Mental health encounters between general practitioners and individuals with a refugee background

Help seeking and provision in the resettlement context

Samantha Marie Harris

Thesis for the degree of Philosophiae Doctor (PhD)
University of Bergen, Norway
2022

UNIVERSITY OF BERGEN

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Date of defense: 22.04.2022

Year: 2022

Title: Mental health encounters between general practitioners and individuals with a refugee background

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Print: Skipnes Kommunikasjon / University of Bergen

Scientific environment

This research was conducted as part of my doctoral education at the Department of Psychosocial Science, Faculty of Psychology and the Graduate School of Clinical and Developmental Psychology (CDP) at the University of Bergen (UoB). I was affiliated with the Society and Workplace Diversity research group and my PhD was a part of the 'Clinical Encounters with Refugees Suffering from Mental Health Problems' project.

This research was funded by the Norwegian Research Council (project number: 273645).

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Acknowledgements

During the first year of my PhD, the film Free Solo was aired, which documented Alex Honnold free soloing El Capitan in Yosemite National Park. Climbing this 2307m granite tower without the support of a rope was a feat that many considered impossible and nothing short of suicidal. As I sat in the cinema, my hands shaking in fear for Honnold's life, I also felt surprisingly motivated. If a man can do that, I should be able to complete my PhD. Fortunately, *I* had support...

Some of my most important guides have been my supervisors: Per-Einar Binder, Gro M. Sandal, and Esperanza Diaz. With complementary skill sets and decades of joint experience in a variety of highly relevant and fascinating subjects, you were an ideal supervisory team. Your guidance has always been kind and encouraging, and I cannot thank you enough for all your time and support. Gro, I also want to thank you personally again for offering me this opportunity despite initial language barriers. At this point I must thank and give credit to Ulla Stang Dahl for helping me achieve what I believed was an impossible task: learning enough Norwegian in a matter of weeks to get through a PhD interview and prepare me for this journey.

Vebjørn Ekroll, thank you for accepting my invitation to collaborate on article 2 and for providing not only important and, amazingly, accessible statistical guidance but also occasional German-speaking relief. My work on article 2 benefited hugely from your help. I also want to thank Hege H. Bye for jumping onboard as a 'sparring partner' during our work on article 3. You thankfully became much more than a sparring partner. Working with you has been inspiring and made not only an impact on my work but on me as a researcher. Last, but certainly not least, I want to thank Larry Palinkas. It was a pleasure to have you (virtually) onboard for article 3. Your medical anthropologists' perspective made for a refreshing addition to the group of co-authors. I am still hoping we may get to meet in person one day (ideally in Southern California). To you, and all the co-authors: Thank you for always remaining patient and encouraging.

Not only am I grateful for the support of my supervisors and academic guides, but I am also grateful to my PhD colleagues at the psychology faculty. You are perhaps the only people who really understand what it is to go through this process. Louise, Razieh, Thea, Valeria, and Vivian: it is clearly insufficient to call you colleagues. I feel so lucky to have landed in an academic environment where I can genuinely call my colleagues *friends*, and in addition: well-positioned allies.

To the current and previous members of the Society and Workplace Diversity research group, including, but not limited to, Clovis, David, Dixie, Eugene, Hajra, Iphigenia, Kristin, Michalis, Shahnaz, Synnøve, Tonje, and Tuva. Thank you for all the thought-provoking discussions. It has been an honour to work alongside you and learn from your individual, unique perspectives. I hope to continue collaborating with you in the future.

I could not complete this section without mentioning our fantastic reference group. Your thoughts and perspectives kept our research grounded and relevant. Thank you for drawing on your work and lived experience and dedicating your valuable time to improving our research.

In addition to the academic support I have received, I also want to thank other friends and my loved ones for their emotional support.

The climbing metaphor becomes particularly meaningful thanks to my climbing tribe: Alicia, Jesse, Linn, and Maaike (also with special thanks to Franck and Thyra and the rest of the extended G-house and climbers – there are too many of you to mention but you know who you are!). Your supportive encouragements at the crag ('trust your feet') echoed in my mind when I did not trust my metaphorical feet at work. Thank you also to Emilie, Marianne, and Marita. The last few years of this PhD would have been significantly harder without you. Thanks also to Pedro and Luciana, not only for your academic contribution, but also for our countless discussions over dinner and

cathartic karaoke sessions. I am so grateful l that you have been there throughout this entire journey.

Mama and Papa. Thank you for supporting me unconditionally when I made the daring decision to move to Norway to take on this project. Thank you for sharing my emotional load whenever I felt overwhelmed. You are the safety net that allowed me to take the risks involved in coming here.

Finally, thank you also to my wonderful partner, Soran, for keeping a cool head even when mine was not. Thank you for all the distractions, discussions, solutions, and inspiration. If it weren't for you, I would never have embarked on this journey in the first place. I am so grateful that I did!

Abbreviations

GP	General practitioner
ICD-10	International statistical classification of diseases and related health problems 10th revision
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5th revision
PTSD	Post-traumatic stress disorder
HSCL-25	Hopkins Symptom Checklist 25 items
UNHCR	The United Nations High Commissioner for Refugees
IPL	Immigration Policy Lab (12 item or 24 item)

Definitions

Migrant. According to the UNHCR Master Glossary (UNHCR, 2006), the term migrant has no agreed upon definition, but typically refers to people who voluntarily move across international borders. Where possible, this thesis specifies whether the populations in question are voluntary migrants or forcibly displaced migrants, to avoid perpetuating unclear terminology and risk undermining access to specific legal protections afforded to refugees.

Forcibly displaced person. The definition of forcibly displaced employed in this thesis leans on the UN Guiding Principles on Internal Displacement as 'persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters…' (United Nations Office for the Coordination of Humanitarian Affairs, 2004). In the context of this thesis, we refer to individuals who have crossed national borders. This includes both refugees and asylum-seekers.

Refugee. A refugee is defined in line with the UN General Assembly's 1951 refugee convention (UN General Assembly, 1951) as someone who "…owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [or her] nationality and is unable or, owing to such fear, is unwilling to avail him [or her]self of the protection of that country; or who, not having a nationality and being outside the country of his [or her] former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."

Asylum-seeker. The term asylum seeker refers to individuals who are seeking asylum in a different country on the grounds set out in the 1951 UN General Assembly but have not yet gained asylum.

Abstract

English version

Background. Research suggests that individuals with a refugee background have higher rates of certain mental health problems and unmet mental healthcare needs than non-refugee populations in resettlement countries. The mechanisms underlying these disparities are still being delineated. The general practitioner (GP) plays an important role in refugees' mental healthcare, managing cases of mild to moderate mental health problems within primary care and acting as gatekeeper to specialist services. However, GPs have reported feeling uncertain about working with refugee patients, and it has been suggested that individuals with a refugee background may not necessarily consider the GP as a source of help for mental health concerns, although this may vary based on level of integration in the resettlement society. **The overall aim** of this thesis is to examine how GPs experience and manage the provision of mental healthcare to individuals with a refugee background with a focus on perceived barriers and facilitators. Furthermore, this thesis aims to examine how the GP fits into the larger context of mental health help-seeking preferences among Syrians with a refugee background living in Norway, and the role of integration in considering the GP as a source of help.

Methods. First, we conducted semi-structured interviews with 15 GPs working in Norway, to investigate barriers and facilitators regarding the provision of mental healthcare to individuals with a refugee background. Inspired by the findings from these interviews, we developed and distributed an online experimental survey to GPs in Norway (N=133), to examine whether they made different clinical decisions about simulated clinical consultations with Somali refugee vs. Norwegian patients. Participants were randomized to watch a film vignette of a simulated consultation with either a female Norwegian, female Somali refugee, male Norwegian, or male Somali refugee vignette character, presenting the same symptoms of depression. GPs indicated which diagnoses, assessments, and treatments they would endorse for the patient and

their level of certainty in their decisions. To examine the help-seeking preferences of Syrians with a refugee background living in Norway (N=92), we conducted a combined text vignette and survey design. We explored how the GP fits into the larger context of help-seeking preferences among this sample, what barriers they perceived in accessing help from the GP, and how indicators of integration relate to seeking help from the GP.

Results. The main challenges presented by GPs regarding working with refugees suffering from mental health problems related to language barriers, that refugee patients had different expectations of them than other patients did, that they had different understandings of health and illness than refugee patients, and that GPs felt unprepared to work with this patient group. However, they highlighted that the above-mentioned challenges were improved when they had a trusting relationship with their patient and pointed out that working with refugee patients was meaningful for them. The experimental survey revealed that GPs' clinical decisions about Somali refugee and Norwegian vignette characters displaying identical symptoms of depression were similar, with a few exceptions. There was less consensus regarding the first prioritized diagnosis for Somali characters vs. Norwegian characters. Somalis more frequently received PTSD diagnoses, while Norwegians received diagnoses of feeling depressed. GPs endorsed sick leave more often for Norwegian characters and medication for physical complaints for Somali characters. However, despite having mentioned feelings of uncertainty during the interviews, we found no strong evidence of a substantial difference in GPs' self-reported certainty regarding clinical decisions made about Somali vs. Norwegian vignette characters. Finally, the survey conducted among Syrians with a refugee background found that participants were somewhat likely to seek help from the GP, although it was indicated that seeking help from one's relationship with Allah/God and one's partner was preferred. Furthermore, while the GP was rated a somewhat likely help-seeking source, most participants indicated an average of two barriers to seeking help from the GP. The most common barriers included 'language barriers', 'I don't think it would help', 'the waiting times are too long', and 'I don't think my GP would understand'. Finally, social ties to the majority

population in the form of social integration and feelings of connectedness with the host country (psychological integration) were positively correlated with likelihood of seeking help from the GP.

Conclusions. The findings suggest that GPs and Syrians with a refugee background living in Norway perceive both practical as well as interpersonal barriers to providing, and accessing, mental healthcare. Our findings suggest that even in the absence of barriers and confounding variables, GPs may be influenced by patient characteristics when making clinical decisions, albeit to a small degree. Furthermore, our findings suggest that the GP is considered a viable source of help among Syrians with a refugee background in the current sample, but that their willingness and ability to seek help from the GP may be influenced by perceived barriers. A main take home message from this thesis is the facilitating effect of social connection, both between GP and patient, in the form a trusting relationship, but also regarding the patient's social network in the host country. This suggests that a focus on a trusting relationship and a consideration of the patients' social network may act as a facilitator to being able to offer appropriate mental healthcare, as well as facilitate refugee patients' ability to consider and access this care. Furthermore, findings highlight the impact of psychological integration, i.e., feelings of connectedness with the host country, as a potential facilitator of considering the GP as a viable source of help for mental health problems. Our findings give an important insight into how the GP can be understood in the integration/resettlement process, and what the characteristics are of individuals, who are more or less likely to seek professional help.

Norwegian version

Bakgrunn. Forskning viser at personer med flyktningbakgrunn har høyere forekomst av psykiske lidelser og udekkede behov for psykisk helsevern enn majoritetsbefolkningen. Mekanismene som ligger til grunn for disse forskjellene er fortsatt ikke helt klare. Fastlegene spiller en viktig rolle i flyktningers psykiske helsevern, håndterer tilfeller av milde til moderate psykiske problemer i primærhelsetjenesten og fungerer som døråpner til spesialisttjenester. Fastleger har imidlertid rapportert at de føler seg usikre på det å arbeide med flyktningpasienter. Det har blitt antydet at personer med flyktningbakgrunn ikke nødvendigvis anser fastlegen som en kilde til hjelp for psykiske helseproblemer, selv om dette kan variere basert på integreringsnivå i det nye landet. Målet med denne doktorgraden er å undersøke hvordan fastleger opplever og håndterer kliniske møter med flyktninger som har psykiske lidelser, og i hvilken grad flyktninger selv vurderer fastlegen som en kilde for hjelp i slike situasjoner.

Metoder. Først gjennomførte vi semistrukturerte intervjuer med 15 fastleger i Norge, for å undersøke hva de syntes sto i veien for, eller hjalp, det å kunne gi effektiv psykisk helsehjelp til personer med flyktningbakgrunn. Inspirert av funnene fra intervjuene utviklet og distribuerte vi en nettbasert eksperimentell undersøkelse, for å undersøke om fastleger (N=133) tok ulike kliniske beslutninger om simulerte kliniske møter med somaliske flyktninger vs. norske pasienter. Deltakerne ble randomisert til å se en kort filmsnutt av enten en kvinnelig norsk, kvinnelig somalisk, mannlig norsk eller mannlig somalisk vignettkarakter, som presenterte de samme symptomene på depresjon. Vi spurte fastleger til å angi hvilke diagnoser, vurderinger og behandlinger de ville ha valgt for pasienten og deres grad av sikkerhet i den beslutningen. For å undersøke preferansene til å søke psykisk helsehjelp blant syrere med flyktningbakgrunn i Norge (N=92), gjennomførte vi en undersøkelse hvor syriske deltakere leste en vignette som beskrev personer som viste symptomer på depresjon. Etterpå spurte vi deltakerne til å angi hvor de hadde søkt hjelp, dersom de følte seg

som vignettekarakteren. Vi spurte også om hvilke barrierer de oppfattet som kunne stå i veien for å søke hjelp fra fastlegen. Til slutt undersøkte vi hvilken rolle deltakernes integrering spilte i deres sannsynlighet til å søke hjelp fra fastlegen. **Resultater.** Hovedutfordringene fastlegene beskrev og fortalte om i intervjuene var knyttet til språkbarrierer, at flyktningpasienter hadde andre forventninger til helsetjenestene enn andre pasienter, at fastleger hadde en annen forståelse av helse og sykdom enn flyktningpasienter, og at fastlegene følte seg uforberedt til å jobbe med denne pasientgruppen. Utfordringene lettet imidligertid når de hadde fått bygge et tillitsfullt forhold til pasienten sin og påpekte at arbeidet med flyktningpasienter var meningsfullt. Den eksperimentelle undersøkelsen viste at fastlegenes kliniske beslutninger om somaliske og norske vignettkarakterer var like, med noen få unntak. Det var mindre enighet om den første prioriterte diagnosen for somaliske karakterer vs. norske karakterer. Somaliere var de eneste som fikk PTSD-diagnoser, mens nordmenn oftere fikk diagnosen 'feeling depressed'. Fastlegene foreslo oftere å skrive ut sykemelding for norske karakterer, og oftere medisiner for fysiske plager for somaliske karakterer. Til tross for å ha nevnt følelser av usikkerhet under intervjuene, fant den eksperimentelle undersøkelsen ingen vesentlige forskjeller i fastlegenes selvrapporterte sikkerhet angående kliniske avgjørelser tatt for somaliske vs. norske vignettkarakterer. Til slutt fant undersøkelsen utført blant syrere med flyktningbakgrunn at deltakerne beskrev noe sannsynlighet for å søke hjelp fra fastlegen for psykiske plager, selv om det ble indikert at det å søke hjelp fra Allah/Gud og ens partner var foretrukket. Videre, mens fastlegen ble vurdert som en noe sannsynlig kilde for hjelp, anga de fleste deltakerne i gjennomsnitt to barrierer for å søke hjelp hos fastlegen. De mest indikerte barrierene inkluderer «språkbarrierer», «Jeg tror ikke det ville hjelpe», «ventetidene er for lange» og «Jeg tror ikke fastlegen min ville forstå». Til slutt var sosiale tilknytning til majoritetsbefolkningen i form av sosial integrasjon og følelser av tilknytning til det nye landet (psykologisk integrasjon) positivt korrelert med sannsynligheten for å søke hjelp hos fastlegen. **Konklusjoner.** Funnene tyder på at fastleger og pasienter oppfatter både praktiske og mellommenneskelige barrierer i det å gi eller få psykisk helsehjelp. Funnene våre

tyder også på at selv i situasjoner der barrierer og andre faktorer ikke spiller inn, kan fastleger bli påvirket av pasientens bakgrunn og kjønn når de tar kliniske beslutninger, men bare i liten grad. Videre tyder våre funn på at fastlegen anses som en aktuell kilde til psykisk helse hjelp blant syrere med flyktningbakgrunn i utvalget vårt, men at deres vilje og evne til å søke hjelp hos fastlegen kan være påvirket av opplevde barrierer. Et hovedbudskap fra denne doktorgraden er den gode effekten av sosial tilknytning, både mellom fastlege og pasient, i form av et tillitsfullt forhold, men også når det gjelder pasientens sosiale nettverk i det nye landet samt følelser av tilknytning til det nye landet. Dette tyder på at det å legge vekt på å bygge et tillitsfullt forhold og å ta hensyn til pasientenes sosiale nettverk kan bidra til å kunne gi bedre psykisk helsehjelp, samt å legge til rette for flyktningpasienters mulighet til å få tilgang til denne omsorgen. Våre funn gir videre et viktig innblikk i hvordan det å gå til fastlegen kan forstås i flyktningens integrerings-/bosettingsprosessen, og hvem som har mindre sannsynlighet for å søke profesjonell psykisk helsehjelp.

List of Publications

Paper 1:

Harris, S. M., Binder, P. E., & Sandal, G. M. (2020). General practitioners' experiences of clinical consultations with refugees suffering from mental health problems Running title: GP consultations with refugees. Frontiers in Psychology, 11, 412.

Paper 2:

Harris, S. M., Binder, P. E., Diaz, E., Ekroll, V., Sandal, G. M. General Practitioners' management of depression symptoms in Somali refugee and Norwegian patients: A film vignette experiment. (*under review*).

Paper 3:

Harris, S. M., Sandal, G. M., Bye, H., Palinkas, L. A., Binder, P. E., (2021). Integration is correlated with mental health help-seeking from the general practitioner: Syrian refugees' preferences and perceived barriers. Frontiers in Public Health. (*in press*)

Contents

1. Introduction

1.1 Purpose and scope of the thesis

In this thesis, I examine different aspects of the inter-cultural mental health encounter between the general practitioner (GP) and individuals with a refugee background. The aim of the thesis is to identify areas for improvement in the provision of healthcare to individuals with a refugee background and to shed light on possible mechanisms underlying inequities in mental health and healthcare. I do so, by taking into consideration both the perspective of the GP as well as individuals with a refugee background. First, I focus on barriers and facilitators perceived by GPs in providing mental healthcare to patients with a refugee background. Inspired by findings from these interviews, I then examine systematic variations in GPs' clinical decisions based on patient characteristics, i.e., background and gender. To take into consideration the refugee perspective, I explore to what extent the GP is considered a viable source of mental health help among Syrians with a refugee background in Norway and examine variables and barriers which influence the likelihood of seeking help from the GP. The thesis will address the following overarching research questions:

What facilitates, influences, and hinders GPs' provision of mental healthcare to refugees in Norway? Where do Syrian refugees prefer to seek mental health help in Norway, and what influences and stands in the way of their seeking help from the GP?

1.2 Background

In 2015, Norway experienced a sharp rise in asylum applications marking the peak of the refugee crisis (Statistics Norway, 2016). Norway received over 30,000 asylum applications that year, a large surge compared to the already unusually high 11,480 in 2014 (UDI, 2014). At this time, the majority of refugees arrived from Somalia, Syria,

Afghanistan, Iraq, Eritrea, and Ethiopia (Statistics Norway, 2016). Once refugees are officially settled in a Norwegian municipality they have the same rights as Norwegian citizens, including being entitled to healthcare, and have the right to being allocated a GP. GPs are often the first line of contact for refugees for both physical and mental healthcare (Lu et al., 2020; WHO, 2008). They manage many cases of mental health problems within primary care and act as gatekeepers to secondary, specialist services.

The Norwegian public healthcare system is characterised by universal health coverage for all residents, although individuals make modest co-payments for different services. Services covered by universal healthcare include primary care, hospital care, and mental healthcare. Enrolment in universal healthcare is automatic, meaning that all residents have the right to state funded primary healthcare. GPs are trained to manage mild to moderate cases of mental health problems (within primary care) and play a large role in determining appropriate preliminary diagnoses, assessments, treatments, and referrals for patients (Hunskår, 2013). It is recommended that the GP employ a psychotherapeutic approach, for example cognitive behavioural, when treating mental health problems in primary care (Hunskår, 2013). Collaboration with, or referral to, a psychiatrist is indicated in cases where there is little response within 4-6 weeks and substantial side effects from medication, relapse within one year, evidence of psychotic disorders, suicidality, severe depression, pregnancy, patient's requesting referral, and patient's inability to take sufficient care of themselves (Hunskår, 2013).

Studies consistently suggest that refugees have poorer general mental health (Porter & Haslam, 2005; Straiton et al., 2017) and suffer specifically from higher rates of anxiety, depression (Lindert et al., 2009), post-traumatic stress disorder (PTSD) (Fazel et al., 2005; Richter et al., 2018), and non-affective psychoses (Hollander et al., 2016) than non-refugee migrants or the majority population of the resettlement country. This is often attributed to refugees' experiences pre, during and post migration. Such experiences include war, torture, cultural integration issues, the loss

of family and community support, discrimination and adverse political climate, loneliness and boredom, prohibition to work, and disruption of education for children (Kirmayer et al., 2011; Miller & Rasmussen, 2010; Sijbrandij et al., 2017). Prolonged delays in being granted asylum, extended stays in relocation centres, multiple dislocations, and the lack of recognition of degrees and other qualifications have also been shown to increase levels of stress (Sijbrandij et al., 2017). It is important, however, to note that refugees' mental disorders have been found to change with time spent in the resettlement country (Butler et al., 2015).

Health professionals have reported finding it challenging to provide healthcare to refugees and other non-refugee migrants due to their psychosocial problems and distinct cultural and religious conceptualisations of mental health (Cavallera et al., 2016; Terraza-Nunez et al., 2011), which may include the belief that mental illness is the result of spiritual possession or of being a bad Muslim (Guerin et al., 2004; Markova & Sandal, 2016). A survey from 2009 found that 28% of GPs in Norway rated their competence of working with refugees as low, and 29% disliked working with this patient group (Varvin & Aasland, 2009). It is also important to note that general practice in Norway is not without its challenges. According to the Journal of the Norwegian Medical Association (Tidsskrift den Norske Legeforening), Norway has struggled to recruit and retain GPs (Birkeli et al., 2020), who have reported professional exhaustion and demoralization (Kjosavik, 2018). This backdrop highlights how improving healthcare must consider both the practitioner's and the patient's perspectives and circumstances.

Previous literature has focused heavily on delineating the prevalence of mental disorders among refugee populations and examining disparities in healthcare (Fazel et al., 2005; Hollander et al., 2016; Lindert et al., 2009; Porter & Haslam, 2005; Richter et al., 2018; Straiton et al., 2017). However, less attention has been paid to what occurs in clinical consultations, including GPs' clinical decisions, which may provide an insight into possible mechanisms underlying disparities in healthcare. It has been

shown, for example, that a patients' country of birth (described in the article as 'Norway', 'Western', 'Non-Western'[1]) and gender systematically influence GPs' clinical decisions (Øyeflaten et al., 2020). Øyeflaten and colleagues found that individuals born in 'non-Western' (not further specified in the article) countries received insufficient follow-up for sick-leave compared to those born in Norway (Øyeflaten et al., 2020). Variation in GPs' clinical decisions about minority vs. majority population groups have sometimes been attributed to discrimination (Kumar & Diaz, 2019; McGuire et al., 2008) and, mainly in the US, racism (Hall et al., 2015; Mikuls et al., 2005). However, a theory that is rarely considered is the impact of health professional clinical uncertainty on clinical variation, although it has previously been suggested that higher clinician uncertainty leads to larger clinical variation (Adams et al., 2014; Eddy, 1984). This is important in the context of inter-cultural consultations as previous literature shows that practitioners have reported feeling uncertain and unsure about their clinical decisions regarding patients with a refugee background (Grut et al., 2006; Pieper & MacFarlane, 2011).

