data base* [Centrala utlänningsdatabasen].

Swedish Migration Agency. (2021a). *Migration till Sverige/ Historik* [Migration to Sweden/History].  https://www.migrationsverket.se/Om-Migrationsverket/Migration-till-Sverige/Historik.html.

Swedish Migration Agency. (2021b). *Inkomna ansökningar om asyl 2016* [Applications for asylum received 2016]. https:// www.migrationsverket.se

Swedish Migration Agency. (2021c). *Sveriges flyktingkvot* [The Swedish resettlement programme]. https://www.migrationsverket.se

Swedish Migration Agency. (2021d). *Asylsökande till Sverige 2000-2020* [Applications for asylum received 2000-2020]. https:// www.migrationsverket.se

Swedish refugee law center [Asylrättscentrum]. (2021). *Sweden's new migration legislation* [Sveriges nya migrationslagstiftning]. https://sweref.org.

Terhune, J., Dykxhoorn, J., Mackay, E., Hollander, A. C., Kirkbride, J. B, & Dalman, C. (2020). Migrant status and risk of compulsory admission at first diagnosis of psychotic disorder: a population-based cohort study in Sweden. *Psychological Medicine, 1–10.* https:// doi.org/10.1017/S0033291720002068

Tinghög, P., Al-Saffar, S., Carstensen, J., & Nordenfelt, L. (2010). The association of immigrant- and non-immigrant-specific factors with mental ill health among immigrants in Sweden. *International Journal of Social Psychiatry, 56*(1), 74–93. https://doi.org/10.1177/0020764008096163

Tinghög, P., Arwidsson, C., Sigvardsdotter, E., Malm, A., & Saboonchi, F. (2016). *Nyanlända och asylsökande i Sverige. En studie av psykisk ohälsa, trauma och levnadsvillkor. Röda Korsets Högskolas rapportserie 2016:1.* [Newly arrived and asylum seekers in Sweden. A study of mental ill-health, trauma and living conditions. Report from the Swedish Red Cross University College 2016:1]. Röda Korset.

Titelman, D. (2006). Primo Levi's loneliness: Psychoanalytic perspectives on suicide-nearness. *Psychoanalytic Quarterly, 75*(3), 835-58. https://doi.org/10.1002/j.2167-4086.2006.tb00059.x.

Titelman, D. (2021). "On Nomadic Shores Inward": Harry Martinson's journey to late-life suicide. *Psychoanalytic Quarterly, 90,* 235-266. https://doi-org.proxy.kib.ki.se/10.1080/00332828.2021.1882257

Tracy, E. M., & Whittaker, J. K. (1990). The Social Network Map: assessing social support in clinical practice. *Families in society: the journal of contemporary human services, 71*(8), https://doi-org.proxy.kib.ki.se/10.1177/104438949007100802

United Nations High Commissioner for Refugees. (2021). *Global Trends. Forced displacement in 2020.* United Nations High Commissioner for Refugees. Statistics and Demographics section.

Vaage, A. B., Thomsen, P. H., Silove, D., Wentzel-Larsen, T., Van Ta, T., & Hauff, E. (2010). Long-term mental health of Vietnamese refugees in the aftermath of trauma. *British Journal of Psychiatry, 196*(2), 122-5. https://doi.org/10.1192/bjp.bp.108.059139.

Vaishnavi, S., Connor, K., and Davidson, J. T. (2007). An abbreviated version of the Connor-Davidson Resilience Scale (CD-RISC), the CD-RISC2: Psychometric properties and applications in psychopharmacological trials. *Psychiatry Research, 152,* 293–297. https://doi.org/10.1016/j.psychres.2007.01.006

van Bergen, D. D., van Balkom, A. J. L. M., Smit, J. H., & Saharso, S. (2011). ''I felt so hurt and lonely'': Suicidal behavior in South Asian-Surinamese, Turkish, and Moroccan women in the Netherlands. *Transcultural Psychiatry 49*(1), 69–86. https://doi.org/10.1177/1363461511427353.