Ultimately, this thesis is interested in identifying areas for improvement in the provision of mental healthcare to individuals with a refugee background. While the GP plays a vital role in this process, it is also crucial to gain the perspective of the potential service users. The thesis has focused on the perspective of Syrians with a refugee background living in Norway. Syrians make up one of the largest groups of recently arrived refugees in Norway (Statistics Norway, 2017). There has been relatively extensive research conducted on other refugee groups' help-seeking preferences and their interactions with Scandinavian health services (Ahrne et al., 2019; Byrskog et al., 2015; Fangen, 2006; Kuittinen et al., 2017; Madar et al., 2020; Markova et al., 2020). Since the 2015/16 refugee crisis, research regarding Syrian refugees' help-seeking behaviours and preferences in Norway are gaining momentum. A recent longitudinal study, for example, found that Syrian refugees' use

[1] A critical discussion of the terms 'Western' vs. 'Non-Western' is presented in Section 5.3.

of the GP increased from 33% to 85% upon arrival to Norway from Lebanon, while use of emergency services and hospitalizations remained the same (Haj-Younes, Stromme, et al., 2021). This suggests that the GP is an important source of help for Syrian refugees in Norway, more so than in Lebanon. However, to what extent Syrian refugees consider the GP as a source of help for mental health problems in comparison to other formal and informal sources, and the characteristics of individuals that are more, or less, likely to seek professional mental health help is not clear.

To better understand the situation of Syrian refugees in Norway, it is important to briefly address the context from which they fled as well as the context into which they arrived. In 2011, pro-democracy demonstrations swept across Syria in protest of authoritarian president Bashar al-Assad. Due to a variety of economic problems, as well as Assad's use of force to quash demonstrations, a civil war broke out. In 2021, the war in Syria entered its 10th year. The majority of the 6 million Syrians that were forcibly displaced were, and are, hosted in neighbouring countries. However, Syrian refugees also make up one of the largest groups of newly arriving refugees to European countries. According to data from Statistics Norway (personal correspondence, 2021), over 32,000 Syrian refugees and family reunification cases moved to Norway between 2000 and 2021. This makes Syrian refugees an important group to consider in terms of their health and access to health services, and the role of integration becomes particularly pertinent as many are currently going through the beginning stages of navigating the cultural context of their resettlement country.

It is important also to briefly examine the Norwegian context into which refugees enter and how integration has been understood here. Prior to the 1970s, Norway was considered a culturally relatively homogeneous country in terms of integration (Hagelund, 2002; Norges offentlige utredninger, 2017). This is not to say that Norway is, or has been, entirely homogeneous. The country has previously had immigrants, including but not limited to the Hanseatic times, as well as cultural

diversity with regards to the indigenous Sami tribes. However, it wasn't until the arrival of labour migrants from Pakistan, Turkey, and Morocco in the 1970s and 80s that the issue of diversity and its implications became highly relevant, and indeed politicized (Hagelund, 2002). In the last 20 years, immigration to Norway has been one of the highest per capita compared to other OECD countries (Norges offentlige utredninger, 2017). As a result, the make up of the Norwegian population has changed markedly, and the proportion of individuals with a migrant background has increased substantially (Norges offentlige utredninger, 2017). This makes Norway a particularly interesting context in which to examine healthcare provision to, and help-seeking among, refugees with a specific focus on integration.

In 2018 the Norwegian Ministry of Education released the white paper 'Integration through knowledge', which outlined their immigrant integration strategies, with a heavy focus on integration into the job market (Kunnskapsdepartementet, 2018). This document suggested that integration was seen mostly in terms of how immigrants can become economically viable members of society. It has been suggested that integration in Norway works reasonably well with regards to income, education, and labour market participation, however disparities between majority and minority population persist (Straiton et al., 2019; Straiton et al., 2017; Søholt & Tronstad, 2020). This may present concerns for the Norwegian welfare state, which aims for equality of both rights and duties to participate for everybody, irrespective of origin (Hagelund, 2002).

The importance of examining Syrian refugees' needs and help-seeking preferences is highlighted by international literature, which suggests that they may experience high levels of unmet mental health needs (Fuhr et al., 2020), and that these may relate to a variety of barriers to seeking and accessing healthcare (Kohlenberger et al., 2019; Renner et al., 2020; Sijbrandij et al., 2017). However, based on the differences in healthcare services across countries we cannot assume that international findings are translatable to a Norwegian context. In line with the UNs Sustainable Development

Goals #3 and #10, 'Good health and well-being' and 'Reduced Inequalities', it is important to explore and understand issues that may underlie health inequities, unequal access, and treatment in healthcare related to cultural differences and individuals' backgrounds in Norway.

I would like to finish this section by highlighting that some individuals who are experiencing mental distress will, of course, not require the support of their GP and are well served by non-professional sources of help. This thesis does not claim that the GP is the only appropriate source of help. However, considering the GP as a viable source of help can offer individuals a broader variety of choices for seeking help. Additionally, given the important role of the GP in the Norwegian healthcare system, it is important to identify to what extent barriers may stand in the way of individuals accessing and receiving appropriate professional healthcare.

1.3 The research project

The thesis includes three studies that were conducted as part of the overarching Norwegian research council funded project 'Clinical encounters with refugees suffering from mental health problems'. This overarching project includes several sub-projects examining explanatory models, i.e., explanations or understandings of episodes of illness and their treatment framed within the context of the cultural beliefs and norms (Kleinman, 1981), coping strategies, i.e., constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984), and help-seeking, i.e., behaviors involving a request for assistance from informal or formal support with the purpose of resolving, for example, health problems (Unrau & Grinnell, 2005), among Somali, Syrian, and Afghan refugees. Furthermore, the project examines experiences and clinical decisions of the GPs working with these patient groups through qualitative and quantitative methods. The overarching project is motivated by the challenges of providing efficient mental

health services to refugee and other non-refugee migrant groups in Norway and aims to contribute to the development of equitable mental healthcare. This thesis and the three papers described here focus on the second part of the overarching project, the experiences and clinical decisions of GPs, as well as an aspect of the first sub-project regarding help-seeking preferences of Syrians with a refugee background.

1.4 The structure of the thesis

The three papers in this thesis inform and complement one another with varying perspectives and methodologies to shed light on the mechanisms that influence GPs' provision of help to individuals with a refugee background as well as help-seeking preferences of, specifically, Syrian refugees in Norway. The thesis begins with a qualitative exploration of GPs' experiences of providing mental healthcare to individuals with a refugee background, with a specific focus on their perceived barriers and facilitators. Inspired and informed by the findings in paper 1, paper 2 presents an experimental survey study, which explores whether patient characteristics, i.e., background and gender, systematically influence GPs' clinical decisions and examines the role of uncertainty on the part of the GP. Papers 1 and 2, thereby, approach the following overarching research question using mixed methods: how do GPs experience consultations with refugee patients suffering from mental health problems and what influences their clinical decisions?

Paper 3 addresses the refugee perspective and explores how the GP fits into the larger context of help-seeking sources for mental health considered by Syrians with a refugee background, what barriers they perceive to accessing mental healthcare from the GP, and the role of integration. The barriers identified by participants in paper 3 provide a complementary perspective and an extension to the barriers identified by GPs in paper 1. The structure of the thesis is visualized in Figure 1.

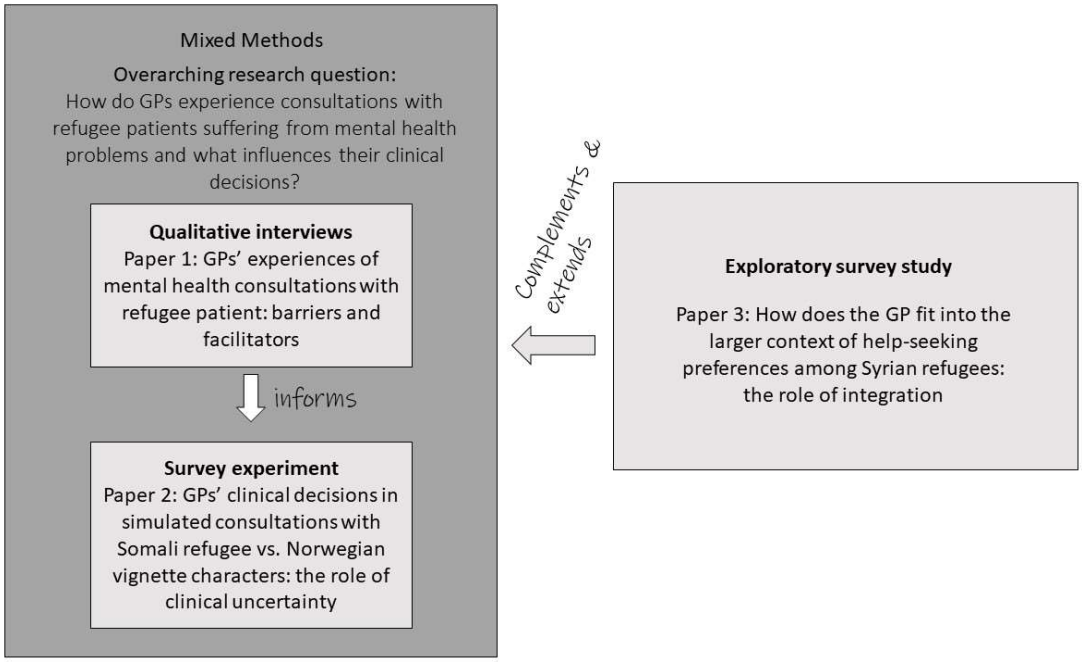

Figure 1. The structure of the thesis, including papers 1 and 2 (mixed methods) and paper 3.

In the following section I will introduce the concept of culture and how it pertains to the current work. Then, I describe previous literature relevant to papers 1, 2, and 3 and justify the need for each of these studies.

1.5 The role of culture in health and healthcare encounters

> *Engagement with the idea of culture can enable a change in health-care planning and delivery, from a focus on medical technocracy to humanity; from biomedical cures to the uses and misuses of such potential cures; and from often unrealistic magic bullet research to improved wellbeing.*
>
> - (Napier et al., 2014, p. 27)

The main underlying assumption of this thesis is that cultural context plays a role in how we understand, experience, and communicate mental health, and as a result, in

help-providing and help-seeking preferences and behaviours (Bhui & Dinos, 2008; Gone & Kirmayer, 2010; Kirmayer, 2012; Kirmayer et al., 2011; Kirmayer et al., 2015). According to Jahoda (2012):

> …much of the time it is quite practicable and defensible simply to use the term ['culture'] without seeking to define it. However, if either for a theoretical or empirical reason clarification is essential, then the author should explain the specific manner in which she employs the term 'culture' in that particular context (p. 300).

Defining what is meant by the term 'culture', in for example inter-cultural[2] clinical encounters, ensures that we are not in fact referring to a range of other concepts, as pointed out by Brumann (1999), such as ethnicity, identity, locality, community, society, group, or tribe. Although it is important to note that while culture ought not to be equated with geographic region or nation (Kirmayer, 2012), it is often demarcated as such (Hong, 2009; Jahoda, 2012).

The term culture is furthermore useful, as it allows us to:

> Bring together race, ethnicity and ways of life under one broad rubric to examine the impact of social knowledge, institutions and practices on health, illness and healing. (Kirmayer, 2018, p. 3)

Over time, there have been developments in our understanding of culture. Initially culture was understood as what we now think of as 'high culture', i.e. being cultured, which was a characteristic held only by a subsection of the society (Arnold, 1867; Spencer-Oatey, 2012). A few decades later, culture was recognized as something that

[2] Note that in this thesis we employ the term inter-cultural to refer to interactions between doctors and patients from different cultures (Tseng, 2001). The term trans-cultural is mostly used in psychiatry to stress applications through cultural barriers, while cross-cultural is mostly used within psychology to refer to cross-cultural comparisons. Note that this was not followed in paper 1, in which we refer to clinical encounters between GPs and refugees as 'cross-cultural'.

was possessed by everyone, but still as existing on a continuum between 'civilized' and 'savage' (Spencer-Oatey, 2012; Tylor, 1924). It wasn't until the 20th century, when Franz Boas and his students pioneered a way of thinking about culture as something that was not associated with values such as good or bad, that we ended up with the view of culture that most resembles our current understanding and the one this thesis subscribes to, i.e. cultures should not be understood as lying on a continuum from high to low/better to worse (Spencer-Oatey, 2012).

I will first discuss culture in general to clarify how it can be understood and why it might be relevant in health, before examining more carefully the specific role of culture in health. A common analogy to describe culture is that it is to humans as water is to fish. In other words, we 'swim' in a cultural context that we are not explicitly aware of, but which influences the way we experience, and interact with, the world around us. This metaphor is relevant in terms of illustrating culture's implicit impact on us but is insufficient in other ways. It does not, for example, illustrate the impact of different cultural contexts on individuals. Nor does it allude to the fact that culture is learned. This thesis, therefore, considers culture more in line with Hofstede's metaphor, who proposes that culture can be thought of like the software of the mind, or collective programming of the mind, which lies within one's social environment and in the context within which one grew up and collected one's life experiences (Hofstede et al., 2010).

While it is beyond the scope of the thesis to review all definitions of culture ever proposed, Gustav Jahoda (2012) has provided a useful overview over some of the more recent definitions. He classifies these into those that present culture as external, internal, and those that present it as both internal and external. For example, he cites Shalom Schwartz's definition as an example of a definition of culture as external:

> I view culture as a latent, hypothetical variable that we can measure only through its manifestations. The underlying normative value emphases that are central to culture influence and give a degree of coherence to these

> manifestations. In this view, culture is outside the individual. It is not located in the minds and actions of individual people. Rather, it refers to the press to which individuals are exposed by virtue of living in a particular social system. (Schwartz, 2009, p. 128 in Jahoda, 2012)

Schwartz's definition presents culture in terms of its measurable manifestations, which he later points out include, for example, themes of children's literature, movies, books, and legal systems (Jahoda, 2012; Schwartz, 2009). Schwartz's definition of culture as something purely external stands in contrast to other definitions, which see culture as beliefs and/or styles of thinking (Hong, 2009; Napier et al., 2014; Schwartz, 2009; Singer et al., 2016; Tseng, 2001). Instead, he claims, pressures and 'primes' from the environment encourage certain behaviours. However, this does not sufficiently account for the dynamic nature of culture, how it is acquired, and how it can change within an individual because of, for example, migration, including the influence of two cultural contexts on a single individual.

Alternatively, Tseng (2012) presents culture as both external *and* internal:

> The behavior patterns and lifestyle shared by a group of people, which is unique and different from that of other groups; it is the totality of knowledge, customs, habits, beliefs, and values that shape behaviors, emotions, and life patterns. (Tseng, 2001, p. 3)

Tseng's definition recognizes the interplay of external and internal elements of culture, by presenting culture both as beliefs and the resulting behaviours. However, Tseng's definition does not address how culture is acquired, a pertinent element when considering how an individual may adopt or be influenced by a new cultural context following migration. Another alternative definition, presented by Hong addresses both the internal/external nature of culture, as well as how it is acquired, by describing culture as:

> . . . networks of knowledge consisting of learned routines of thinking, feeling, and interacting with other people, as well as a corpus of substantive assertions and ideas about aspects of the world . . . it is . . . shared . . . , among a collection of interconnected individuals who are often demarcated by race, ethnicity, or nationality; (b) externalised by rich symbols, artefacts, social constructions, and social institutions (e.g. cultural icons, advertisements and news media); (c) used to form the common ground for communication among members; (d) transmitted from one generation to the next . . . ; (e) undergoing continuous modifications . . . (Hong, 2009, p. 4 in Jahoda, 2012)

This definition recognizes the fact that culture is learned, overlapping with other characteristics, such as nationality, and that it influences how we interpret and behave. Furthermore, it recognizes the fact that culture is dynamic and constantly undergoing modifications, and leaves room for the idea that individuals may be influenced by several cultural contexts simultaneously.

Based on the above-mentioned aspects of culture, it becomes clear that culture may play a role in health. The 'learned routines of thinking, feeling, and interacting with people', which 'form the common ground for communication among members' (Hong, 2009), can have important implications for the communication that occurs in healthcare encounters. The importance of considering culture in health is illustrated by Napier and colleagues:

> For many people concerned about global health, culture is less important than addressing political and socioeconomic inequality, even perhaps a thing best de-emphasised, if not wholly forgotten. We completely disagree. Worldwide equality can only be achieved by recognising cultural systems of value and countering the idea that local cultures are obstacles to worldwide equality. (Napier et al., 2014, p. 1611)

Singer and colleagues (2016) conducted a multidisciplinary effort to find consensus on essential elements of culture in the context of health and health behaviours. A lack of such a definition, it has been argued, has significantly hampered our ability to explain health disparities between minority and majority groups (Napier et al., 2014; Singer et al., 2016). They propose two definitions of culture, on the one hand that culture ought to be seen as what it is and on the other what it does. They argue that culture is:

> …an internalized and shared schema or framework that is used by group (or subgroup) members as a refracted lens to "see" reality, and in which both the individual and the collective experience the world. (p. 242)

In terms of what culture does, they state:

> Cultural tools enable group members to make sense of their world and to find meaning in and for life by providing a sense of safety and wellbeing, integrity, and belonging as a contributing member of one's social network. (p. 242)

Similarly, Napier recommends a broad view of culture that sees culture as consisting of both social systems of beliefs, as well as presumptions of objectivity that influence health and healthcare (Napier et al., 2014). They see culture as:

> Not only habits and beliefs about perceived wellbeing, but also political, economic, legal, ethical, and moral practices and values. (Napier et al., 2014, p. 1)

These definitions mostly agree with more general definitions of culture as something that is to some extent internal and external, influences interpretation, is dynamic, and constantly evolving (Hong, 2009; Napier et al., 2014; Schwartz, 2009; Singer et al., 2016; Tseng, 2001). However, they also extend these general definitions by highlighting that in the context of health, culture is a collective experience that contributes to feelings of safety, wellbeing, as well as being represented in 'political,

economic, legal, ethical, and moral practices and values' (Napier et al., 2014). As a result, Napier and colleagues claim that

> Health should be promoted more broadly, encompassing positive wellbeing, its origins in cultural value systems, and its maintenance through social processes that affect biological wellness (Napier et al., 2014, p. 24)

Napier (2014) suggest that in line with a focus on culture in health and healthcare clinical culture must be reshaped so that culture takes a central role in healthcare provision. They highlight that intercultural health communication is not just about bridging language barriers, but requires an exploration of people's beliefs about health and healthcare (Napier et al., 2014). Lacking such an exploration of cultural system of value in health, including one's own and one's patient's beliefs, and focusing heavily on biological wellness as the only indicator of wellbeing may lead to the erosion of culture as a key component in health maintenance and promotion (Napier et al., 2014).

While definitions are helpful when aiming to conceptualize culture, in this thesis the aim is not to study culture itself, but rather to see it as the backdrop and an underlying assumption as to why we might expect inter-cultural consultations to be different from other consultations. In this sense, it may be unhelpful to see culture in terms of a definition, particularly while there is no consensus regarding the most appropriate definition of culture. Consequently, this thesis cautiously orients itself as seeing culture in terms of key characteristics that are relevant in the context of health on which there is some consensus (Spencer-Oatey, 2012):

- Culture is manifested at different layers of depth: observable artifacts (such as dress code), values, and underlying assumptions. The latter are most relevant in the context of this thesis as they consist of beliefs that are taken for granted, such as what mental health is and how it ought to be treated (Napier et al., 2014; Schein, 1990).

- Culture is learned rather than genetically inherited and influences the way we interpret behaviour. It is dynamic and constantly evolving (Hofstede et al., 2010; Kagawa-Singer, 2011). Consequently, individuals learn from, and are influenced by, several cultural contexts, which may include holding several beliefs around mental health and healthcare simultaneously. Furthermore, which culture influences behaviour most, might be dependent on the context the individuals find themselves in. This goes for both patients and health professionals.

1.5.1 Acculturation

Berry has defined acculturation as 'the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members' (Berry, 2005, pp. 698-699). According to Berry, such changes can occur both at the societal and the individual level. At the societal level, acculturation might involve changes in social structures and institutions and in cultural practices, while at the individual level, it might involve changes in a person's behavioral repertoire, attitudes and/or values, although not necessarily simultaneously (Berry, 2005; Sam & Berry, 2016). To what extent individuals wish to hold on to their original culture or adopt that of the majority in the new country varies.

Several models of acculturation have been proposed. These can be largely divided into unidirectional, which focus on assimilation on the one hand vs. maintenance of the original culture on the other, and bidimensional models, which view maintenance of original culture and adoption of host culture as lying on orthogonal axes (Ngo, 2008). Unidirectional models (see for example Gans, 1997) have been criticized for focusing heavily on assimilation as the main goal of acculturation, where the result is often the extinction of migrants' culture in favour of the host culture, and where retaining one's original culture is seen as a rejection of the host culture (Ngo, 2008). Bidimensional models, such as the model proposed by Berry and Sam (Berry, 2005; Sam & Berry, 2016), present several acculturation orientations beyond assimilation.

According to Berry and Sam's model, acculturation occurs on two main axes: a) maintenance of heritage culture and identity, b) orientation towards the majority culture of the resettlement country. This results in four main acculturation orientations: assimilation, separation, marginalization, and integration (Sam & Berry, 2016). Assimilation refers to the process in which individuals do not wish to retain their original cultural identity and adopt the majority culture of the resettlement country (Sam & Berry, 2016). When individuals wish to retain their cultural identity and avoid contact with the majority culture, this is called separation. However, when there is little interest in contact with the majority culture in combination with little interest in retaining one's cultural identity, this is called marginalization. Finally, integration refers to the process in which individuals wish to retain their cultural identity and seek out contact with the majority culture. Berry and Sam's model arguably improves on unidirectional models by recognizing a more complex picture of acculturation.

This thesis defines integration in line with Sam and Berry as an orientation in which 'some degree of cultural integrity is maintained, while at the same time the individual seeks, as a member of an ethnocultural group, to participate as an integral part of the larger social network' (Sam & Berry, 2016, p. 22). To clarify, however, this thesis approaches integration in terms of the individual's current circumstances, as opposed to their acculturation preferences, since an individual's preferences do not necessarily map directly on to how they in fact behave or the outcome of that behaviour (Sam & Berry, 2016). This may be the result of social constraints in the resettlement country, for example lack of opportunities (Sam & Berry, 2016). In this sense acculturation does not reflect only the willingness or behaviour of immigrants themselves, but also the willingness and behaviours of the host society regarding engaging with immigrant populations. For example, immigrants may become marginalized as a result of perceived discrimination or prejudice in the resettlement country, even if the immigrants themselves may have a willingness to integrate (Sam & Berry, 2016). In fact, well documented contextual factors, including discrimination, language barriers,

and social support, seem to be more predictive of migrants' adaptation than individual acculturation strategies (Bierwiaczonek & Kunst, 2021).

1.5.2 Refugee populations in Norway: health beliefs and behaviours

Keeping in mind the limitations of equating nationality with culture, previous literature suggests that there are patterns within groups of people from similar backgrounds with regards to explanatory models of mental illness, as well as preferred coping and help-seeking behaviours. These may have implications for the inter-cultural clinical encounter.

Somalis in Norway

There are currently more than 27,000[3] Somali refugees in Norway (Statistics Norway, personal communication, October 1, 2021). Refugee groups, in general, have reported poorer mental health (Ben Farhat et al., 2018; de Jong et al., 2003; Fazel et al., 2005; Harris et al., 2019; Hassan et al., 2016; Poole et al., 2018; Steel et al., 2009), and lower use of health services than the majority population (Fuhr et al., 2020; Satinsky et al., 2019). However, this pattern may not apply to Somali refugees, who have self-reported good physical and mental health (Madar et al., 2020; Rask et al., 2016), are more likely to make use of GP services than other sub-Saharan non-refugee migrants in Norway for somatic complaints (Diaz et al., 2017), and have higher contact rates to emergency services than the majority population (Sandvik et al., 2012). Despite a higher use of services for physical health complaints, Somalis in Finland have been found to have low use of mental health services (Molsa et al., 2019) even though it has been suggested that they reported similar rates of depressive and anxiety symptoms as the majority population in Finland when assessed using the Hopkins Symptom Checklist-25 (Rask et al., 2016). Underuse of mental health services has also been observed among Somali women with a refugee background in Norway

[3] Number retrieved by internal employee at Statistics Norway from Table "08144: Personer med flyktningbakgrunn, etter statistikkvariabel, flyktningstatus, år, region og landbakgrunn".

(Elstad et al., 2015), and it has been suggested that this underuse does not necessarily mean that Somali women do not experience psychological distress, but rather that they feel they must conceal their distress (Naess, 2019). Somalis have previously reported hesitation regarding seeking mental health help due to the stigma associated with mental health problems (Cavallera et al., 2016; Piwowarczyk et al., 2014), or the belief that mental disorders ought to be treated through spiritual approaches (Markova & Sandal, 2016). This suggests that while Somalis have self-reported good mental health, the issue may be more complex.

In Norway, and most other European countries, conditions such as depression and anxiety are largely accepted and considered to be real disorders. Among people from Somalia, however, the conditions called depression and anxiety in the DSM-5 and ICD-10 may be seen as normal reactions to stressful life events, as opposed to disorders that require treatment (Cavallera et al., 2016). Among Somali refugees, mental illness has previously been attributed to shock and devastation of war, dead, missing, or separated family members, and spirit possession or a curse (Carroll, 2004). Explanatory models and coping strategies of Somali refugees in Norway have been previously described through focus group interviews (Markova & Sandal, 2016). In Markova and Sandal's study, for example, participants were asked to read a vignette about a character with symptoms of depression, in line with ICD-10 and DSM-5 criteria (American Psychiatric Association, 2013; World Health Organization, 1993) and to discuss what they felt caused the character's problem, as well as how best to cope with it. Participants described the condition presented in the vignette as an 'illness of thought' or something spiritual inside the person that needed to be taken out. Stress and biological causes, such as drug use, were also mentioned, but were not the focus of the discussion. Many participants attributed the vignette characters' condition to their family situation, i.e., being unmarried and living alone. Participants explained that the family's views played a large role in an individual's likelihood to seek mental health support. While the choice of coping or help-seeking strategies depended on the believed cause of the problem, participants preferred

coping with the condition described in the vignette by religious practices and reliance on family, rather than seeking professional treatment. Similar findings have previously been found among refugees from Somalia in New York (Carroll, 2004). These findings are furthermore in line with a UNHCR report on culture, context, and mental health of Somali refugees, which suggests that discussing mental health in purely psychological terms may seem unhelpful to individuals from Somalia, where health is more often seen holistically and intertwined with spiritual forces (Cavallera et al., 2016).

Syrians in Norway

While Somalis consistently constitute one of the largest refugee and non-refugee migrant groups in Norway over the last decades, one of the largest recently arrived groups of refugees to Norway originated from Syria. A recent cross-sectional study found that 33% of Syrian refugees in Norway reported symptoms indicative of anxiety or depression, and 7% reported symptoms of post-traumatic stress disorder (PTSD) (Strømme et al., 2020). These rates are substantially higher than the 12-month prevalence of 10-15% for anxiety or depression (Norwegian Institute of Public Health, 2016), and 1-1.7% for PTSD (for men and women respectively) among the Norwegian majority population (Lassemo et al., 2017).

Explanatory models and coping strategies among Syrian refugees in Norway have been examined through focus group interviews (Aarethun et al., 2021). Participants were presented either with a vignette character showing symptoms of depression or PTSD, in line with ICD-10 and DSM-5 criteria (American Psychiatric Association, 2013; World Health Organization, 1993). In the case of the PTSD vignette, the participants explained that the vignette character's experiences were likely to be the result of difficult experiences they had had in Syria. Participants stated that the problems experienced by the vignette character were not purely psychological and should not be labelled as such. This is in line with a report suggesting that labelling emotional reactions to difficult experiences as disorders can be seen as shameful in

Syrian culture (Hassan et al., 2016). Similarly, participants focused on external factors that were influencing the vignette character's problems, including being unmarried and living alone (Aarethun et al., 2021).

The different role of the GP in Syria and Norway was also highlighted among Syrian participants (Aarethun et al., 2021). They explained that in Syria, one could go directly to a specialist for support. In Norway, on the other hand, individuals are required to initially contact their GP, wait for an appointment, and then receive a referral, often resulting in further waiting times.

The explanatory models and coping mechanisms of Somali and Syrians in Norway have implications for clinical consultations. For example, the spiritual explanation of mental illness among Somali populations may not align with the perspectives of GPs in Norway, who rarely focus on religious or spiritual explanations or treatments for mental illness. Similarly, the differing role of the GP in Syria vs. Norway may lead to patients having different expectations of GPs in Norway, which may lead to dissatisfaction if GPs do not live up to these expectations. Some of these issues are taken up in Rothlind's (2018) 'circling the undefined' model (Figure 2). Their model, which is the result of a qualitative study examining physician-patient communication in primary care consultations, addresses the perceived complexities of inter-cultural consultations. It presents the concept of 'circling the undefined', referring to the presumed agreement between patient and practitioner regarding format and content of the consultation as well as their fundamental views on what constitutes health and illness. It describes how both practitioner and patient hold certain assumptions and expectations about one another and the consultations that may remain unspoken and lead to misunderstandings and dissatisfaction (Rothlind et al., 2018). They present themes that impact communication such as 'fragmentizing the story' i.e., only fragments of a patient's history being available to the clinician due to time constraints and communication problems, 'culture blaming and explaining', i.e., using culture as an explanation of differences and challenges perceived in consultations, and 'fitting

the box', i.e., patients are made to fit diagnostic categories. They also present themes that make the framework of the consultation unclear, such as 'expanding one's role', i.e., the clinician being expected to take on roles beyond their job, and 'shuffling responsibilities', i.e., the behaviour associated with being unclear about which responsibilities the patient and the clinician have in the consultation. The model is based on a modest sample size of 15 clinicians and 30 patients with a migrant background, but it highlights the importance of considering culture, different explanatory models, and coping strategies, as well as taken for granted assumptions about health and healthcare in the inter-cultural clinical encounter.

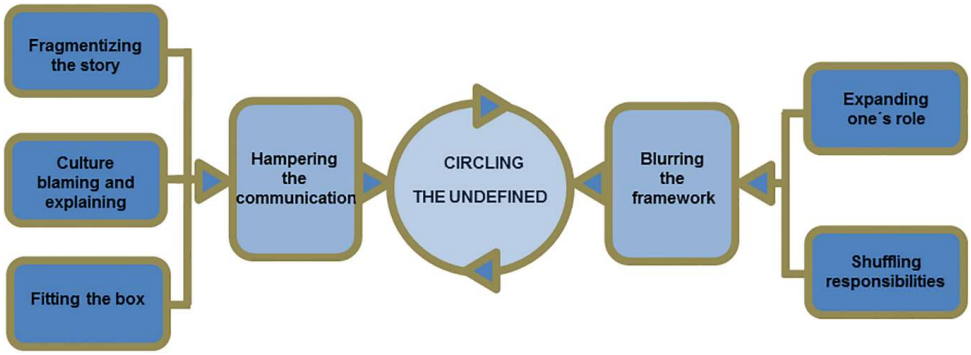

Figure 2. Rothlind and colleagues' (2018) conceptual model describing how clinicians and patients continue to 'circle the undefined' through their behaviours in intercultural consultations. Reprinted under PLOS open access license.

1.5.3 Socioeconomic status and health

While not the focus of this thesis, it is important to note that culture is not the only important issue regarding disparities in health and healthcare. The important role of socioeconomic status in well-being has been documented extensively. For example, unemployment (Milner et al., 2014; Paul & Moser, 2009) and poverty (Chang et al., 2020; Frankham et al., 2020) have been associated with poor mental health. This is important given that refugees as a group, particularly those that arrived recently,

typically have lower rates of employment than non-refugee migrants and the majority population (Djuve & Kavli, 2019) and as a result may be faced with poorer financial situations and lower socioeconomic status. Inequities in mental health and well-being among adolescent migrants in Scandinavian countries have been attributed to differences in socioeconomic status (de Luna et al., 2019). Furthermore, high pre-migratory socioeconomic status among Syrian refugees in Germany has been shown to relate positively to several subjective health indicators, but this protective effect seems to attenuate with time spent in the resettlement country (Bauer et al., 2020). When discussing mental health inequities, it is important, therefore, not to forget the impact of socioeconomic circumstances.

1.6 Inter-cultural consultations: the GP perspective

1.6.1 Previous literature: GPs' experiences working with forcibly displaced individuals suffering from mental health problems

While many GPs are sympathetic to the needs of refugees and asylum-seekers, it has also been suggested that they struggle to meet their psychological needs (Begg & Gill, 2005). This may be the result of their experiences and perceived barriers in providing mental health care to forcibly displaced individuals.

Robertshaw and colleagues' (2017) systematic review collates the majority of qualitative studies examining the challenges and facilitators experienced by health professionals providing primary healthcare for refugees and asylum seekers in high-income countries (Australia, Canada, Denmark, Ireland, Netherlands, Switzerland, UK, and the USA). The authors organize the literature according to overarching themes in which barriers and facilitators occur: the healthcare encounter (including the doctor-patient relationship, communication, cultural understanding, health and social conditions, and time constraints), the healthcare system (including training and

guidance, professional support, connecting with other services, organisation, resources, and capacity), and the asylum process.

Of the studies included in Robertshaw's review, three focus specifically on the experiences of GPs or family physicians (Crowley, 2005; Furler et al., 2010; Jensen et al., 2013). The most important barriers presented in these three studies include communication, cultural understandings, and time constraints. Communication and cultural understanding were presented as intertwined with language barriers. For example, GPs in Denmark identified difficulties referring refugee patients to specialist services due to language barriers (Jensen et al., 2013). The use of interpreters was considered highly useful, although GPs were concerned with the accuracy of translations (Furler et al., 2010). GPs also reported struggling with patients' different expectations of treatment (Jensen et al., 2013). Some participants felt that individuals from other cultures had a different understanding of, and different ways of talking about, mental health (Furler et al., 2010). The above-mentioned barriers often resulted in more time-consuming consultations (Crowley, 2005). GPs suggested that time constraints could result in rushed consultations and voiced a fear of missing important aspects of the symptom presentation as a result (Crowley, 2005).

The three studies presented above were conducted several years prior to the peak influx of refugees to Europe in 2015. To check for literature published since Robertshaw and colleagues' review, I conducted a brief literature search of MEDLINE based on the search terms used by Robertshaw and colleagues (Robertshaw et al., 2017). I limited my search to papers from general practice and primary care and papers published since Robertshaw's review, August 2017. The specific search terms used in the current literature search were otherwise identical to those outlined in Robertshaw's review. In line with Robertshaw and colleagues, I did not limit this search to mental health consultations or purely qualitative papers, as I felt that other studies may include useful descriptions of relevant experiences.

The search returned 90 hits. First, titles were skimmed and articles that were not related to the experiences of primary care practitioners regarding refugees/asylum-seekers, or that were related to practitioners' experiences of providing sexual and reproductive healthcare to refugees/asylum-seekers were excluded. Twenty articles remained. In the second round, the abstracts of the remaining articles were read, and further articles that were not relevant were excluded. These included, for example, intervention evaluation studies or articles that focussed on the experiences of child and adolescent psychiatrists or of refugees themselves, that had not been obvious from the title. The two remaining articles were read in full and are described below. The flow of papers is visualised in Figure 3.

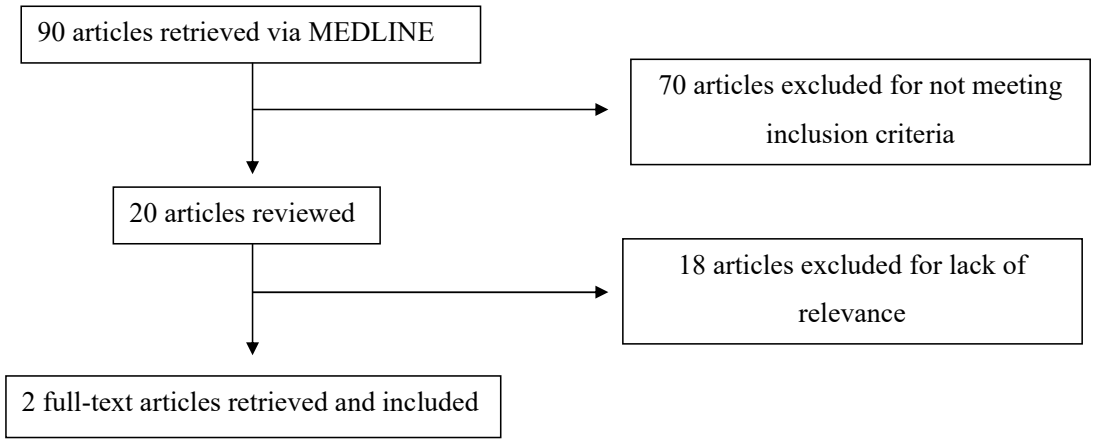

Figure 3. Flow of papers of literature review based on search strategy outlined in Robsertshaw and colleagues (2017).

The two studies identified by the literature search were based on data collected in the UK and New Zealand (Richard et al., 2019; Scott et al., 2019). Note that Scott and colleagues conducted a survey, as opposed to a qualitative study. However, the search failed to pick up several relevant references, which did not specifically include the words barriers and facilitators. These included two qualitative interview studies of GPs, one of which focussed on strategies in consultations with migrant patients in Norway (Hjørleifsson et al., 2018) and the other on perceptions about collecting data

on ethnicity in primary care in Ireland (Roura et al., 2021), which are also described below.

The above-mentioned studies mirror some of the barriers presented in previous literature, including the obstacles of language barriers, time constraints, concerns around legislative policy about refugees and asylum-seekers, feelings of uncertainty, and needing more training.

Communication was mentioned as an important issue in all studies. Participants recognized the important and detrimental effect of language barriers and difficulties associated with using interpreter services (Hjørleifsson et al., 2018; Richard et al., 2019; Scott et al., 2019). In line with relevant research, Norway has recently implemented new regulations on national guidelines for medical education from 2020, and is addressing this issue by making communicating with the help of an interpreter a required skill for medical students (Diaz et al., 2020).

The majority of GPs reported feeling less confident providing care to refugee patients than patients from the majority population, which may furthermore relate to the fact that less than half of the participants were fully aware of their patients' rights (Scott et al., 2019). In Norway, a qualitative study amongst interpreters suggested that patients themselves are often not aware of their own rights, for example the right to an interpreter, making it all the more vital for healthcare professionals to be aware of patients' rights (Diaz et al., 2020). Participants furthermore raised concerns about gathering sensitive information from their patients, which was often not possible due to the lack of time during consultations, fear that gathering sensitive data may disrupt their relationship, inability to get consent from their patients due to language barriers, and concerns around data protection (Richard et al., 2019; Roura et al., 2021). As a result of several of the barriers presented above, patients pointed out that consultations often became time-consuming (Hjørleifsson et al., 2018; Richard et al., 2019). Some participants recognized the beneficial impact of having worked with culturally diverse patients previously or having had cultural competence training, but

most participants indicated requiring more training (Hjørleifsson et al., 2018; Richard et al., 2019).

The newer studies also extend earlier findings. For example, participants in Richard's (2019) and Hjørleifsson's (2018) studies recognized the importance of particularizing care and voiced concerns about lacking the infrastructure to care appropriately for patients with a refugee background. Participants in Richard's study (2019) highlighted the importance of building meaningful relationships with their patients through openness to difference. Similarly, participants pointed out that they felt they were contributing to a greater cause by providing care to refugee patients (Richard et al., 2019). The feeling of contributing to a greater cause may relate to the timing of the later study in comparison with the earlier ones presented in Robertshaw's review. The refugee crisis was frequently covered in the media, and activists have voiced their opinions about the importance of showing support for refugees. This may have led to GPs in the later studies experiencing a feeling of contributing to a greater cause, moreso than participants in previous studies. However, this often came at the expense of their own wellbeing and participants described feeling disempowered, overwhelmed, and unrecognized (Richard et al., 2019).

It should be noted that the above-mentioned studies largely focus on GPs' experiences of consultations in which GP and patient do not share a cultural background. Approximately 20% of GPs in Norway have a migrant background, however (Diaz & Hjorleifsson, 2011; Diaz et al., 2014). Previous literature suggests that some of the barriers experienced by GPs in inter-cultural consultations are improved when patient and GP share a similar cultural background, although this might also come at a cost, including migrant GPs receiving more migrant patients and, consequently, a higher workload (Diaz & Hjorleifsson, 2011).

1.6.2 Limitations of previous literature and contribution of paper 1

The studies reported above give helpful insights into the experiences of health professionals working with refugee patients. However, only 7 out of 23 of the studies

presented in Robertshaw's (2017) systematic review focus specifically on the experiences of GPs. Given the important role of GPs as managing mental health in primary care and acting as gatekeepers to secondary services, barriers and facilitators they perceive are likely to have important consequences for patients' treatment. This highlights the importance of examining GPs separately from, for example, nurses and midwives. Some studies since the publication of Robertshaw's review have focussed on the experiences of GPs but were conducted outside the Norwegian context (Scott et al., 2019), and did not use qualitative methods (Richard et al., 2019). Similarly, only 3 studies (Crowley, 2005; Furler et al., 2010; Jensen et al., 2013) focused on GPs' experiences working with refugees suffering from *mental* health problems. It has been shown that practitioners experience higher levels of uncertainty in mental health consultations vs. consultations regarding physical health complaints (Smith & Dumont, 1997). In addition, themes and challenges related to the healthcare system, such as the theme 'the healthcare system' mentioned in Robertshaw's review (2017), are unique to individual countries and the resulting barriers and facilitators cannot necessarily be translated to other healthcare systems. The above-mentioned limitations warrant new, in-depth examination of GPs' experiences in clinical consultations with refugees suffering from mental health problems in Norway, which is addressed in paper 1.

1.7 GPs' clinical decisions in inter-cultural consultations

We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is a science in what we do, yes, but also habit, intuition, and sometimes plain old guessing –

(Gawande, 2003)

1.7.1 Previous literature: Clinical variation based on patient characteristics

Previous literature suggests that individuals who have been forcibly displaced may elicit distinctly different reactions among the majority population than voluntary migrants. The knowledge that a patient has undergone forced migration may increase empathy towards the individual, but may also increase anxiety and feelings of threat (Echterhoff et al., 2020). This is supported by findings indicating that GPs evaluate forcibly displaced patients differently from majority population and other patients with foreign descent, for example being less optimistic about their recovery (Delaruelle et al., 2021) and feeling less confident about providing care to them (Grut et al., 2006; Harris et al., 2020; Kai et al., 2007; Scott et al., 2019). Consequently, forcibly displaced individuals may be handled and treated differently by health professionals. Asylum-seekers in Sweden, for example, who had attempted suicide received more diagnoses of PTSD on average than non-asylum-seeking controls, who had also attempted to commit suicide but were more likely to receive diagnoses of personality disorders or substance abuse (Sundvall et al., 2015). Similarly, Somali and Iraqi migrants have been referred more often for laboratory tests for physical health complaints in emergency primary healthcare services for non-urgent purposes, in comparison with German and Polish migrants, and the majority population in Norway (Sandvik et al., 2012). While this study was not specifically conducted on forcibly displaced individuals, it is likely that many Somali and Iraqi migrants had a refugee background during the time the study was conducted in 2008[4] (Statistics Norway, personal correspondence 2021). Furthermore, asylum-seekers in Switzerland have presented high psychiatric morbidity but received very little specific treatment, although they sought medical advice more than twice as often as did 'average residents' (term employed by original article) (Maier et al., 2010). Asylum-seekers in Sweden were more likely to be hospitalized at local mental health services, and were

[4] According to personal correspondence with Statistics Norway, almost 59% of Somali migrants and 58% of Iraqis arrived in Norway as refugees in 2008. Note also that this number does not include family reunification cases, which may also include forcibly displaced individuals.

more often referred to primary care rather than outpatient mental health services than controls (Sundvall et al., 2015). It has also been shown that refugees in Sweden were more likely than the general population to be admitted to psychiatric hospital for inpatient and compulsory care (Manhica et al., 2017).

Gender in combination with background may furthermore influence health professionals' clinical decisions. Female asylum-seekers in Sweden, for example, received more intense and prolonged in-patient treatment than female controls (Sundvall et al., 2015). This may be the result of women with a refugee background being perceived as more at risk for violence (Byrskog et al., 2015), such as female genital mutilation (Mbanya et al., 2019). Similarly, a study on managing mental health problems among migrant women in primary care in Norway showed that while patients referred for psychiatric services and sick leave did not vary by country of origin, women from the Filipines, Thailand, Pakistan, and Russia were less likely to receive talking therapy (Straiton et al., 2016).