van Bergen, D., Eikelenboom, M., Smit, J. H., van de Looij-Jansen, P. M., & Saharso, S. (2010). Suicidal behavior and ethnicity of young females in Rotterdam, The Netherlands: rates and risk factors. *Ethnicity and Health, 15*(5), 515-30. https://doi.org/10.1080/13557858.2010.494719

van Bergen, D., Elyem-van Bergeijk, O., & Heredia Montesinos, A. (2021). Attempted suicide and suicide of young Turkish women in Europe and Turkey: A systematic literature review of characteristics and precipitating factors. *PLoS One, 16*(8), e0253274. https://doi.org/10.1371/journal.pone.0253274.

van Oostrum, I. E., Goosen, S., Uitenbroek, D. G., Koppenaal, H., & Stronks, K. (2011). Mortality and causes of death among asylum seekers in the Netherlands, 2002-2005. *Journal of Epidemiology and Community Health 65*(4), 376-383. https://doi.org/10.1136/jech.2009.087064

van Praag, H. H. (2009). The role of religion in suicide prevention. In D. Wasserman & C. Wasserman (Eds.), *Oxford textbook of suicidology and suicide prevention: a global perspective* (pp. 7-12). Oxford University Press.

Wahlberg, A., Källestål, C., Lundgren, A., & Essén, B. (2014). Causes of death among undocumented migrants in Sweden, 1997–2010. *Global Health Action, 7*(1), 24464, https://doi.org/10.3402/gha.v7.24464

Wahlström, L., Michélsen, H., Schulman, A., & Backheden, M. (2013). Support, opinion of support and psychological health among survivors of a natural disaster. *International Journal of Social Psychiatry, 59*(1), 40-7. https://doi.org/10.1177/0020764011423174.

Walker, K. N., Macbride, A., & Vachon, M. L. S. (1977). Social support networks and the crisis of bereavement. *Social science & medicine, 1,* 35-41. https://doi.org/10.1016/0037-7856(77)90143-3.

Wasserman, D. (2001). A stress-vulnerability model and the development of the suicidal process. In D. Wasserman (Ed.), *Suicide – an unnecessary death* (pp. 13-27). Martin Dunitz.

Wasserman, D. & Värnik, A. (2001). Perestroika in the former USSR: history's most effective suicide-preventive programme for men. In D. Wasserman (Ed.) *Suicide – an unnecessary death* (pp. 253-257). Martin Dunitz.

Weiss, M. (1997). Explanatory model interview catalogue (EMI): framework for comparative study of illness. *Transcultural Psychiatry, 34*(2), 235-263. https://doi.org/ https://doi-org.proxy.kib.ki.se/10.1177/136346159703400204.

Westman, J., Sundquist, J., Johansson, L. M., Johansson, S. E., & Sundquist, K. (2006). Country of birth and suicide: A follow-up study of a national cohort in Sweden, *Archives of Suicide Research, 10*(3), 239-248. https://doi.org/10.1080/13811110600582471.

World Health Organisation. (1980). *International classification of diseases* (9th rev., clinical modification).

World Health Organisation. (2014). *Preventing suicide: A global imperative.*

World Health Organisation. (2019). *Suicide in the world. Global health estimates.*

World Medical Association. (2016). *WMA resolution on refugees and migrants.*

Xu, Q. (2017). How resilient a refugee community could be: The Vietnamese of New Orleans. *Traumatology, 23*(1), 56–67. https://doi-org.proxy.kib.ki.se/10.1037/trm0000091

Ødegaard, Ø. (1932). Emigration and insanity. *Acta Psychiatrica et Neurologica Scandinavica* Suppl., 4, 1–206.

Öhlander, M. (Ed.). (2010). *Bruket av kultur. Hur kultur används och görs socialt verksamt.* [Practising culture. How culture is used and made socially effective.] Studentlitteratur.