1.7.2 Limitations of previous literature and the contribution of paper 2

The literature presented above indicates that some differences have been documented in health professionals' clinical decisions between refugee/asylum-seekers and the majority population, and that this may further be influenced by the patient's gender. It is difficult to conclude, however, to what extent the findings are the result of patient characteristics as opposed to a true difference in prevalence or confounding variables. An experimental design, in which all confounding variables are kept constant, may be able to give an insight into the clinical variation that occurs as a function of patient characteristics. The utility of such an approach has been highlighted by McKinlay and colleagues (2002), who point out that 'possibly the only way to estimate the independent and joint contribution of co-varying patient characteristics … on clinical decision making is to undertake carefully controlled randomized experiments where selected social attributes of patients are deliberately manipulated to estimate their unconfounded contribution' (p. 94). Furthermore, several of the studies presented

above draw conclusions based on broad migrant groups, although there is high heterogeneity within such categories. Consequently, it is important to focus on more narrowly defined groups, for example focusing on clinical decisions made about forcibly displaced individuals from one specific country or specific geographic area. Previous studies have furthermore attributed the differential treatment of migrants to bias (Ceuterick et al., 2020), discrimination (Hall et al., 2015; Kumar & Diaz, 2019; McGuire et al., 2008; Mikuls et al., 2005), and cultural and linguistic barriers (Kirmayer et al., 2011). A theory that is rarely considered, however, is the impact of health professionals' clinical uncertainty in inter-cultural consultations, which is addressed in paper 2.

GP clinical uncertainty as a mechanism underlying clinical variation?

Uncertainty has previously been defined by Penrod (2001) as 'a dynamic state in which there is a perception of being unable to assign probabilities for outcomes that prompts a discomforting, uneasy sensation that might be affected (reduced or escalated) through cognitive, emotive, or behavioural reactions, or by the passage of time and changes in the perception of circumstances' (p. 241). The important role of being able to tolerate the experience of uncertainty in clinical practice has further been highlighted by Simpkin and Schwartzstein in their paper 'Tolerating clinical uncertainty – the next medical revolution?' (Simpkin & Schwartzstein, 2016).

It has previously been suggested that practitioners feel uncertain and unsure about their clinical decisions regarding patients with a migrant background, including refugees (Grut et al., 2006; Pieper & MacFarlane, 2011). This is supported by findings suggesting that GPs experienced high levels of uncertainty in the US and UK when diagnosing depression among African Caribbean and African Americans non-refugee populations (Adams et al., 2014). Clinical uncertainty is inherent to clinical practice (Guenter et al., 2011), but 'is exacerbated in underserved and vulnerable patient populations with high prevalence of chronic medical problems, complicated by cultural differences and psychological challenges' (Kenyon et al., 2013, p. 219).

Nevertheless, medical curricula and the culture of medicine often place little weight on acknowledging, accepting, and managing uncertainty in a clinical context (Guenter et al., 2011; Simpkin & Schwartzstein, 2016). Clinicians have described uncertainty as having a disempowering effect on them (Kai et al., 2007), taking an emotional toll (An et al., 2009; Cooke et al., 2013), resulting in higher medical costs and poorer patient care (Evans & Trotter, 2009), and disproportionately impacting inexperienced clinicians (Kenyon et al., 2013). Furthermore, diagnostic uncertainty can impede the clinician's ability to identify and initiate appropriate treatment (Bhise et al., 2018), and is considered one of the main causes of variation in clinical decision making (Eddy, 1984).

Clinical uncertainty is particularly relevant in primary care consultations, where clinicians are often confronted with undifferentiated illness presentations, as well as in mental health consultations (Guenter et al., 2011; Smith & Dumont, 1997). A patient's background may introduce uncertainty into the clinician's judgement, which can result in the increased use of diagnostic tests (Royl et al., 2012; Terraza-Nunez et al., 2011). Recommending diagnostic tests may be a sign of attempting to be thorough for fear of making a mistake, which can be seen as an advantage of uncertainty (Eliasson, 2013). However, the overuse of diagnostic tests can also be a sign of a 'premature closure' (Guenter et al., 2011). A premature closure has been described as a 'flailing attempt to impose a higher level of certainty on a situation than the situation is ready for' (Guenter et al., 2011), which may occur when a clinician attempts to reduce the discomfort of clinical uncertainty by making a hasty clinical decision or delegating responsibility to another professional (Borrell-Carrio & Epstein, 2004). The result of such processes might be that practitioners make rash decisions regarding certain patients, such as those with a refugee background, not necessarily out of prejudice or bias but out of the discomfort of clinical uncertainty and fear of making mistakes associated with the perceived complexity of inter-cultural consultations.

Uncertainty in relation to inter-cultural consultations may be mitigated by cultural competence and/or humility. While it is still somewhat unclear how exactly to conceptualize cultural competence, it can be thought of as the ability to work and communicate effectively and appropriately with people from culturally different backgrounds (Alizadeh & Chavan, 2016). It is broadly made up of the elements: cultural awareness, an individual's awareness of their own views; cultural knowledge, continued acquisition of information about other cultures; cultural skills and behaviour, i.e., communication and behavioural ability to interact with culturally different people; cultural desire/motivation, defined as someone's willingness to engage with cultural diversity; and cultural encounters/interactions, i.e., contact with culturally different people (Alizadeh & Chavan, 2016). It is important to note, however, that cultural competence has previously been criticized for presenting culture as a matter of ethnicity and race, as something that is possessed by the Other, and presenting 'competence' as the practitioner's knowledge of the Other (Kumas-Tan et al., 2007). This may give the impression that GPs should attain vast amounts of knowledge about other cultures, an arguably unrealistic endeavour, while it underestimates the importance of reflecting on one's own cultural context. Many of these criticisms have been addressed in more recent cultural competence measures (Schwarz et al., 2015). Nevertheless, the concept cultural humility has gained support in recent years, partly because of the controversial connotations associated with cultural competence (Mosher et al., 2017). Cultural humility focusses more heavily on an individual's engagement in critical self-examination and awareness, building a therapeutic alliance, repairing cultural ruptures, and navigating value differences (Mosher et al., 2017). It has been defined as 'a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals' (Foronda et al., 2016, p. 213). A culturally competent or humble approach, therefore, may contribute to GPs' abilities to tolerate uncertainty in inter-cultural consultations, which may in turn reduce it's impact on, for example, their clinical decisions and the discomfort experienced as a result of uncertainty (Simpkin & Schwartzstein, 2016).

Importantly, uncertainty can exist at the individual level (micro-certainty), referring to the subjective experience of an individual GP regarding their confidence or certainty in the clinical decision they have made, or at the aggregate level, which refers to the consensus across GPs regarding the most appropriate clinical decision for a particular case (macro-certainty) (Baumann et al., 1991). At the aggregate level, a lack of consensus as caused by macro-*un*certainty, may lead to variations in the care given to patients. Clinical uncertainty becomes particularly problematic when it results in variations in clinical practice that put certain patients at a disadvantage in comparison to other patients. The mechanism through which clinical uncertainty may lead to clinical variation may relate to heuristic decision making. When confronted with circumstances lacking sufficient information and associated with high levels of uncertainty, GPs may rely on stereotypes and heuristics when making decisions (Neth & Gigerenzer, 2015). Heuristics are 'efficient cognitive processes, conscious or unconscious, that ignore part of the information' (Gigerenzer & Gaissmaier, 2011). Heuristic decision making has the advantage of allowing people to make quicker and accurate decisions when faced with uncertainty, however they are also more to prone human error and bias (Neth & Gigerenzer, 2015). As a result, even harmless stereotypes and biases can influence decisions and cause clinical variation. The presence of clinical uncertainty in GPs' clinical decisions regarding Somali refugee patients vs. Norwegian patients is examined in paper 2.

1.8 The perspective of Syrians with a refugee background: is the GP a viable source of help?

1.8.1 Previous literature: Mental health help-seeking among Syrians with a refugee background

A recent meta-analysis suggests that despite a seemingly higher need for mental health support, refugees, including Syrian refugees, in Europe tend to underuse mental health services (Byrow et al., 2020). To better understand the use of

professional sources of help among Syrian refugees, it is important to better understand different factors that influence their willingness and ability to seek help.

Considering mental health and help-seeking in Syria may place refugees' engagement with health services in Europe into context. It has been suggested that mental healthcare in Syria has been neglected for decades (Kakaje et al., 2021). The Syrian government introduced mental health legislation in 1965 and introduced a national mental health program in 2001 (Al-kurdi, 2015), but in 2012 there were only approximately 8 psychiatric beds, 0.5 psychiatrists, and 0 psychologists per 100,000 inhabitants in Syria (Okasha et al., 2012). Studies examining the mental health burden in Syria are heterogeneous, but the burden appears to be high. A recent systematic review found that levels of depression ranged from 11-49% among Syrians in Syria and neighbouring countries (Hendrickx et al., 2020). Another systematic review and meta-analysis recently estimated the prevalence of mental disorders at 21.1% in conflict-affected settings (Charlson et al., 2019). Little is known about Syrians use of mental health services in Syria, however, it has been suggested that stigma associated with psychological disorders may present a significant barrier (Hassan et al., 2015; Aarethun et al., 2021).

Given the different role of the GP in Norway vs. Syria, it is important to note that help-seeking behaviours may change as individuals migrate. A recent longitudinal study among Syrian refugees in Lebanon, suggested that only 33% of participants visited the GP in Lebanon, whereas this increased to 85% upon arrival to Norway (Haj-Younes, Stromme, et al., 2021). This may both relate to becoming more integrated in the resettlement country and therefore accepting the dominant care models of that country (Wikberg & Eriksson, 2008), as well as the availability of, and differential role the GP plays in Norway vs. Syria (Aarethun et al., 2021). In addition, health literacy and higher scores on the environmental domain of the Quality of Life (QoL) questionnaire (which includes facets such as financial resources, physical

safety and security, health and social care, transport etc.) may be associated with utilizing GP services among Syrian refugees (Haj-Younes, Stromme, et al., 2021).

Patients are influenced by several factors when making decisions about whether and where to seek help for health problems. Andersen's behavioral model of health services utilization (Behavioural Model) is one of the most commonly employed frameworks to examine help-seeking behaviours and preferences (Andersen, 2008; Andersen et al., 2014). The model presents how contextual and individual factors, as well as health behaviours and outcomes, interact and influence the use of healthcare services (referred to as personal health services in the model) (Andersen, 2008; Andersen et al., 2014). Individual characteristics refer to the predispositions of people, which enable or impede health service utilization. Contextual factors, which are measured at an aggregate level, refer to provider-related and community characteristics. The current study focuses on the individual characteristics. According to the Behavioural Model, the individual characteristics that influence help-seeking include predisposing (demographic, social, beliefs), enabling (financial resources, organisation), and need (perceived and evaluated) (Andersen, 2008; Andersen et al., 2014). While predisposing and enabling factors are sometimes difficult to disentangle (Babitsch et al., 2012), a predisposing factor can be thought of as something that would influence a person's willingness to seek help, while an enabling factor would influence their ability to receive help. The Behavioral Model in relation to help-seeking preferences among Syrian refugees is explored in paper 3.

Barriers to seeking help

In addition to individual characteristics, refugees' help-seeking preferences and behaviours may be influenced by perceived barriers. In Germany and Austria, Syrian refugees have identified barriers to help-seeking, such as stigma and shame, not speaking the language of the host country, and lacking information about health services (Kohlenberger et al., 2019; Renner et al., 2020; Zehetmair et al., 2021). Similarly, Syrian refugees in Turkey have identified barriers such as not knowing

where or how to get help, financial concerns, unavailability of appointments, fear of being hospitalized, and finding the process inconvenient or time-consuming (Fuhr et al., 2020), difficulties obtaining medicine, personal rights (e.g. valid ID card), and discrimination (Dogan et al., 2019).

1.8.2 Limitations of previous literature and contribution of paper 3

It is unclear whether, and if so where, Syrian refugees in Norway consider seeking help for mental health problems, how a variety of sociodemographic variables impact help-seeking, and to what extent stigma and other barriers plays a role in this process. To examine the factors that influence help-seeking, we are guided by Andersen's Behavioral Model (Andersen, 2008; Andersen et al., 2014). However, the Behavioral Model has the weakness in the context of the current study that it does not explicitly take into consideration culture and more importantly how shifting from one cultural context to another may impact help-seeking preferences. It can be argued that culture is a fuzzy construct that is made up of elements that are in fact included in Andersen's model, such as individual demographic characteristics, including ethnicity and beliefs around health, as well as personal health practices. However, it is the unique circumstances of having one foot in several cultural contexts and the consequences of this transnational belonging that is particularly relevant in the current study. The experience of illness as well as preferences for seeking help are embedded in larger cultural and social systems (Kirmayer et al., 2015). As an individual's cultural context changes, help-seeking preferences are likely to change as well, perhaps as a function of integration and availability of services (Wikberg & Eriksson, 2008; Aarethun et al., 2021).

The important role of integration has been suggested in other domains. Social integration[5] for example, is associated with health-related quality of life, decreased

[5] Note that social integration in Schick's study (2016) does not refer to the social integration index proposed by Harder and colleagues (2018) but consists of a mean score based on the Post-Migration Living Difficulties Checklist adapted to the Swiss context. The key domains examined by this measure include issues related to language, employment, access to healthcare, financial situation, accommodation, social participation, and discrimination

functional impairment and severity of symptoms of depression, anxiety, and PTSD (Schick et al., 2016). Similarly, while the beneficial impact of inter-ethnic friendships on the integration and wellbeing of migrant youths (Reynolds & Crea, 2017; Windzio, 2015) and adults (Wessendorf & Phillimore, 2019) has been supported in previous research, the role of friendships in migration research has been largely treated as a side issue (Décieux & Mörchen, 2021). The impact of integration and connection to the host country through social networks suggests that integration may play an important role in several areas.

Harder et al.'s (2018) multidimensional measure of immigrant integration, or Immigration Policy Lab (IPL), outlines several facets of integration and how these can be measured. Harder's measure includes: psychological integration, which broadly captures feelings of connectedness with the host country, linguistic integration, which captures language skills, economic integration, which captures income and the ability to meet unexpected expenses, navigational integration, which captures the ability to manage basic needs in the host country, and social integration which captures social ties and interaction in the host country (Harder et al., 2018). Harder's measure can be used to measure integration overall or in its individual facets, in contrast to several other measures, such as the Vancouver acculturation inventory (Ryder et al., 2000) and the cultural competence scale (Lay & Nguyen, 1998; Safdar et al., 2003; Safdar et al., 2021) which examine similar facets, but combine these into an overall score. Furthermore, Harder and colleagues' measure examines the current social situation of the participants, including amount of contact with members of the host society, while the Acculturation orientation scale (Safdar et al., 2021) and Vancouver acculturation inventory (Ryder et al., 2000) focus on individuals' preferences, including how important social contact with ingroups and outgroups is to participants. For the current study, we felt it was more helpful to employ a measure, which considers the participants' current situation rather than their preferences. Furthermore, as Harder et al. (2018) point out, by 'directly measuring the frequency of a social interaction, the question has face validity for measuring social integration' (Harder et al., 2018). Importantly, other scales assume that participants

have friends in the resettlement country. However, this is not necessarily the case for all refugees. Additionally, in a relatively hard to reach population, such as Syrian refugees in Norway, it is important that surveys remain short and concise. Harder's measure captures 'key aspects of integration with a small number of widely applicable questions' and 'can be used at low cost and facilitate comparability' (p.11484). Their measure can therefore be used as a 'common measure of integration, which would allow for the accumulation of knowledge through comparison across studies, countries, and time' (p. 11483, Harder et al., 2018, p. 11483). Harder's measure has furthermore been validated among relevant populations, including refugees as well as migrants both in Europe and the United States (Harder et al., 2018).

The current study attempts to take a step towards considering culture in more dynamic terms in relation to help-seeking. It does so by integrating the multidimensional model of immigrant integration proposed by Harder and colleagues (2018) into Andersen's Behavioral Model (Andersen, 2008; Andersen et al., 2014). The resulting conceptual model (Figure 4) is presented below. Based on previous literature that has used the Behavioral Model, we include age, gender, relationship status (Babitsch et al., 2012; Johnson et al., 2010), and education (Johnson et al., 2010; Magaard et al., 2017) as predisposing demographic factors. In addition, we include perceived benefit of seeking help from the GP under predisposing beliefs, as this taps into individuals' attitudes, values, and knowledge about health and health services (Andersen et al., 2014). Here, we also incorporate Harder's social integration index and number of Syrian and Norwegian friends, because this maps onto the social predisposing factors described in the Behavioral Model (Andersen, 2008; Andersen et al., 2014). We chose to include psychological integration under predisposing factors, as we felt it best related to beliefs about health and healthcare (Andersen, 2008; Andersen et al., 2014), although it could also be argued that psychological integration can be seen as an enabling factor. We include Harder's economic integration index under enabling financing, similar to Johnson and colleagues (Johnson et al., 2010).

We examine lack of access to the GP under enabling characteristics, as it either facilitates or impedes use of GP services (Andersen, 2008; Andersen et al., 2014), and does not predispose an individual to seek health help. We incorporate the indices for navigational and linguistic integration within a separate box entitled 'Knowledge' within enabling factors, as these did not fit within another category of the model but have been shown to have important implications regarding help-seeking (Hassan et al., 2016; Kirmayer et al., 2011; Satinsky et al., 2019). Navigational integration, referring to an individual's ability to manage basic needs in the host country, best matched the element 'organization' in the Behavioral Model, which includes the existence of, and ability to access, a regular source of care. Furthermore, language proficiency, which can be understood as linguistic integration, has previously been included as an enabling factor (Li et al., 2016). Finally, we include perceived severity of the problem under perceived need, because it captures participants' own perception of the severity of the symptoms. Severity of depression has previously been shown to relate to help-seeking (Magaard et al., 2017), although it is unclear whether this is the case when responding to a vignette. Evaluated need from the original model is excluded as participants were not evaluated by a health professional.

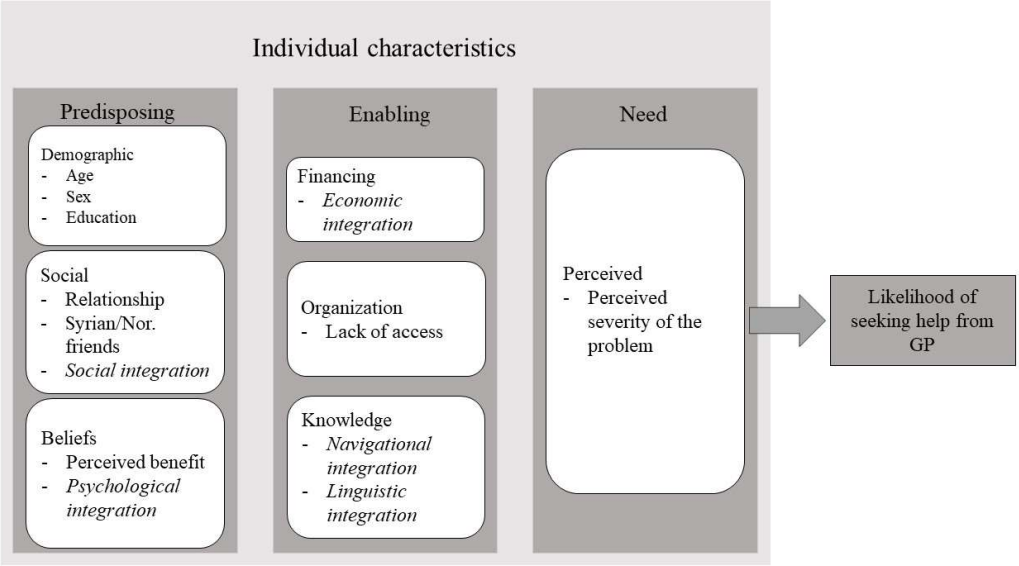

Figure 4. Conceptual model of the current study based on the 'individual characteristics' element of Andersen's Behavioral Model of Health Services Use and including elements of Harder's multidimensional measure of immigrant integration (in italics).

1.9 Research questions

The theoretical background presented above has led to the following research questions.

1.9.1 Paper 1

What are the main challenges and facilitators perceived by GPs in clinical consultations with refugees suffering from mental health problems?

1.9.2 Paper 2

Are there differences in the diagnoses, assessment, and treatment options chosen by GPs regarding Norwegian and Somali refugee vignette characters presenting with the same symptoms of depression in simulated primary care consultations? Are GPs less certain about their clinical decisions regarding Somali vs. Norwegian vignette characters?

1.9.3 Paper 3

How does the GP fit into the larger context of help-seeking preferences among Syrian refugees in Norway, and what barriers do participants identify in accessing help from the GP? How does the likelihood of seeking help from the GP relate to indicators of integration as well as other social, psychological, and demographic variables?

2. Materials and Methods

In the following section I describe the overall design and methodology of the thesis, the materials and methods of each individual study, and the mixed methods component.

2.1 Research design

The current project partly follows a mixed methods design, consisting of papers 1 and 2. Paper 1, which employs a qualitative methodology inspires and informs paper 2, which employs an experimental survey design. The qualitative interviews with GPs in paper 1 indicated that GPs perceived consultations with refugee patients as different from consultations with Norwegian patients and identified several barriers and facilitators to providing mental health care to refugee patients. Among other things, participants discussed feelings of clinical uncertainty regarding how to work with patients with a refugee background. Note that this paper focusses on GPs' experiences working with refugees in general, as GPs may not always know their patients' specific countries of origin. Paper 2 examined whether patient characteristics (background and gender) systematically influenced GPs' clinical decisions, and whether clinical uncertainty was in fact higher among GPs who viewed simulated vignettes with Somali refugee rather than Norwegian patients. In paper 2, the vignette character was specified as coming from Somalia, as they have consistently been one of the largest migrant groups in Norway. Paper 3, while not directly informed by papers 1 or 2, provides an important extension and complementary angle by exploring the perspective of Syrians with a refugee background. It explores how the GP fits into the larger help-seeking context of Syrian refugees, and whether they consider the GP a viable source of help. Furthermore, it examines barriers to accessing the GP for mental health help, providing a complementary perspective to the barriers identified by GPs in paper 1. Paper 3 focuses on Syrians, since they constitute a group of refugees that have arrived

relatively recently, and little is known about what contributes to their engagement with professional health services in Norway, while research regarding Somali help-seeking preferences in Norway have been studied previously (Diaz et al., 2017; Gele et al., 2017; Markova & Sandal, 2016; Markova et al., 2020).

To examine the above-mentioned issues, I apply both qualitative and quantitative methods. This combination of methodologies allows a breadth and depth to understanding the overarching research question that a single methodology could not offer. A matrix presenting an overview over the entire thesis is provided in Table 1.

Study purpose	To gain a deeper understanding of mental health consultations between GPs and individuals with a refugee background, with the aim of identifying areas for improvement and further research.		
Main research questions	*What facilitates, influences, and hinders GPs' provision of mental health care to refugees in Norway? Where do Syrian refugees prefer to seek mental health help in Norway, and what influences their seeking help from the GP?*		
	Paper 1	**Paper 2**	**Paper 3**
	Mixed Methods		
Title	General practitioners' experiences of clinical consultations with refugees suffering from mental health problems	General Practitioners' management of depression symptoms in Somali refugee and Norwegian patients: A film vignette experiment	Integration is correlated with mental health help-seeking from the general practitioner: Syrian refugees' preferences and perceived barriers
Mixed Methods research question	How do GPs experience and make clinical decisions in mental health consultations with refugee patients?		
Research question	What were the main challenges and facilitators GPs perceived in clinical consultations with refugees suffering from mental health problems?	Are there differences in the diagnoses, assessment, and treatment options chosen by GPs regarding Norwegian and Somali vignette characters presenting the same symptoms of depression in simulated primary care consultations? Is GPs' clinical uncertainty higher regarding clinical decisions made about Somali refugee vs. Norwegian characters?	How does the GP fit into the larger context of help-seeking preferences among Syrian refugees in Norway, and what barriers do participants identify to accessing help from the GP? How does the likelihood of seeking help from the GP relate to indicators of integration as well as other social, psychological, and demographic variables?
Design	Qualitative interviews	Survey experiment	Survey study
Sample	GPs that were currently working or had previously worked in Norway.	GPs that were currently working or had previously worked in Norway.	Syrian refugees over the age of 18.
Data	Semi-structured interviews	Survey	Survey
Analysis	Thematic analysis	Simpson coefficients, frequentist, and Bayesian ANOVA	Exploratory analyses including descriptives, Wilcoxon signed rank test, Pearson and Spearman correlations.

Table 1. Matrix describing the overall design of the project.

2.2 Ontological and epistemological stance

Clarifying coherence between the different methodologies and their philosophical underpinnings is a challenge in mixed methods research. It requires, more so perhaps than pure quantitative or qualitative enquiries, a clear justification of the researcher's methodological choices.

Regarding my project, I take a dialectical pluralistic perspective regarding ontology and epistemology (Johnson, 2017). Johnson (2017) proposes dialectical pluralism as a metaparadigm for mixed methods research, which at its core aims to provide a framework through which researchers (as well as policy makers etc.) can 'carefully, systematically, and thoughtfully listen, understand, appreciate, and learn from multiple paradigms, disciplines, values, methodologies, standpoints, ethnicities, and perspectives' (p. 156). Dialectical pluralism involves taking a pluralistic stance, but what differentiates it from a pure pluralistic ontology is its reliance on a dialectical, dialogical, and hermeneutical approach to studying phenomena (Johnson, 2017; Onwuegbuzie & Frels, 2013). In contrast to, for example, a multiple paradigms stance, which recognizes that different paradigms are relevant for different mixed methods research designs, a dialectical stance emphasizes the strength of mixing methodologies to contribute to greater understanding of the underlying phenomenon (Onwuegbuzie & Frels, 2013; Tashakkori & Teddlie, 2010). Taking a dialectical pluralistic stance furthermore brings with it certain methodological and philosophical assumptions. These include, for example, that reality is multiple, recognizing the objective, the subjective, and the intersubjective, and that several true statements can be made about reality (Johnson, 2017). It emphasizes the importance of divergence and convergence, of the different and the shared, and can respect and listen to multiple standpoints and perspectives (Johnson, 2017).

In practice, dialectical pluralism inspired mixed methods research aims to achieve the following: take into consideration different paradigms, combine important ideas from competing paradigms, explicitly include stakeholders' values to guide the research,

conduct the research ethically, facilitate the dissemination of the research, and evaluate whether it is having the effect it was intended to have (Johnson, 2012, 2017; Onwuegbuzie & Frels, 2013).

The mixed methods approach takes into consideration different paradigms and recognizes how each of their strengths can to some extent make up for the weaknesses of the other. It respects and values both quantitative as well as the qualitative methods and recognizes that research may have different purposes and therefore also a need for different methodologies (Johnson, 2017). In paper 1, I approach the research question from a more interpretivist perspective, recognizing reality as socially constructed and multiple. The goal of this research was a deeper understanding of GPs' experiences that might be transferred to other relevant situations, but not to achieve generalizability in a statistical sense. Participants' narratives are considered as relative to their context and the influence of the researcher in the production of knowledge is recognized and reflected upon (Ryan, 2018). Paper 2 take a more post-positivist perspective, recognizing that there may be a reality about which science can attempt to make theories, but simultaneously recognizing that such theories are falsifiable (Gamlen & McIntyre, 2018; Popper, 2005; Scotland, 2012). The aim within this approach is to propose falsifiable predictions, which are formulated as hypotheses, and to test these. While the post-positivist perspective recognizes that there are reality has predictable elements that can be observed and measured, it also acknowledges an element of uncertainty and recognizes the role of the researcher in the interpretation of observations (Gamlen & McIntyre, 2018; Popper, 2005; Scotland, 2012). The combination of qualitative and quantitative methodologies allows us to both describe and try to explain GPs' experiences and behaviours in clinical consultations.

I furthermore follow a dialectical pluralistic stance by actively involving stakeholders (a reference group including individuals from the local Bergen municipality, and Syrian and Somali medical doctors with a refugee background), conducting the

research ethically, and attempting to disseminate the research. Finally, I intend to continue evaluating the effect my findings have on future research as well as primary care in Norway.

Dialectical pluralism can simultaneously be an ontological as well as an epistemological stance. In a similar way that it allows for dialogue between two or more ontological stances, it does the same for epistemological stances (Johnson, 2017). In taking a dialectical pluralistic perspective, I identify both common and divergent goals and use a 'multiprong approach' to achieve them (Johnson, 2017). Common goals of paper 1 and 2, for example, were to gain an insight into inter-cultural mental health consultations between GPs and refugees, by exploring how GPs experience consultations with refugee patients with mental health problems and to what extent the patients' characteristics impact their clinical decisions. Each paper also had its own individual goals. Paper 1 aimed to describe and gain an insight into the subjective experience of providing care in an inter-cultural mental health consultation taking the researcher into consideration as the lens through which the data were interpreted. Paper 2, on the other hand, aimed to set up and test hypotheses.

The philosophical and methodological perspectives of this thesis are illustrated in Figure 5.

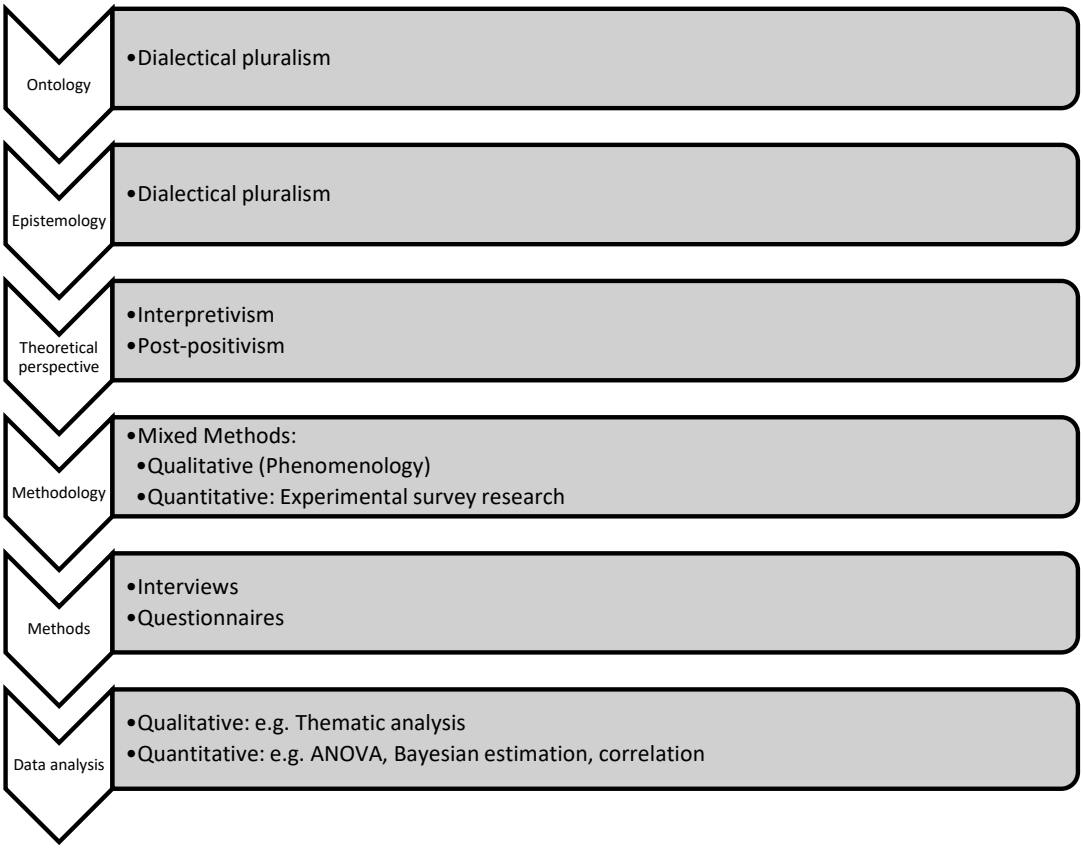

Figure 5. Overview over the philosophical and methodological perspectives of the thesis.

2.3 Qualitative methods

Qualitative research recognizes that subjective experiences are valuable and worth studying. The insights gained through qualitative interviews can also be relevant and transferable to other contexts, although one cannot generalize these with the same certainty as generalizing based on statistical analyses. Transferability has also been referred to as analytic generalization, which 'involves a reasoned judgement about the extent to which the findings from one study can be used as a guide to what might occur in another situation' (Kvale, 2007) and 'rests on contextual descriptions and includes the researcher's argumentation for the transferability of the interview

findings to other subjects and situations, as well as the readers' generalizations from a report' (Brinkmann & Kvale, 2014). Qualitative methods have been used previously to explore the experiences of primary care practitioners, often with the aim of identifying potential areas for improvement within primary care (Green & Ruff, 2005; Long et al., 2020; Sekimoto et al., 2006; Spiers & Riley, 2019).

Paper 1 of this thesis is concerned with exploring GPs' experiences providing mental health care to individuals with a refugee background in a bottom-up manner. I approached this paper from a hermeneutic phenomenological perspective. The hermeneutical element in this approach implies that interpretation is necessary when we try to understand and point out the meaning of an utterance, and that the description of the participants' lived experiences needs to be understood within the participant's but also the researcher's context (Finlay, 2011). The researcher then, in interpreting the participants' experiences, invariably draws on their own preconceptions and understandings of the world and can never be impartial (Finlay, 2011). As a result, self-reflection is an important aspect of the hermeneutic phenomenological approach (Laverty, 2003), and involves reflecting on possible preconceptions and experiences that could shape and influence how the researcher understands the participants' narratives (van Manen, 2014).

2.3.1 Paper 1

Sample and procedure

To explore GPs' experiences working with refugees suffering from mental health problems, I conducted individual semi-structured interviews with 15 medical professionals who were currently working or had previously worked as GPs in Norway. Interviews were conducted either in person at the participant's practice or via video call, between February and June 2019. The interview guide was developed prior to the interviews to prompt discussions surrounding barriers and facilitators but were updated throughout the interview process as participants themselves brought up relevant issues. The initial interview guide was pilot tested with a GP and a

psychologist. Two iterations of the interview guide, one that was developed prior to pilot-testing and interviewing and the final one (Norwegian versions), can be found in the appendix (Appendix 1 and 2 respectively).

Thematic analysis

Interviews were analysed in an inductive way using reflexive thematic analysis (TA) (Braun & Clarke, 2006, 2019; Clarke & Braun, 2018). TA aims to 'identify patterns and meanings within data' (Finlay, 2021, p. 103).

TA has several characteristics that make it appropriate for the current paper. For example, it was most compatible with the aim of the paper to describe themes across participants, in contrast to a more idiographic approach such as interpretative phenomenological analysis (IPA). Additionally, TA is accessible, flexible, and analyst driven, allowing the researcher to, for example, determine what constitutes a theme. As a result, researchers must remain consistent and transparent about the decisions they have made. This furthermore makes TA accessible for readers from other methodological backgrounds.

I attempt to follow an approach inspired by reflexive thematic analysis outlined by Braun and Clarke (2019). I was guided by the following steps, although not necessarily in this order: familiarization with the data, coding, generating themes, reviewing themes, defining and naming themes, and writing up (Braun & Clarke, 2006; Clarke & Braun, 2018). Familiarization involves becoming familiar with the data. Transcribing the interviews was considered the first step of familiarization followed by frequent rereading of the transcripts. Coding involves determining specific codes to describe the content of the text. I conducted this using the software programme NVivo (NVivo qualitative data analysis software, 2018), and highlighted sentences in the interviews that seem to describe an important issue. An example of this might be a sentence, such as 'So we have problem number one, which is language, right'. Not only does this sentence include the word language, but it also indicates that language in this case was a problem, and in fact that this problem is

'problem number 1' indicating that it is perhaps more important than several other problems.

Coding contributes to generating themes, in which patterns in the codes are identified. I looked over the codes and examined whether certain topics came up regularly and whether there were patterns across codes, such as codes discussing language. Once the themes were chosen, they were reviewed to determine their usefulness and accurate representation of the data through comparison with the original data. Next, the themes were named and defined, clarifying the exact content of each theme. This entire process resulted in the 2 overarching themes, barriers and facilitators, and the 6 sub-themes, language barriers (Language barriers limit our ability to give and receive help), different understandings of health (When worldviews clash), mismatched expectations (Great expectations and not living up to them), GPs feeling unprepared (I was not prepared for it), trust (Trust as a bridge) and meaningful work (These consultations are deeply meaningful). The final stage consisted of writing up the analysis.

2.3.2 Evaluating the analysis: Finlay's 4 R's

In the following section I reflect on the quality of the thematic analysis, guided by the four key criteria to evaluate thematic analysis, i.e., the 4 Rs, presented by Finlay and Evans (Evans & Finlay, 2009; Finlay, 2011): rigour, relevance, resonance, and reflexivity.

Rigour

Rigour refers to whether the analysis has been competently managed and systematically worked through (Finlay, 2021). Rigour can be established by presenting evidence of systematic work (Finlay, 2021). Examples of work that might lack rigour include themes that are incomplete or unfinished, an analysis that has not been categorized meaningfully, or when there is a large number of themes that ought to have been grouped together (Finlay, 2021). I attempted to achieve this ideal of rigour by following the steps outlined by Braun and Clarke (Braun & Clarke, 2006;

Clarke & Braun, 2018) as described in the previous section. In this process I received intersubjective input from colleagues and supervisors.

Relevance

Relevance refers to the value of the research in terms of its applicability and to what extent it contributes to our understanding of the phenomenon under investigation (Finlay, 2021). Since the refugee crisis, the issue of how to appropriately care for forcibly displaced individuals has become particularly pressing. We have taken this context as the background for paper 1 and describe GPs' own perceptions of issues that hinder or facilitate working effectively with refugee patients. Our findings identify avenues for future research, as well as suggesting areas in which inter-cultural consultations between GPs and refugees could be improved. These furthermore have implications for the healthcare system and may be transferrable to other settings in which individuals work with refugees. Finally, they have implications for medical training, including cultural competence.

Resonance

A phenomenological text, Finlay (2021) states, is most successful when readers feel drawn in and addressed by its poignancy. Whether resonance has been achieved becomes evident through responses from readers. I tried to achieve resonance among readers by using everyday language and describing participants' emotional experience, as well as gathering concrete examples of their experiences that may resonate with readers and other GPs.

Reflexivity

Reflexivity refers to a researcher's critical self-awareness and the examination of how their preconceptions influence the research (Finlay, 2021). I have engaged in reflexivity to consider my own positioning in my interpretation of GPs' narratives, which can be found in section 3.2.

2.4 Quantitative Methods

Paper 2 employs an experimental survey approach, while paper 3 employs a survey approach without experimental manipulation. The goal in paper 2 was to test specific hypotheses, while the aim in paper 3 was to use an exploratory approach and hopefully contribute to the formulation of such hypotheses in future research. The procedures used in papers 2 and 3 are described in more detail below.

2.4.1 Paper 2

Sample and procedure

Participants were initially recruited through snowball sampling, through the research group's network, and later, through convenience sampling, via a newsletter/bulletin for GPs circulated by Bergen municipality. The final sample consisted of 133 medical doctors in Norway, who were either currently working as GPs or had previously done so.

Participants completed an online survey (Appendix 4), in which they were randomized to one of four groups, each watching one of four film vignettes depicting a simulated primary care consultation with a single character who was either a Somali male with a refugee background ("Abdi Warsame"), Norwegian male ("Emil Olsen"), Somali female with a refugee background ("Hodan Osman"), or Norwegian female ("Mari Berg"). The survey was distributed via the survey platform Survey Xact (Rambøll Management Consulting, 2020).

The survey was pilot tested among 12 medical students as participants, who indicated suggestions for improvements. Based on their feedback, information was included stating that the patient's symptoms had no known somatic causes.

The film vignettes

Symptoms presented by the vignette characters were based on DSM-V and ICD-10 criteria for depression (American Psychiatric Association, 2013; World Health Organization, 1993). However, similar to Lawton et al.'s study (2019), symptoms

were presented in a relatively ambiguous manner so that a range of diagnoses, assessment, and treatment options could be considered appropriate. The scripts were developed by authors SMH, PEB, GMS, and ED as well as two medical doctors from our reference group of which one has a Somali background. To improve the realism of the scripts, small gender differences in the expression of symptoms based on previous literature were included (Cavanagh et al., 2017). Actors were recruited from the Bergen Dramatic Society (BADS) and the research group's network. The vignettes were filmed at Media City Bergen.

Measures

Diagnoses, Assessment, and Treatment options. Participants indicated up to three possible diagnoses, three possible assessment options, and three possible treatment options they would endorse for the vignette character and ranked the options according to priority. These will be referred to as D1, D2, D3, A1, A2, A3, T1, T2 and T3, where the letters are short for Diagnosis, Assessment and Treatment, respectively, and the numbers represent first, second, and third priority. The participants were also asked to indicate their level of certainty in each of these clinical decisions (8-point Likert scale where 0='very uncertain' and 7='very certain'). The diagnostic options were based on the International Classification of Primary Care (ICPC) codes (World Organization of National Colleges, 1998). The assessment and treatment options were developed by the authors, of whom ED is a medical doctor and specialist in Family Medicine.

Uncertainty. GPs indicated self-reported clinical uncertainty in response to the item: 'Given the information you received about this patient, how certain are you about the first/second/third diagnosis/assessment/treatment you chose'. This approach is similar previous studies that have measured uncertainty among medical staff, although these have employed various response scales, such as 4 or 11 -point Likert scales (Buntinx et al., 1991; Meyer et al., 2013) and continuous scales ranging from 0-100 (McKinlay et al., 1998). The 8-point Likert scale was chosen, because it provided GPs

sufficiently varied response categories without leading to potential overload of choices. The 8-point scale furthermore eliminated a middle category, which is often interpreted as 'neither certain nor uncertain', which is not a meaningful response and may be chosen to pick an easy answer when motivation to complete the survey is low.

Consensus across participants was measured using the Simpson index. This is described in more detail below.

Statistical analyses

The main analyses were preregistered, and the data are publicly available on the Open Science Framework (osf.io/qexrj).

As a measure of inter-rater agreement with respect to the diagnosis, assessment and treatment options chosen by the participants, we calculated the Simpson indices of the distributions of corresponding responses. Figure 6 illustrates the connection between the Simpson index and inter-rater agreement for a hypothetical example where each rater chooses one out of K = 5 different response options. If all raters choose the same alternative (Figure 6a), the inter-rater agreement may be considered perfect. In that case, the Simpson index, which is defined as

$$S = \sum_{i}^{K} {p_i}^2,$$

where p_i is the relative frequency of responses for response option i, is 1. If all options are chosen equally often, however (i.e. p_i = 1/K, see Figure 6c), one may say that there is no inter-rater agreement. In this case, the Simpson index equals 1/K. Hence, the Simpson index can be considered a measure of inter-rater agreement that ranges from 1/K (minimal agreement) to 1 (maximal agreement). Couched in terms of probabilities, the Simpson index represents the probability that two randomly chosen responses sampled from the theoretical probability distribution are identical.

Figure 6 illustrates how the Simpson index depends on the distribution of responses using three hypothetical examples with K=5 available response options.

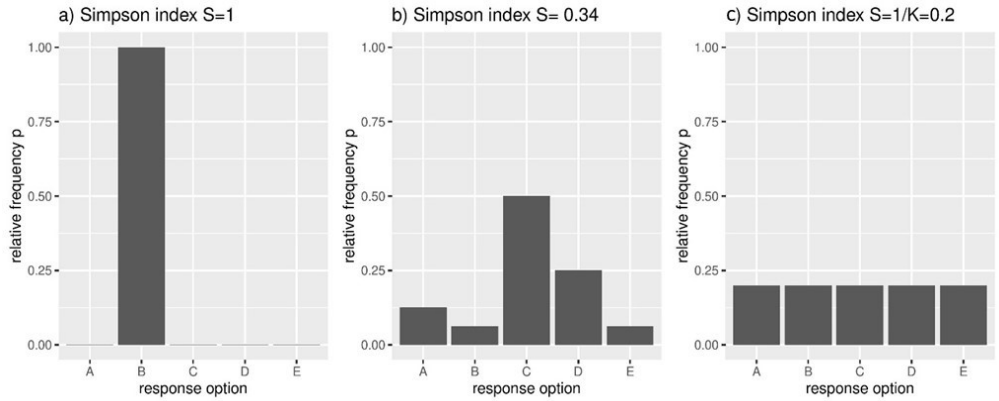

Figure 6. Illustration of how the Simpson index depends on the distribution of responses using three hypothetical examples with K=5 available response options. a) When one option is chosen over all other options the Simpson index equals 1. b) A distribution with an intermediate Simpson index. c) When the responses are uniformly distributed across the response options, the Simpson index equals 1/K, which in this case (with K=5 response options) equals 0.2.

To test for statistically significant differences between the Simpson indices for different groups we used bootstrapping (Efron, 1982) since the theoretical distribution of the Simpson index under the null hypothesis is unknown. More specifically, we used the percentile bootstrap and one-tailed tests.

To examine whether GPs' self-reported certainty about their clinical decisions depends on the nationality and gender of the vignette characters, as well as any interaction of these two factors, we conducted 2x2 independent samples ANOVAs.

Bayesian estimation

In addition to the frequentist ANOVAs, we also used corresponding Bayesian estimation (Kruschke, 2015). Bayesian estimation has the advantage of allowing the researcher to examine not only evidence for the alternative hypothesis, but for the null hypothesis as well. Note that we performed the estimation using the hierarchical

model (as well as the accompanying R-script) described in Kruschke (2015), which uses vague priors for the main and interaction deflections. The model assumes that the standard deviation of the error is normally distributed and equal in all groups, and the prior used for this parameter was a uniform distribution ranging from 0.01 to 10 times the standard deviation in the data. For the overall level across all groups, the prior was a normal distribution centered at the grand mean with a standard deviation 5 times the standard deviation in the data. The deflections from the overall level corresponding to each of the two factors, as well as the interaction deflections were assumed to be normally distributed and centered at zero, and the prior for the corresponding standard deviations was a gamma distribution with a mode corresponding to half of the standard deviation in the data and a standard deviation twice that of the data. All analyses were conducted using R (R Core Team, 2020). The Bayesian ANOVA was conducted following the procedures outlined in Kruschke (2015), using JAGS version 4.3.0 (Plummer, 2003).

Even though the field of psychology has long been dominated by frequentist methods, there has been a rise in the use of Bayesian analysis over the last 25 years (van de Schoot et al., 2017). This rise is in part due to advances in numerical computing and the increasing availability of user-friendly statistical software, which makes the necessary numerical computations feasible, as well as several conceptual strengths of Bayesian analysis over frequentist methods.

The goal of research is typically to estimate the likelihood of different hypotheses given the data one has collected. The p-values obtained by frequentist methods, however, while sometimes incorrectly interpreted, do not in fact specify the probabilities of hypotheses given the data, but rather the probability of the data (or more extreme data) given the null hypothesis. Results from Bayesian analysis on the other hand, can be interpreted as providing estimates of the likelihood of different hypotheses given one’s data.

Similarly, researchers often aim to quantify the certainty with which a value lies within a given interval. Credible intervals in Bayesian analysis indicate the range within which the true value is most likely to lie based on the data observed. For example, 95% credible intervals can be interpreted as: we can be 95% certain that the true value lies within the given interval based on the current data set. Confidence intervals are sometimes interpreted incorrectly as credible intervals, but they present a range, which is supposed to include the true value at some probability. A 95% confidence interval, then, can be interpreted as: if we were to repeat a study 100 times, the true value would lie within this given range 95 times.

Bayesian analysis has the key strength of taking prior knowledge into account in an explicit way. In the words of Haig, the aim of Bayesian analysis is 'orderly revision of opinion in the light of new information' (Haig, 2012, p. 14). As data are updated, possibilities that are in line with the original data will be supported, while possibilities that are not will lose credibility (Kruschke, 2015). To employ Bayesian terms, our prior (i.e., our expectation) combined with the data we have observed leads to our posterior.

To illustrate this, I have included examples of posterior distributions of our data below. These are the result of an uninformative prior (Kruschke, 2015) and the data that was collected. The prior can be imagined as a near flat distribution, which when combined with the data that was collected resulted in the distributions that can be seen in Figure 7. This figure shows the likely difference between the certainty GPs reported in their first diagnosis, assessment, and treatment (from left to right) for the Somali vs. the Norwegian vignette characters. The distributions can be interpreted as follows: the mode indicates the most likely difference between groups (must be considered in the context of the 8-point Likert scale, meaning a difference of 1 is 1 point on the Likert scale). The numbers in green indicate the percentage of values that lie above and below 0, i.e., no difference. The bold line at the bottom of each panel

indicates the 95% highest density interval (HDI), or credible interval, within which we can be 95% certain that the true value lies.

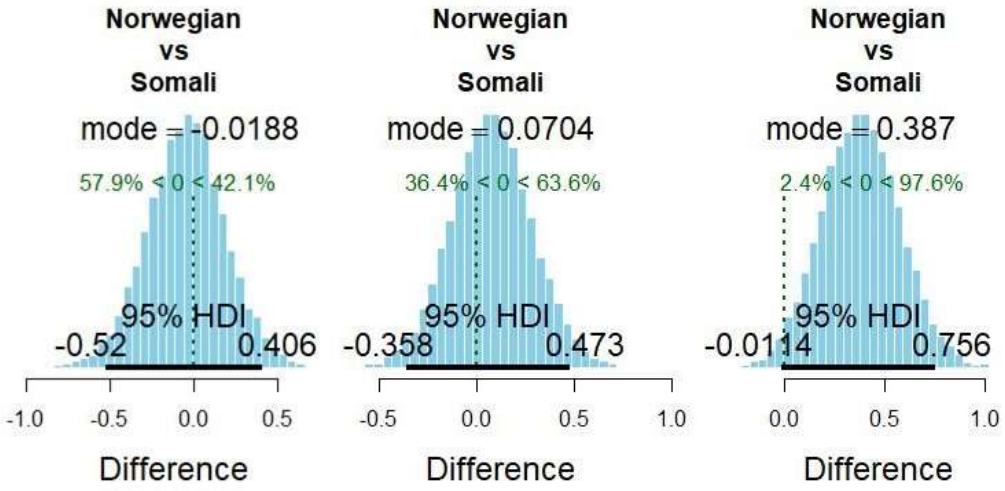

Figure 7. Posterior distributions of GPs certainty ratings for Somali vs. Norwegian vignette characters regarding first diagnosis (left), first assessment option (middle), and first treatment option (right).

In all cases, the most likely true difference (the mode) lies well below an absolute value of 1. However, the distributions and 95% HDI give us information regarding the evidence we have for different values. For example, in the panel to the right, regarding the first treatment option, the peak of the distribution and 97.6% of values lie above 0. This would suggest that we have relatively strong evidence that the difference between groups was above 0. However, the 95% HDI and the mode suggest that the most likely difference is still likely to be below 1, which when seen in the context of the Likert scale suggests that there is little evidence for a large practical difference.

2.4.2 Paper 3

Sample and procedure

Our target population were Syrian refugees over the age of 18. Participants were recruited through a purposive sampling strategy (Palinkas et al., 2015). Participants were mainly contacted through adult education programs[6] in two large Norwegian cities. Most participants completed the survey onsite, either on their own mobile devices, or on an iPad provided by the researchers. Participants were also given the option to respond to a paper version of the questionnaire, and to complete the survey in Arabic or Norwegian. An Arabic speaking research assistant was available for support onsite. A link to the survey was furthermore advertised on the research group's official website and shared via personal and professional networks. Data were collected throughout 2019, and the final responses were collected on the 14th of February 2020. Recruitment of participants was planned to continue beyond this time frame but had to be terminated due to the COVID-19 pandemic and the ensuing lock down.

The current study was embedded in a larger survey study on refugees and mental health. A total of 478 participants opened the survey link. Participants who consented to take part (N=275) (57.5%) were randomized to one of two survey versions after answering demographic questions. Sixty-eight participants consented but dropped out prior to randomization. Of those that were randomized, 101 were randomized to the current study on help-seeking (Appendix 5). Despite stating that we were recruiting participants from Syria with a refugee background, 4 individuals born in Norway participated. These were excluded from the final analysis. Similarly, participants were excluded if they did not respond to the help-seeking questions (n = 5), leaving a

[6]The adult education programs are part of a broader service offered to migrants by the Norwegian authorities and provide training for individuals to qualify for further study or employment in Norway. This includes the introductory program, which is mandatory for refugees, as well as other courses to improve individuals' job and further education opportunities.

final sample of n = 92. Among these, there were some missing datapoints, but 82 completed the entire survey (Figure 8).

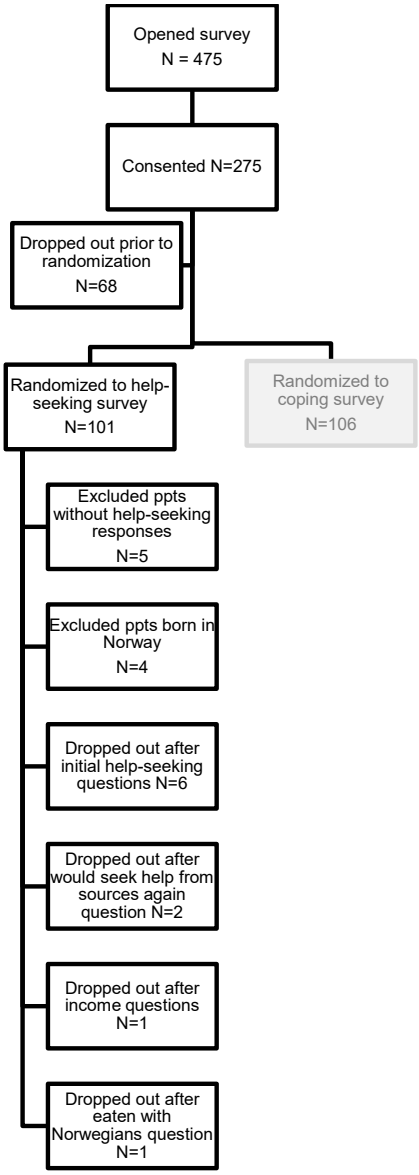

Figure 8. Flowchart illustrating the loss of participants at different stages of data collection.

The final sample included 55 men and 37 women. According to data from Statistics Norway (personal correspondence, 2021), of the over 32,000 Syrians that moved to Norway between 2000 and 2021, 78% arrived as refugees and 22% arrived as family reunification cases. A vast majority of these individuals immigrated in 2015 and 2016. Consistent with this, participants in our study indicated that their age of arrival corresponded to their present age group (58.7 %) followed by having moved one age bracket up since arrival (39.1 %). This suggests that our sample comprises recently settled refugees, in line with the pattern of immigration to Norway from Syria (Statistics Norway, 2017).

To establish the power of the current study, since our sample size was relatively small, we conducted an a posteriori sensitivity test. Based on our sample size, (given α=0.05, two-tailed), we had a power of 0.80 to detect a medium effect size of r = 0.31, a power of 0.99 to detect a medium to large effect of r = 0.45, and a power of 0.15 to detect a small effect size of r = 0.11 (Faul et al., 2007).

Given the high prevalence of depressive symptoms and related mental health problems in refugee populations, it is likely that some of our participants experienced depressive symptoms at the time of the survey. We included common psychiatric disorders, general self-rated health, and identification with the vignette character in the current study to examine the relationship between these variables and what participants report they would do in case they felt like the vignette character.

Measures

Help-seeking. To measure help-seeking preferences, participants were presented with a text vignette describing an individual, who was experiencing symptoms in line with DSM-V and ICD-10 criteria of depression (American Psychiatric Association, 2013; World Health Organization, 1993). The vignette is the same as used by Aarethun and colleagues (2021) and Markova and colleagues (2016; 2020), which is based on Erdal and colleagues (2011). To facilitate participants' ability to identify with the vignette character, female participants were presented with a female vignette character and

males with a male vignette character. The vignettes were otherwise identical (Appendix 5).

After reading the vignette, participants indicated how likely they were to seek help from different sources, if they felt like the vignette character (6-point Likert scale where 1=Very unlikely, 6=Very likely, and 7= NA). Participants could select from a list of different sources, based on categories used by Markova and colleagues (2020) and the General Help-seeking Questionnaire (Wilson et al., 2005). Next, the participants were asked to indicate their first, second, and third most preferred help-seeking sources.

Barriers to seeking help from the GP. Based on barriers commonly mentioned in the literature (Bhatia & Wallace, 2007; D'Avanzo, 1992; O'Donnell et al., 2007; Wong et al., 2006) a list of potential barriers for seeking help from the GP were developed. Similar barriers have since been described in more recent studies (Byrow et al., 2020; Satinsky et al., 2019).

Integration indices

The integration indices were employed as described in the supplementary material of Harder and colleagues (2018). We followed Harder's IPL-12 version of the measure for all indices apart from social and psychological integration, for which we included additional items from the IPL-24. Note that we excluded the index for political integration, as it had no obvious link to help-seeking preferences.

Social integration. The social integration index consisted of three items, such as 'In the last 12 months, how often did you eat dinner with *Norwegians* who are not part of your family?' (1=Never, 5=Almost every day). The index had 'acceptable' internal consistency ($\alpha = 0.64$) according to previous literature (Taber, 2018).

Psychological integration. The psychological integration index consisted of four items, such as 'How connected do you feel with Norway?' (5=I feel an extremely

close connection, 1=I do not feel a connection at all). The index had good internal consistency (α = 0.83).

Linguistic integration. Linguistic integration was measured by two items as follows: 'Communicating in *Norwegian* has many components, like reading, writing, and speaking skills. Please evaluate your own skills in *Norwegian*': 'I can read and understand the main points in simple newspaper articles on familiar subjects' and 'In a conversation, I can speak about familiar topics and express personal opinions' (5=Very well, 1=Not well at all) (r =0.83).

Navigational integration. We initially based navigational integration on the two items included in the IPL-12 (Harder et al., 2018): 'In this country, how difficult or easy would it be for you to do each of the following? A) See a doctor. B) Search for a job (find proper listings)' (1=Very difficult, 5=Very easy). However, the items were uncorrelated in our sample (r =0.07). Therefore, we employ only the single item regarding finding a doctor, which was most relevant to within the scope of this paper.

Economic integration. The economic integration index consists of one item examining household income equalised by household size. Originally, this item is to be combined with occupational status, but these two items were uncorrelated in our sample (r=0.09), and we thus focus on equalized household income only.

Number of Norwegian and Syrian friends. Number of Norwegian and Syrian friends was examined through the items 'Do you have one or more Norwegian friends' and 'Do you have one or more Syrian friends?' (1=No, 2= Yes, I have one friend, 3= Yes, I have several), which was dichotomized for the analysis (1=No, 2=Yes, I have one or several friends). Single item measures have been used previously to measure number of friends among refugee groups (Ahmad et al., 2021; Hynie et al., 2019).

Perceived severity. Perceived severity was measured by asking participants whether they felt the vignette character's condition was severe enough to warrant sick leave (Yes/No).

Identification with the vignette character. We measured identification with the vignette character by asking participants to what extent two progressively overlapping circles represent them and the vignette character. Circles A, for example, represented two separate circles (coded as 1), while circles G were almost entirely overlapping (coded as 7).

Self-rated health. Participants' general self-reported health (GSRH) was measured through the single item: 'Overall, would you say your health is:' with the response options ranging from (5) Excellent to (1) Very Poor. This question has previously been used to measure self-rated health among Syrian refugees migrating to Norway (Haj-Younes et al., 2020) and has been validated among Arabic speaking refugee populations (Dowling et al., 2017).

Common mental disorders. Common mental disorders were measured using the HSCL-25 (Derogatis et al., 1974). Participants were asked to report to what extent a range of experiences applied to them over the last 14 days (1=Not at all, 4= A lot). The Norwegian and Arabic translations of this survey have been validated in Norwegian and Arabic samples (Sandanger et al., 1998; Selmo et al., 2019). In our sample, mean HSCL score for men was 2.20 (SD=0.71) and 2.04 (SD=0.67) for women. Of these, 63% of women and 75% of men scored above the clinical cut-off of 1.75 (Ventevogel et al., 2007). While we are cautious to determine an optimal clinical cut-off in the current sample, it appears that a substantial number of participants reported symptoms indicative of psychological distress.

Statistical analyses

Paper 3 follows an exploratory design. Exploratory research, otherwise known as hypothesis generating research or non-confirmatory research, is often descriptive and

involves examining patterns in the data through the use of simple statistical methods (Haig, 2012). Tukey claimed that research needed to be seen as a two-staged process in which one should initially identify patterns in data, through exploratory research, which are then tested through confirmatory data analysis (Haig, 2012; Tukey, 1980). This approach has been encouraged in a recent call for more hypothesis-generating research (Scheel et al., 2020). Exploratory research is particularly valuable in situations where little is known about a certain topic. While research has previously been conducted on help-seeking preferences and integration of refugees in high-income countries, less is known about how newly arrived Syrian refugees use the GP as a help-seeking source in Norway and the role of Harder's integration indices in this process (Harder et al., 2018). An exploratory approach allowed us to identify interesting avenues for future research. Due to the COVID-19 lockdown, we were limited in the number of participants we could recruit for our study, and consequently lacked the power for complex statistical analyses. The exploratory approach was compatible with conducting simple, descriptive analyses and allowed us to contribute to the research field despite a relatively small sample size.

We present means and standard deviations of likelihood scores to examine participants' likelihood of seeking help from different sources. First, second, and third help-seeking choices are presented in proportions. Furthermore, Wilcoxon signed rank tests were conducted to test whether the likelihood of seeking help from one's GP differed significantly from other sources of help. Barriers to seeking help from the GP are presented in frequencies, based on the number of participants that indicated each barrier. We conduct correlation analyses (Spearman's with ordinal variables and Pearson's with the remaining variables) to examine the relationship between the independent variables, guided by the Behavioural Model, and the outcome, likelihood of seeking help from GP.

3. Mixed methods: papers 1 and 2

The mixed methods approach of paper 1 and 2 is visualised in the Figure 9 below:

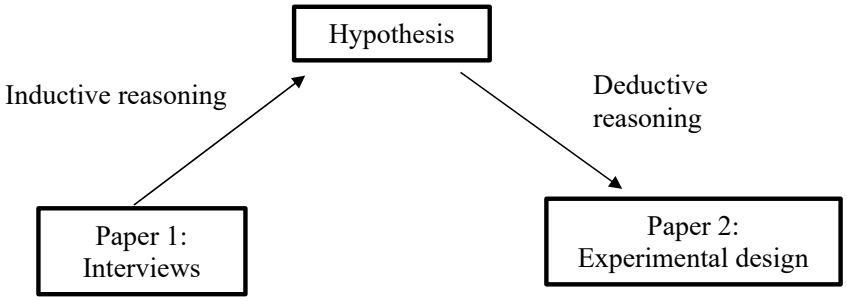

Figure 9. Visualisation of how inductive and deductive reasoning are combined in papers 1 and 2.

A mixed methods approach in this thesis is particularly important, because while there are some universal aspects of the experience of mental illness, I also take the perspective that these are heavily modified by cultural context. From a methodological point of view, therefore, I want to use mixed methods and some standardized instruments while supplementing these with qualitative understanding.

3.1.1 Exploratory sequential design

The mixed methods element of the project follows a QUAL→QUAN exploratory sequential design, consisting of one qualitative study (paper 1), which informs and inspires the subsequent quantitative study (paper 2). QUAL in this case refers to the qualitative, and QUAN refers to the quantitative component. They are both upper case as neither is primary, and they are separated by an arrow, which indicates that the quantitative component came after, and was informed by, the qualitative component.

I employ Fetters and colleagues' (2013) model as a framework for the design of this mixed methods approach. The purpose of the mixed methods approach is both development, i.e. 'seeking to use the results from one method to help develop the

other method', as well as expansion, i.e. 'seeking to extend the breadth and range of inquiry by using different methods for different inquiry components' (Greene et al., 1989; Schoonenboom & Johnson, 2017).

As pointed out by Schoonenbom and Johnson (2017, p. 6), mixed methods studies may have an overall "theoretical drive". While my PhD project's overall theoretical drive is to better understand the clinical encounters between GPs with regards to refugee patients suffering from mental health problems, each component uses a different perspective to address this phenomenon, and therefore also a different approach to examining previous literature. The theoretical drive for the qualitative component follows an 'exploration-and-deduction' approach, while paper 2 follows a 'testing-and-prediction' approach. Moreover, the studies have an exploratory sequential design, in that the qualitative component is conducted first and goes on to inform the quantitative component. Hereby, the 'first phase of qualitative data collection and analysis is followed by the collection of the quantitative data, which are used to test or generalize the initial qualitative results' (Schoonenboom & Johnson, 2017, p. 11).

The two studies are integrated at the interpretation and reporting level, meaning that findings from the qualitative and quantitative studies are presented through a staged narrative approach, where both findings are analysed and published in separate reports, although they contribute to the same overarching research question as described in this thesis (Fetters et al., 2013).

3.2 Reflexivity

Reflexivity has been described as turning a critical gaze towards oneself (Finlay, 2003). In qualitative research, the researcher is seen to play an important role in the construction of knowledge. Finlay illustrates this by stating:

> As qualitative researchers, we now accept that the researcher is a central figure who actively constructs the collection, selection and interpretation of data. We appreciate that research is co-constituted - a joint product of the participants,

> researcher and their relationship. We realise that meanings are negotiated within particular social contexts so that another researcher will unfold a different story. (Finlay, 2003, p. 5)

Given the researcher's important role as a lens through which the data are constructed and interpreted, reflexivity allows the researcher's influence to become transparent and act as a strength rather than a weakness (Finlay, 2003). It should be mentioned that my supervisors' and co-authors' disciplinary backgrounds will have impacted the design and interpretation of the studies presented here. Two of my supervisors, Prof Binder and Prof Sandal have academic and clinical experience in clinical psychology. My third supervisor, Prof Diaz, has academic and clinical experience from migration and health and Family Medicine. The remaining co-authors had experience from social psychology, cross-cultural psychology, and medical anthropology. Similarly, this research was regularly presented to and influenced by a reference group, including stakeholders in the local municipality and GPs, some of which had Syrian and Somali refugee backgrounds. Their feedback during the design and interpretation phase are also likely to have influenced the studies presented here. Consequently, the studies are highly influenced by traditions and experiences from several disciplines and lived experiences beyond my own. As the first author, however, I will focus on my own reflections in the following section.

In line with Finlay's view, Braun and Clarke's reflexive thematic analysis approach sees researcher subjectivity as a resource. They argue that themes do not passively emerge but that the researcher is at the heart of the knowledge production (Braun & Clarke, 2019). Therefore, it is highly important that the researcher engages in reflexivity to gain an insight into how their own view of the world may influence their work.

Our expectations about how things ought to be, or work, are based on what we previously have experienced. Consequently, my expectations of mental health and health care are heavily influenced by my own experiences with it. I grew up in Berlin,

Germany, around the turn of the millennium. While I did not personally encounter mental health services while growing up, and neither did many around me (at least not to my knowledge), I grew up with the belief that mental health was real and distinct from physical health. While there was some stigma attached to mental illness (not depression and anxiety disorders so much as psychotic disorders), I was aware of the existence and importance of psychologists, psychotherapists, and psychiatrists, perhaps moreso than others since I took a keen interest in abnormal psychology at a relatively early age. My surroundings imparted upon me the idea that mental health is important, and that mental illness is just that, an illness, that can be cured. I have since challenged my taken for granted beliefs around mental illness, having witnessed discussions within the field of critical psychiatry as well as having worked with clients with mental health problems. However, I feel that certain underlying assumptions remain. These include the idea that mental illness is something an individual is not to blame for, that some individuals can gain a lot from mental health interventions, that studying and better understanding mental health is valuable, and that mental health professionals are indispensable, including GPs, who often treat mild to moderate cases of mental health problems without referral to specialist services. These assumptions undoubtedly influenced the design of the current studies and study materials/methods, as well as my interpretation of both the qualitative and quantitative results.

The assumption that mental health exists underlies all papers in this thesis. Paper 1, for example, explored the experiences of GPs working with refugees suffering from mental health problems. More specifically, however, when considering this underlying assumption, we are examining GPs' experiences working with refugee patients whom GPs have deemed to suffer from mental health problems. I felt that this slight adjustment in nuance is important for the appropriate interpretation of the results.

Another element to reflect on in the context of this thesis is my status as an immigrant, whose native language is not Norwegian. Gadamer claims that 'language is the universal medium in which understanding occurs' (Gadamer, 2013). An obstacle I faced during the qualitative interviews in paper 1 was my limited knowledge of the Norwegian language. I gave participants the choice to hold the interviews in Norwegian or English (or German, although nobody chose this option). I felt that participants would be able to express themselves more precisely in the language in which they felt most comfortable and that their comfort was more important than my own, given that it was their narratives I was trying to gain insight into. Most participants chose to conduct the interviews in Norwegian, naturally. While this filled me with some dread initially, I invited a Norwegian-speaking researcher to observe the first three interviews to ensure that the language barrier was not an obstacle for effective communication. We concluded that even with my limited knowledge of Norwegian, I was able to understand and transcribe the interviews accurately. I furthermore invited one of our Norwegian-speaking research assistants to compare the audio recordings of the interviews with my transcriptions to check for mistakes prior to conducting the analysis.

I eventually considered that my Norwegian language skills might even be an asset, allowing me to probe deeper into phrases and experiences I may have taken for granted in my native languages. For example, one of the participants mentioned that information from the patient came in 'fragments' or 'bits and pieces' ('bruddstykker'). I asked the participant to explain what they meant, as I was not familiar with the term. They continued to explain that the patient did not enter the consultation and immediately state their name and age and explain their entire life story. Instead, the patient entered the consultation and focussed initially only on certain symptoms, such as restlessness, racing thoughts, lack of sleep. The participant then explained that the patients' beliefs about the potential causes of these symptoms were only revealed after a few meetings. This clarification showed me that the 'bruddstykker' this GP was referring to, were in fact different types of information

that were being revealed as opposed to bits and pieces of, for example, symptom presentations. This allowed me to further reflect on the role of a trusting relationship between GP and patient, which may facilitate the sharing of important information. In this situation, my linguistic weakness became a strength, because I gained a deeper insight into the GP's narrative.

In a similar vein, I became aware of my potential status as an outsider, not only as an immigrant with broken language skills, but within my role as a non-GP researcher. In research, an 'insider' shares the 'characteristic, role, or experience under study with the participants' (Dwyer & Buckle, 2009). However, the more I reflected on this, the more I found that I am both an insider and outsider in this research. While I am not a medical doctor, and therefore not strictly an insider, I am aware of some of the challenges of working in a clinical setting, as well as working with individuals from different cultural backgrounds. Before moving to Norway, I worked in the UK's national health service as a psychological wellbeing practitioner with clients suffering from mild to moderate depression and anxiety disorders. I remember working with a client, who did not speak English as a first language. She decided against using an interpreter in our sessions, because she felt this would stand in the way of her being able share her experiences with me comfortably. The language barrier was a significant obstacle in our work. I noticed myself becoming frustrated and worrying about how to communicate with her let alone do any therapeutic work. This meant that our sessions often ran over time, and she eventually dropped out of treatment. While these types of experiences have made me more sympathetic to some of the challenges GPs may face working with refugees, they also put me at risk of 'being inherently biased, and too close to the culture to be curious enough to raise provocative questions' (Merriam et al., 2001). Having reflected on this I made an active effort to see the GPs' experiences as distinctly different from my past experiences.

On the other hand, I was also an outsider. Despite certain commonalities, the interviews made me acutely aware of aspects the GPs and I did not have in common. During one interview, the participant pointed out that I must know a lot about a certain mental health diagnosis if I work in psychology. While I was familiar with the diagnosis she mentioned, I later felt that I should have probed deeper into what the diagnosis meant to her.

It was vital to be aware of the effect my insider/outsider status might have on the interpretation of the data. However, ultimately, neither is more beneficial than the other, and 'what an insider 'sees' and 'understands' will be different from, but as valid as what an outsider understands' (Merriam et al., 2001).

Previous literature has often mentioned the important role of cultural context in our understanding of mental health. Therefore, I attempt to extend my reflections beyond personal reflexivity to cultural reflexivity. According to Aronowitz and colleagues:

> The lens of cultural reflexivity is central to inquiries about how and why people act in certain ways and not others. (Aronowitz et al., 2015, p. 403)

For example, while I did not interview Syrian refugees in paper 3, I still believe it is important to reflect on the potential power imbalance in this research. Despite using quantitative methods, which ideally aim to be limit researcher bias, I believe that research typically prioritizes the researcher's voice over the participant's voice. It is the researcher that is allowed to interpret the data and tell a story in the research paper, rarely the participant alone.

For example, in paper 3, while the help-seeking sources presented were based on previous literature, this literature was largely conducted in Europe and North America. Participants could choose one of the pre-suggested sources of help, or the choice 'Other'. It is important that we are aware of the influences of our underlying assumptions that can permeate the earliest stages of research and therefore colour the entire research process. However, it is notable that participants indicated they were

relatively unlikely to seek help from an 'Other' category. This suggests that while we must be aware of how our choice of categories may have influenced our participants, it is possible that there was no significant omission in relevant sources of help.

Similarly, the idea that mental health exists and can be treated is an underlying assumption in the survey that would have put participants in a situation where they are required to respond despite a premise they may not necessarily agree with. While several participants indicated that they would not seek help for the experiences reported by the vignette character, it is unclear whether they see those experiences as poor mental health or something else entirely. Aarethun and colleagues' paper (2021) gives some insight into this issue, suggesting that Syrian refugees recognized symptoms of PTSD and depression and, in some cases, even named them as such. However, they also add that PTSD, for example, was seen as a normal reaction to extreme situations and depression was often discussed in terms of feelings caused by social problems, and that individuals were hesitant to identify with the diagnoses of depression and PTSD even in cases where symptoms were recognized. I attempted to keep these insights in mind when interpreting data from paper 3, but think it is important to acknowledge that my voice as a researcher is likely to have trumped that of the participants.

3.3 Ethical considerations

Study 1 was approved by the Norwegian Centre for Research Data (NSD notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki (World Medical Association, 2013) (Appendix 3). Audio recordings of interviews were stored on the secure desktop solution 'SAFE' (Secure Access to Research Data and E-infrastructure) and were deleted following transcription, in line with the Norwegian code of conduct for information security in the healthcare sector. Participants received consent forms ahead of time and were encouraged to ask questions at any point. We asked GPs not to disclose any

information that could identify their patients. However, for the purpose of our research we were interested in descriptions of single consultations, including the patient's general area of origin, how they presented their symptoms, their gender, and their approximate age. We continued to encourage participants only to share what they were comfortable with, and anonymised transcriptions to the point that neither participants nor their patients could be identified.

Study 2 was approved by the Norwegian Centre for Research Data (NSD Notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki (World Medical Association, 2013) (Appendix 4). Participation was voluntary, anonymous, and confidential. To claim a gift card worth 500 NOK (€48), participants had the choice of being redirected to another website following completion of the survey. Here, they were given the choice of entering their name and address, which could not be linked to their responses on the survey. The given information was only read by the first author and was deleted once gift cards were posted.

Study 3 was approved by the Norwegian Centre for Research Data (NSD Notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki at the start of the survey (World Medical Association, 2013) (Appendix 5). Participation was voluntary, anonymous, and confidential. Participants were encouraged to contact their GP if they were having experiences as described by the vignette character.

4. Results

4.1 Summary of paper 1

Paper 1 presents six themes based on interviews with GPs regarding their experiences of working with refugees with mental health problems. Of the resulting themes, four were categorized as challenges and two as facilitators, based on participants' own perceptions of whether this theme stood in the way of, or facilitated, the consultation.

One of the most mentioned barriers related to language. This included working with interpreters, which was often presented as time-consuming and difficult. Participants suggested that language barriers stood in the way of being able to effectively provide but also for patients to receive help.

The second theme, 'when worldviews clash', describes GPs' experience that patients had different ways of understanding the body, what constitutes health or illness, and the causes of mental illness. All GPs acknowledged mental illness as a condition to be taken seriously, and as something that could be treated. Some of their patients, however, either did not want to discuss mental health, did not see it as a problem, or did not expect the GP to be involved in matters regarding their mental health. This seemed to cause conflicts for some GPs, who felt their patients had different priorities.

Theme number 3, 'great expectations and not living up to them', describes GPs' impression that refugee patients seemed to have high expectations regarding the Norwegian healthcare system, including the role of the GP, as well as possible treatment options. Patients often hoped for or requested what GPs felt was, a 'quick fix', and expected the GP to go above and beyond their job role.

The above challenges are linked to the final challenge, 'I was not prepared for it', in which GPs pointed out that their medical qualification had not adequately prepared them for working with refugees suffering from mental health problems and how to

navigate the related demands. Here, some participants also reported feeling uncertain about their clinical decisions, due to the lack of sufficient information and a consequent fear of making incorrect clinical decisions.

However, GPs also identified domains that facilitated effective consultations. Participants pointed out, for example, that many of the barriers presented above are improved when patient and GP had established a trusting relationship. A trusting relationship could lead to better communication and treatment adherence, for example. Finally, GPs also conveyed a strong sense that working with refugees suffering from mental health problems was a meaningful and interesting part of their job and served as a reminder for why they became practitioners in the first place.

4.2 Summary of paper 2

Paper 2 aimed to describe differences in clinical decisions made about Somali refugee vs. Norwegian vignette characters and to test whether there is lower consensus among GPs (i.e. higher macro uncertainty) regarding the most appropriate diagnoses, assessments, and treatment for Somali refugee vs. Norwegian vignette character. Furthermore, we predicted that GPs would report lower individual clinical certainty (i.e. micro-certainty) regarding the Somali vs. Norwegian vignette characters, and that we would see an interaction of patient background and gender. Our hypotheses were partly supported.

Overall, clinical decisions GPs made about Somali refugee vs. Norwegian vignette characters were relatively similar, with a few differences found. However, we found no evidence for large differences in GPs' clinical certainty regarding clinical decisions made about the Somali refugee vs. Norwegian vignette characters.

Somali characters were the only group to receive diagnoses of 'P82 PTSD' for D1, where Norwegian characters were more often given a diagnosis of 'P03 Feeling depressed'. There was broader spread in GPs' decisions about D1, indicating less

consensus, for the Somali characters. Somali characters were also more often prescribed medication for physical complaints than Norwegian characters, while Norwegian characters were prescribed more sick leave than Somali vignette characters. However, when examining the four vignette characters separately, the female, Norwegian vignette character received the highest frequency of sick leave in comparison with the other three vignette characters, and may, therefore, account for the difference between the Norwegian and the Somali characters.

Despite some small differences regarding the diagnoses and treatments considered for the Somali vs. the Norwegian vignette characters, GPs' mean certainty ratings did not differ regarding decisions made about the Somali and Norwegian groups for diagnoses and assessments, counter to our hypothesis. We did find that GPs' mean certainty ratings for T1 were lower in the Somali group than in the Norwegian group. However, while this difference is statistically significant it is small and can be considered as having limited practical consequence.

We also used corresponding Bayesian estimation to examine posterior distributions of the differences in GPs' self-reported certainty regarding clinical decisions made about the Somali vs. the Norwegian characters as well examining the interaction of patient gender and nationality. Posterior distributions suggested that any real differences larger than one unit on the rating scale (which ranged from 0 to 7) were implausible in all cases. Similarly, any interaction of patient characteristics was likely to have been small.

4.3 Summary of paper 3

Our findings show that Syrians with a refugee background in the current study considered the GP, as well as the psychologist/psychiatrist, viable sources of help in cases of depression. The GP was considered a significantly more likely source of help than a social worker, but a significantly less likely source of help than Allah/God or one's partner. The GP as a source of help was ranked equally as likely as seeking

help from one's mother, other family member, Syrian friends, one's father, the internet, and Norwegian friends. It is important to remember, however, that help-seeking sources are not mutually exclusive, and this suggests that individuals in the current study may consider seeking help from the GP alongside other informal sources, such as one's family and friends.

However, participants reported an average of two barriers to seeking help from the GP. The most common barriers were language barriers, I don't think it would help, the waiting times are too long, and I don't think my GP would understand.

Our final aim was to explore the role of integration in help-seeking preferences among Syrians with a refugee background. Our findings suggest that psychological and social integration were positively correlated with likelihood of seeking mental health help from the GP.

4.4 Overall results summary

A figure visualizing an overview of the papers from the current dissertation can be found Figure 10. This figure illustrates the connection between the different papers, integrating both the theoretical background and the findings. Note that it aims to describe the insights from the current thesis, and therefore presents a linear simplification of what occurs in a true consultation. The left part of the figure presents the refugee patient related component of the thesis. Based on our findings, and guided by the Behavioral Model (Andersen, 2008; Andersen et al., 2014), the figure visualizes how individuals with a refugee background are influenced to seek mental health help from the GP by demographic factors (including age and relationship status), their beliefs around the benefits of seeking help from the GP, and their level of social and psychological integration. This results in their choice of seeking help from the GP, an alternative source of help, or not seeking help at all. While the role of demographic characteristics and integration in seeking help from sources other than the GP was not the focus of this thesis, an examination of this can

be found in previous literature (Markova et al., 2020). Note, that seeking alternative sources of help and seeking help from the GP are not mutually exclusive and are therefore overlapping in the figure. However, even when a willingness to seek help from the GP exists, barriers, including language barriers and waiting times, may deter individuals from seeking help, which may lead them to seek help from alternative sources or to not seek help at all. The right-hand part of figure focuses more on the GP's perspective. Based on our findings, GPs experience barriers in consultations with refugee patients, including language barriers, feeling that their patients have higher or different expectations of them than Norwegian patients, feeling like they have different understandings of what constitutes health and illness, and feeling unprepared for working with this patient group. Furthermore, GPs recognize the importance of establishing a trusting relationship with their patient and experience their work as meaningful. Once the refugee patient and GP meet in the clinical consultation, each of their experiences and beliefs will impact what happens in the encounter. This is indicated by the mixing of colours, yellow indicating patient and blue, indicating GP. While not specifically examined in this thesis (and therefore indicated through dotted arrows), the barriers and facilitators experienced by GPs are also likely to influence the clinical decisions they make regarding their patient. Furthermore, based on our findings, the symptom presentation of the patient and the characteristics of the patient (their gender and background) influence the GPs' clinical decisions, possibly through the process of heuristic decision making, albeit to a relatively small degree. This complex interplay of both patient and GP related experiences and factors will invariably influence the outcome of the consultation. The outcome may be perceived as satisfactory or not by the GP and the patient, which in turn will influence their expectations for future consultations. This may further influence the patient's willingness to seek help from the GP or may lead them not to seek help at all.

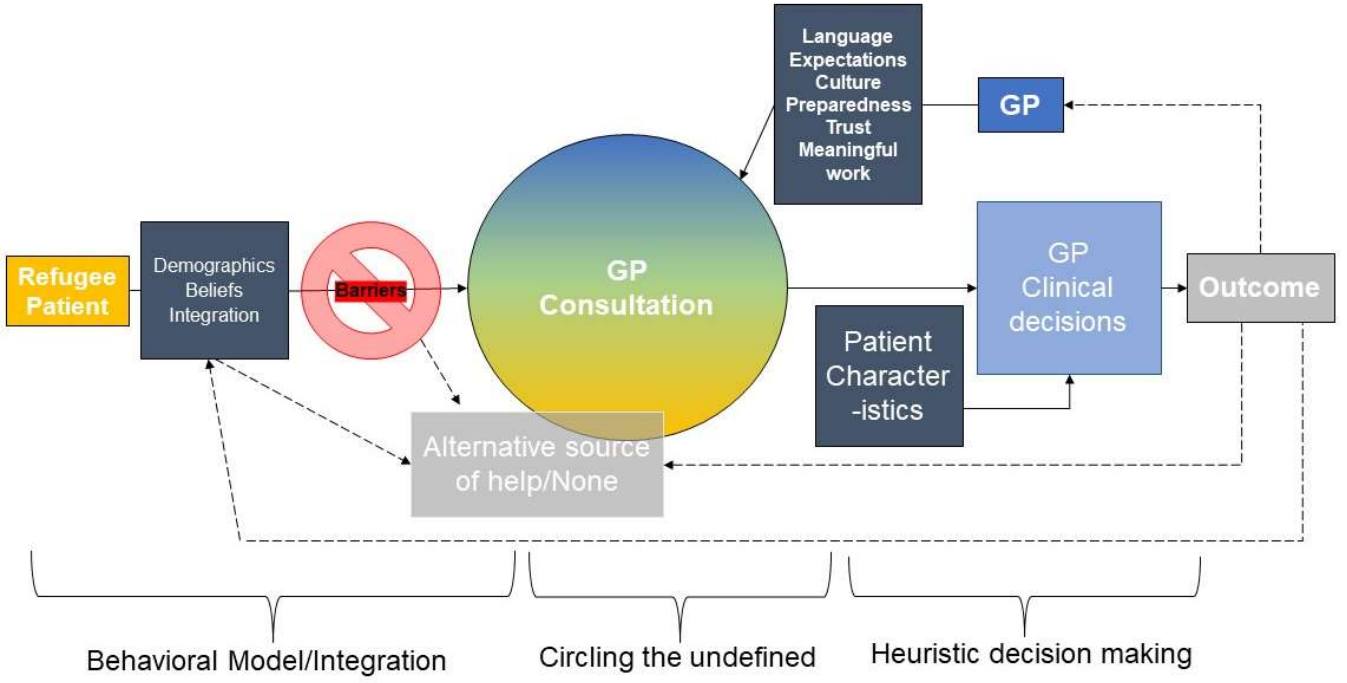

Figure 10. Visualization of the thesis, integrating findings and theoretical background (bottom). Note, dotted arrows indicate aspects not directly examined in this thesis, but which may constitute important implications of the findings and areas for future study.

5. Discussion

The aims of this thesis were to examine what facilitates, influences, and stands in the way of providing effective mental health care to individuals with a refugee background. Furthermore, to explore mental health help-seeking preferences, and perceived barriers, among Syrians with a refugee background.

The following sections are divided into three parts addressing the contributions of this thesis. Section 4.1.1 will discuss the mixed methods component of the thesis (papers 1 and 2) and summarize how GPs experience and manage mental health care provision to refugees gathered through qualitative interviews as well as the experimental survey. Section 4.1.2 will discuss the barriers to mental health care provision identified by GPs in qualitative interviews (paper 1) in comparison to the barriers identified by Syrian refugees in the survey study (paper 3). Section 4.1.3 discusses further factors that influence mental health help-seeking among Syrian refugees in paper 3, including a focus on integration.

5.1.1 Experience and management of mental health care to patients with a refugee background: the GP perspective (papers 1 and 2)

Findings from paper 1 give an insight into the types of challenges GPs perceive when providing mental health care to refugee patients. Overall, the findings imply that GPs perceived certain barriers and facilitators that were unique to consultations with refugee patients vs. non-refugee migrants or the majority population. This included GPs' feeling that they were unprepared for, and less certain about, the clinical decisions they made about refugee patients. We then conducted an experimental survey study to examine to what extent GPs treated or managed refugee patients differently in comparison to the majority population, and whether their feelings of uncertainty were in fact higher in consultations with refugee directly compared with majority population patients presenting identical symptoms.

The findings from paper 1 largely mirror findings in previous literature. Language barriers, for example, have been consistently named as one of the most challenging barriers for healthcare professionals working with diverse patient groups (Furler et al., 2010; Jensen et al., 2013; Kirmayer et al., 2011; McKeary & Newbold, 2010; Sandhu et al., 2013; Satinsky et al., 2019; van den Muijsenbergh et al., 2014). GPs indicated that this often led to a reliance on interpreter services. However, both in our study and previous literature interpreter services themselves have been presented as a barrier and facilitator, as they can facilitate communication, but health professionals may be sceptical of the accuracy of the translations (Feldman, 2006; Furler et al., 2010; Gongguy et al., 1991; Kirmayer et al., 2011; Kirmayer et al., 2015; Mirdal et al., 2012). Language barriers furthermore not only hamper the patient's ability to share their experiences, or the practitioner's ability to explain interventions, but, deeper than that, often stand in the way of being able to clarify the fundamental, taken for granted, elements of the consultation (Rothlind et al., 2018). This failure to make one's expectations of the consultation explicit, can lead to misunderstandings and conflict (Rothlind et al., 2018).

Beyond language barriers, certain cultural differences more generally were cited as barriers to providing mental health care to refugee patients, which is also in line with previous studies (Furler et al., 2010; Jensen et al., 2013; Kokanovic et al., 2010). One participant in our study, for example, referred to the differences between them and their refugee patient as 'different horizons of understanding'. The participant in this situation attempts to illustrate the differences in their understanding of the body, health, and illness in comparison with their patient. This may include having different priorities (Kirmayer et al., 2015), such as the patient not perceiving, for example, 'depression' as a problem that requires treatment (Furler et al., 2010; Kokanovic et al., 2010). A participant in our study pointed out that they felt they needed to convince their patient of the true problem they were suffering from, i.e., mental health problems. This presents a difficult issue, because GPs on one hand are healthcare professionals and must use their knowledge to inform and educate their

patients and are expected to give patients treatment recommendations. However, when the GP feels that their patient has such a different 'horizon of understanding' that communication becomes difficult, a negotiation between GP and patient becomes less feasible. The risks of this may include that interventions are chosen by the GP with less consideration for the patient's explanatory models, which may lead to poorer adherence to interventions among patients (Shahin et al., 2020).

The experience of having 'different horizons of understanding' may furthermore be associated with differences in health literacy, rather than solely cultural differences. Health literacy has been defined in a number of ways, but generally refers to 'the degree to which individuals can obtain, process, understand, and communicate about health-related information needed to make informed health decisions' (Berkman et al., 2010). Health literacy has been examined among Syrian refugees recently, and it was found that higher health literacy was associated with higher rates of seeking help from one's GP, indicating that health literacy may lead to a higher likelihood of adopting the dominant care model of the resettlement country (Haj-Younes, Stromme, et al., 2021). It is possible then that what GPs perceive as 'different horizons of understanding' is only partly rooted in cultural differences, and partly reflects differences in health literacy. However, the concept of health literacy should be approached with caution, as it 'is strongly rooted in models of mental health care in high income countries and does not typically take into account the individual's knowledge or understanding of mental health concepts as expressed within their own cultural group, nor their own lived experience' (Byrow et al., 2020). In other words, the concept of health literacy measures one's ability to obtain, process, understand, and communicate about health-related information *in one's resettlement country*, and it does not necessarily take into consideration explanatory models.

In addition to problems related to communication, GPs in our study perceived that refugee patients tended to have different expectations of the GP and the healthcare system than Norwegian patients, which has also been found in previous studies

(Jensen et al., 2013; Sandhu et al., 2013). This included patients asking of the GP to help them respond to a letter from, for example, the Norwegian Labour and Welfare Administration (NAV), which GPs did not feel was their responsibility. Several GPs chose to go above and beyond for their patients but acknowledged that there were risks of getting too involved, and one participant pointed out that the mismatch of expectations made them feel helpless. Patients and practitioners should reflect on their own expectations from such encounters and make these explicit (Kirmayer et al., 2015). Here, practitioners may want to lean on the cultural formulation interview (CFI), as outlined in the DSM-5, which aims to tackle, among other things, patient and physician expectations (Kirmayer et al., 2011). Use of the CFI may contribute to strengthening the therapeutic alliance, reducing misdiagnosis, and uncovering information that is relevant to identifying the most appropriate intervention (Adeponle et al., 2012; Kirmayer et al., 2015).

Importantly, these above-mentioned barriers not only influence what goes on during clinical consultations but may also influence what GPs expect of similar consultations in the future (Kumar & Diaz, 2019). Similarly, knowledge of the perils typically associated with forced migration may influence GPs' clinical decisions in future consultations with refugee patients (Echterhoff et al., 2020). This is supported and supplemented by our findings from paper 2, which suggested that even in the absence of confounding variables and barriers, patient background and gender impacted the GPs' clinical decisions, albeit to a small degree. The higher number of PTSD diagnoses chosen for Somali vs. Norwegian characters suggest that GPs may have been influenced by their knowledge of the higher prevalence of PTSD and potentially traumatic experiences among refugee and asylum-seeking groups when making these diagnostic decisions (Echterhoff et al., 2020; Fazel et al., 2005; Richter et al., 2018). While practitioners should draw on their knowledge about different patient populations, it clearly raises some concerning questions regarding the validity of PTSD diagnoses among refugee and asylum-seeking groups. Moreover, Somali characters were offered sick leave less often than Norwegian characters, and the

Norwegian female vignette character was offered sick leave more often than all other vignette characters. While this is in line with studies showing that women in general have higher odds of receiving sick leave for symptoms of depression than men (Lytsy et al., 2019), it begs the question why this was not the case for the Somali, female character.

Since vignette characters in paper 2 presented identical symptoms of depression, confounding variables most likely do not explain the variation observed. Findings from paper 1 suggest that GPs may feel unprepared for working with refugee patients suffering from mental health problems. This is supported by the finding that almost 70% of our participants in paper 2 felt they required a course on migration and health. This is also in line with other studies (Begg & Gill, 2005; Fuller et al., 2009; Wylie et al., 2018). Several GPs in paper 1 suggested they were making decisions based on a lack of sufficient information and were afraid of making mistakes that could adversely impact their patients. It has previously been shown that diagnostic uncertainty can impede a clinician's ability to identify and initiate appropriate treatment (Bhise et al., 2018), and is considered one of the main causes of variation in clinical decision making (Eddy, 1984).

As hypothesized in paper 2, we found that there seemed to be slightly less consensus across GPs regarding what first diagnosis was most appropriate for the Somali characters vs. the Norwegian characters. A lack of consensus has previously been associated with uncertainty across practitioners, a phenomenon called macro-uncertainty (Baumann et al., 1991). Coupled with the fact that there was no variation in GPs' individual certainty (micro-certainty), this may indicate a macro-*un*certainty micro-certainty pattern, which has previously been said to suggest clinical overconfidence (Baumann et al., 1991). GPs may feel relatively certain about their clinical decisions, but this does not necessarily correspond to consensus across health professionals. This would imply that patients may receive different diagnoses depending on which GP they visit, but that the individual GPs may be relatively

confident in their own clinical decisions. Clinical overconfidence in true consultations may limit GPs' abilities to update their clinical decisions based on new, possibly conflicting, evidence (Baumann et al., 1991). However, overall, the effect was relatively small. This may furthermore indicate that GPs' experiences of uncertainty could be related to the factors that were controlled for in the experiment, such as communication difficulties.

GPs in paper 1 highlighted the importance of having a trusting relationship with their patients, which they suggested facilitated an effective consultation. Our findings regarding the importance of trust are in line with previous studies. Trust in others has, for example, been shown to moderate the relationship between perceived discrimination and mental health among women with an migrant background in Norway (Straiton et al., 2019). On the flipside, a lack of trust in authorities has been shown to lead to a decrease in engagement with the host community over time (Nickerson et al., 2018). In true consultations, therefore, trust is likely to be an important variable regarding GPs' clinical decisions about refugee patients.

Combining the findings from paper 1 and 2, paints a picture of GPs being affected by barriers in their work with refugee patients, as well as finding this work meaningful and interesting. It furthermore shows that GPs' experiences with and attitudes towards refugee patients may influence their clinical decisions. Even in the absence of barriers and confounding variables GPs seemed to be somewhat influenced by the patients' characteristics when making their clinical decisions. Moreover, the clinical variation observed in paper 2 was unlikely to be the result of clinical uncertainty on the part of the GP in the current sample. I interpret these findings to suggest that GPs may enter clinical consultations with some refugee patients with certain expectations of cultural difference and being faced with individuals that have a higher likelihood of being traumatised, which may influence their experiences and, albeit to a small extent, their clinical decisions. However, these are likely to be influenced or mitigated in true consultations, through, for example, a trusting relationship with the patient.

5.1.2 Barriers to mental health care provision and access: the GP and Syrian participant perspective (papers 1 and 3)

It is important to note that barriers chosen by GPs and Syrian refugees are only comparable to some extent, given that they were ultimately responding to different questions. GPs responded to open ended questions about their experiences working with refugee patients, and spontaneously mentioned certain barriers as standing in the way of an effective consultation and effective treatment. However, the Syrian participants were given a set of barriers to choose from, in response to the question: 'which of these barriers might stand in the way of seeking help from the GP?'.

Nevertheless, the results highlight that language barriers were at the forefront of both GPs' and Syrian refugees' minds with regards to both access to, and provision of, mental health care. Language barriers have been mentioned by both health professionals (Feldman, 2006; Furler et al., 2010; Jensen et al., 2013; Kirmayer et al., 2011; McKeary & Newbold, 2010; Sandhu et al., 2013; van Loenen et al., 2018), and migrant patient populations (Gele et al., 2017; Hynie, 2018; Satinsky et al., 2019) in previous literature, which suggests that this is a highly relevant and supported finding. The research field should turn its attention towards finding effective solutions.

Another overlapping barrier relates to mismatched expectations, where Syrian participants indicated 'I don't think it would help' or 'the waiting times are too long'. This suggests that Syrian refugee patients may expect that seeking help from the GP for mental health problems is not useful and in cases where they would consider it, some feel that waiting times are unreasonable. It is my experience that while Norwegians are not pleased with the waiting times to see specialist services, they oftentimes accept these as they are familiar with the process and have managed their expectations or have the means to access private specialists and bypass the process altogether. For individuals from other countries, including Syria, where publicly funded specialist services are more readily accessible than in Norway, the waiting

times may be highly frustrating (Aarethun et al., 2021). The mismatch of expectations may cause frustration and discontent among patients, as well as frustration and helplessness among GPs, who recognize these mismatched expectations but often have no control over, for example, waiting times. The implication of this is that it may feed back into individuals' willingness to seek professional support in the future.

Different cultural understandings of health and illness also seem to be perceived as barriers by both GPs and Syrian participants. Some Syrian participants, for example, chose the barriers 'I don't think my GP would understand'. This may be an experience shared by some GPs and Syrian refugees, in which both feel that they are neither understood by, nor fully understand, the other. This ties in with Rothlind's circling the undefined model, which suggests that health professionals and their patients in these situations may fail to acknowledge and make explicit their expectations and different explanatory models, which may contribute to misunderstandings (Rothlind et al., 2018). Clarifying both GPs' and patients' explanatory models of mental health, expectations of the healthcare system, and the responsibilities of the healthcare practitioner as well as patient may facilitate effective consultations.

Trust was also an important issue identified by both GPs and Syrian participants. GPs presented trust as a facilitator to an effective consultation but recognized that a lack of trust could stand in the way of gathering the necessary evidence to make appropriate clinical decisions. 'I don't trust my GP' was chosen by some Syrian refugee participants as a reason not to seek help from the GP. This is mirrored in previous literature (Byrow et al., 2020; Gele et al., 2017). However, only few participants in our study chose this barrier, suggesting (promisingly) that the vast majority *did* trust their GP, which is supported by a recent interview study conducted among Syrian refugees in Norway (Haj-Younes, Abildsnes, et al., 2021). Nevertheless, in the cases where trust is lacking, it should be acknowledged that both

patients and their GPs will have the experience that this hampers effective consultations.

Beyond this, however, both GPs and Syrian refugee participants experienced barriers that were unique to their situation. For example, GPs experienced feeling unprepared for working with refugees suffering from mental health problems, while Syrian refugees indicated certain practical barriers, such as financial concerns (although few picked this barrier). Feelings of being unprepared for working with refugee patients should be addressed by the medical curriculum and courses about migration and health. Practical barriers perceived by patients present more sociodemographic and financial issues.

5.1.3 Factors that play a role in mental health help-seeking: perspectives of Syrians with a refugee background (paper 3)

To examine socio-demographic variables that influence mental health help-seeking among Syrians with a refugee background, we were guided by Andersen's behavioural model of health services use.

Increasing age was associated with a higher likelihood of considering the GP as a source of help. This was somewhat surprising given the findings by Aarethun and colleagues (2021), who suggested that younger participants were more likely to endorse formal psychological treatment in general than older men, some of which claimed that one could become sicker when seeking professional mental health help. However, this may be explained by the fact that Aarethun and colleagues' focus group interviews discussed mental healthcare specifically, while we focused on the role of the GP, which may be more acceptable to older adults than mental health services.

Having a partner was associated with lower likelihood of choosing the GP as a source of help. This is in line with our findings that participants considered their partner a likely source of help and suggests that individuals prefer to seek help from their

partner when they experience psychological distress than from a GP, although, as stated earlier, these sources may not be mutually exclusive (Kirmayer et al., 2011).

We also found that feeling like the GP would not be able to help was negatively related to likelihood of seeking help from the GP. This is in line with previous findings suggesting that perceived benefit of seeking help was one of the largest predictors of seeking help among adolescents (O'Connor et al., 2014). Importantly, this study found that perceived barriers become less important when perceived benefit is high. This should be explored among refugee populations in future research, as it may present a powerful way of overcoming barriers.

However, we did not find any relation between gender, education, income, or perceived severity of the vignette character's symptoms and likelihood of seeking help from the GP. This contrasts with some previous literature on non-refugee populations, which found, for example, female gender and higher education as positively correlated with seeking help for depressive symptoms (Magaard et al., 2017). However, the fact that we did not find an effect here may be the result of low variability in our participants' educational attainment and income rather than a true lack of effect. Perceived severity has also previously been linked to help-seeking behaviours (Magaard et al., 2017). However, our findings may indicate that this does not apply when participants are responding in relation to a vignette character.

Our study also considered religious coping in relation to other sources of help and found a preference for religious coping i.e., looking for support in one's relationship with God. It has been suggested that being influenced by both home and host country beliefs around health and healthcare may be an advantage, affording more options for seeking help, but may also pose a barrier, if those sources conflict (Atallah, 2017). We found no evidence that religious coping conflicted with seeking help from the GP, meaning that while there was a preference for religious coping, the sample, on average, still considered the GP a viable source of help. However, it is important not to discard the possibility that there may be a type of conflict on the side of the

practitioner. It is not common in Norway to make use of religious coping as an important aspect of peoples' recovery or care, despite findings suggesting that religious coping has several positive benefits for both physical and mental health (Harrison et al., 2001; Koenig, 2018).

Magaard's systematic review (2017) pointed out that it was unclear how or to what extent social relationships and social support related to help-seeking. Our study takes a step towards addressing this question by suggesting that social integration, i.e., social network in the host country, may be positively related to considering the GP as a viable source of mental health help among Syrian refugees in Norway. The benefits of higher social integration are in line with previous findings, which suggest that increased social integration facilitates entering the labour market (Gericke et al., 2018), increased quality of life, and lower severity of mental disorders (Schick et al., 2016). One of these benefits may include higher likelihood of considering the GP as a source of help. While Magaard and colleagues (2017) suggested that personal health status was related to seeking help, we found that current mental health status did not influence endorsing seeking help from GP. However, it did appear to influence help-seeking behaviours in that individuals with higher rates of mental distress were less likely to rely on the most preferred sources of help in the sample, such as mother and partner. This is particularly important when considering the beneficial effect of a social network on wellbeing and in encouraging seeking professional mental health help. Individuals with more severe symptoms of depression, then, may be especially vulnerable as they are less likely to activate their social network in times of psychological distress.

Regarding psychological integration, it has been suggested that previous studies have examined psychological integration but used different terms, such as identity integration (Lin et al., 2020; Wang & Fan, 2012). However, I was unable to find a study examining feelings of connectedness with the host country in relation to help-seeking. Our study makes a unique contribution by considering psychological

integration in relation to mental health help-seeking in a sample of Syrian refugees. To the best of our knowledge, it is the first study to use Harder's psychological integration measure to do so.

5.2 Strengths and Limitations

5.2.1 Mixed methods research

One of the main strengths of the thesis is its mixed methods approach to examining GPs' experiences with, and management of, mental health consultations with refugee patients. In mixed methods research, the strengths of one method can complement and, in some cases, make up for the weaknesses of another, allowing the study to capitalize on the strengths of both methods. As a result, mixed methods research allows us to gain a better understanding of the world in both its generalities and complexities. In our case, we were able to first explore, in a bottom-up fashion, the issues that GPs found worth mentioning regarding their experiences in mental health consultations with refugee patients. Based on the insight that GPs clearly experienced consultations with refugee patients as different from other consultations and felt unprepared and uncertain about working with this patient group, we were then able to design an experimental survey that allowed us to examine the clinical decisions made by GPs about Somali refugee vs. Norwegian film vignette characters and quantify their clinical uncertainty.

5.2.2 Stakeholder involvement

Throughout the design and interpretation phases of the research, we regularly updated a reference group of stakeholders, including medical doctors some of which had Somali and Syrian backgrounds, members of the local municipalities, clinical psychologists, social anthropologists, and individuals from local charities working with migrants, such as the Red Cross and Kirkens Bymisjon. They provided feedback on the design of the studies as well as the formulation and evaluation of the film

vignettes in paper 2. This ensured that the studies conducted here contributed not only to discussions in the academic literature, but also to a need and an interest voiced by stakeholders.

5.2.3 Vignettes

The use of vignettes has several limitations that may influence the interpretation of our results. It has been suggested, for example, that clinical decisions made about vignettes do not accurately mirror real-world clinical decision making (Mohan et al., 2014; Samuels et al., 2017). For example, practitioners may be influenced by the social desirability effect, which may have led us to overestimate their clinical performance (Peabody et al., 2000; Samuels et al., 2017). We furthermore only presented participants with a single vignette in both papers 2 and 3. Findings may have been more useful and generalizable with the use of several vignettes per participant. Despite these weaknesses, we chose not to present several vignettes, because we thought the surveys would become too long and cause participants to drop out. We furthermore felt there was a risk that an earlier vignette may influence the answers given about a later vignette.

The use of vignettes is, and has been, common (Erfanian et al., 2019). The use of text vignettes was more common previously, however, with the development of technology, video vignettes have become more feasible. Video vignettes have the advantage of presenting a visual depiction of symptoms, through both verbal and non-verbal cues. This adds to the clinical realism of the vignettes (Ceuterick et al., 2020). Another main strength of vignette approaches is that they allow the researcher to collect data which would not be available otherwise (Erfanian et al., 2019). For example, they allow researchers to control for confounding factors and isolate the effect of certain variables of interest. Given our research question, this may have been the only feasible approach to address the impact of isolated patient characteristics on GPs' clinical decisions.

Moreover, while we must consider the above-mentioned limitations of vignette approaches, it is also important to note that the vignette we used in paper 3 was the same as was used in previous cross-cultural studies with Syrian and Somali refugees and non-refugee migrants, such as in Aarethun and colleagues (2021) and Markova and colleagues (2016; 2020). Particularly Aarethun and colleagues' study presents Syrian refugees' interpretation of the vignette and insights from this study complement our findings.

5.2.4 Cross-sectional research

All papers included in this thesis are cross-sectional. While cross-sectional studies are suitable for establishing preliminary evidence that can be used in the planning of future studies, such as in paper 3, they only provide a snapshot in time. A longitudinal study on the other hand can track developments over time as well as draw stronger conclusions regarding causality. We employed the only cross-sectional design that can, in some cases, draw conclusions about causality: the experimental approach. However, where possible, future studies should employ longitudinal designs.

5.2.5 Sample size

Approximately 4.4% of the Norwegian population have a refugee background, making the pool of participants with a refugee background (particularly those originating from Syria) limited. Additionally, those barriers that may stand in the way of individuals accessing healthcare, may also stand in the way of their participation in research. As a result, we unfortunately had a limited number of participants in paper 3. Nevertheless, after participants dedicated their time and energy to this project, there was an ethical obligation to 'make the best' of the data collected. Regarding papers 1 and 2, however, sample size was not a considerable limitation.

5.3 Applying 'Western' nosology to 'non-Western' patients

The following section will discuss issues surrounding the validity of applying 'Western' diagnostic criteria to 'non-Western' patients. First, however, I want to add a disclaimer that the terms 'Western' and 'Non-Western' are highly controversial and are not used here in an attempt to condone them. Instead, I employ them here, because I believe they illustrate the exact issue I address in this section, which is the tendency to consider 'Western' culture as the norm, while all else is not normal, i.e., 'non-Western'[7].

When approaching the discussion regarding the validity of applying diagnostic criteria developed (and often validated) in one part of the world to another, one should be aware of two concepts: the category fallacy (Kleinman, 1987) and the human looping effect (Hacking, 1995). The former, coined by Arthur Kleinman, describes:

> The reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not yet been established. (Kleinman, 1987, p. 452)

In other words, the category fallacy is the act of applying diagnostic categories developed in one cultural context to individuals from another cultural context, in which those categories may not be appropriate. The category fallacy has been described as one of the key limitations of cultural psychiatry (Kirmayer & Ban, 2013). The risks of committing the category fallacy include missing out on and reducing important cultural variation in individuals' experience. This ties in with findings suggesting that Somali refugees, for example, have unique expressions of distress that may not map onto 'Western' diagnostic constructs (Carroll, 2004). This is highly relevant in the context of this thesis, because, for example, we may have

[7] Note that the terms Western and Non-Western are misguidedly employed in paper 1 but were no longer employed in papers 2 and were mentioned once in inverted commas in paper 3 indicating the sentiment that is describe in this section.

encouraged GPs to commit the category fallacy, by allowing them only to choose from pre-determined diagnostic categories in paper 2. When using these categories in practice, GPs are likely to take the self-reported symptoms of the patient and cluster those together in line with the categories in their diagnostic manual. Carroll (2004) points out the risks of this, including that patients themselves may cluster those symptoms differently. She concludes that:

> This difference in grouping or categorization of symptoms could potentially superimpose a different diagnostic formulation than that understood by their patients and risk being overly reductionist ... (Carroll, 2004, p. 124)

It has been suggested that the diagnostic criteria used by clinicians today is not culturally valid, and that we require a new or improved diagnostic system (de Jong, 2014). While the CFI has attempted to address this issue, clinicians have complained of barriers in conducting the CFI (Aggarwal et al., 2013). Such barriers include, for example, being overly standardized and lack of clinician motivation (Aggarwal et al., 2013). While it may not be able to fully tackle the category fallacy, the CFI has been shown to facilitate clinical communication and allows the clinician to obtain new, cultural data in a short period of time (Jarvis et al., 2020).

Clinicians and researchers should also be aware of the looping effect, which refers to the tendency of diagnostic categories to influence the experience of certain phenomena. This is described by Gone and Kirmayer (2010):

> The very act of diagnosing a given pathology can alter an individual's experience of the pathology as well as the subsequent scientific and professional construals of that individual's behaviour. (p. 87)

For example, if an individual is experiencing distress and is confronted with the concept 'depression', they may pay more attention to certain symptoms described in the diagnostic criteria for depression that, in a feedback loop, influence the way they experience their distress. According to the human looping effect, labelling individuals

from other cultures as traumatized or depressed may in turn influence their own experience of distress, in something like a self-fulfilling prophecy.

Given the assumption that depression and PTSD do not describe phenomena that exist in real-life, but are constructed (Marsella, 2003), both the category fallacy and the looping effect lead to the same question: are we describing real distress in some refugee patients or are we creating them? This is a question that health professionals ought to be mindful of, and which highlights the importance of considering cultural context, of both practitioner and patient, in the clinical consultation.

It may be useful for clinicians to have a healthy amount of scepticism towards the ontological stance that mental disorders are universal. One strong proponent of this argument is Derek Summerfield. Summerfield questions the validity of gathering disparate groups of distressed people and categorizing them as depressed, as though 'depression' was a universal label, as opposed to a category developed in the 'West' (Summerfield, 2012).

Furthermore, with a focus on psychological labels we are taking away focus from the socio-economic situation that may contribute to and maintain psychological stress or, on the flipside, facilitate well-being and help-seeking. This is supported by Gone and Kirmayer, who claim that focussing on person-centred factors will downplay situationally relevant factors (Gone & Kirmayer, 2010). Structural and socioeconomic inequalities must be addressed in parallel with mental health problems. As Michael Marmot states in his book The Health Gap: why send someone back to the circumstances that made them sick?

To finish this section, I would like to present an example from the interviews I conducted in paper 1, which illustrates some of the issues presented above. In this case, the GP described a patient, who they claimed was suffering from mental health problems. The GP explained that this patient seemed to be struggling with adapting to the environment of living in a small town. The patient did not have their own car but

had the responsibility of getting themselves and their partner to classes and their children to kindergarden. This often led to problems and the patient became very exhausted, complained of frequent headaches, and began asking for sick leave from the GP. The GP described that the patient was surely suffering from mental health problems, however the patient did not see mental illness as the main issue. The patient explained that their challenges were related to delivering the kids to the kindergarden, to catching a very early bus, to not having a feasible transportation option. However, the GP persisted and tried to explain to the patient that the real issue was an underlying mental health problem, which needed to be treated before one could tackle the practical problems.

This example illustrates the point made by Kirmayer and Rousseau, that the GPs priority may not necessarily line up with the patient's own priority (Kirmayer et al., 2015). Clinicians should be careful not to let an over-focus on psychological health overshadow the patient's priorities, including their socio-economic situation and other structural inequalities. It may be useful to consider systemic and family approaches that can take into consideration an individual's family, community, and larger social milieu.

5.4 Take home messages: Implications for research and practice

Our findings in combination with previous literature led to the following implications for research and practice.

Findings from the papers in this thesis suggest that GPs find working with refugees meaningful, and that Syrian refugees consider the GP a viable source of help for mental health problems. However, barriers are perceived on both sides. Language barriers, for example, have been described extensively here and in previous literature, but continue to present a problem. Norway has recently implemented new regulations on national guidelines for medical education from 2020, and is addressing this issue

by making communicating with the help of an interpreter a required skill for medical students (Diaz et al., 2020). Future research should focus on comparing the efficacy of different types of solutions for language barriers, such as using cultural brokers, interpreters (phone vs. present), and the effect of training GPs to work with different types of interpreters.

Training courses should furthermore raise awareness regarding the risks of over- and mis-diagnosing refugee patients with PTSD. While it is important for GPs to know that refugees are at a higher risk of having potentially traumatic experiences, it is also important to be conscious of the fact that the majority of individuals who experience such events do not develop PTSD (Bonanno, 2005). Clinicians should avoid medicalizing adults and children with a refugee background, which risks downplaying their capacity for resilience (Kirmayer et al., 2011). We need to remember that while migration brings with it a range of stresses that can contribute to mental health problems, most refugees are highly resilient and cope well with transitions and resettlement (Kirmayer et al., 2011). Furthermore, GPs should be mindful of disparities in their provision of sick leave to individuals with a refugee background. This should be tested in large scale, observational studies in future research.

Our findings have highlighted the importance of establishing a trusting relationship in the consultation, which is supported by previous literature (Napier et al., 2014). Future research should further focus on delineating the facilitating impact of a trusting relationship between GP and refugee patient and provide helpful techniques that may contribute to the establishment of trust. Here, it may be useful for GPs to consider the individual's broader context and include their partner and or family in assessments and interventions. Findings from paper 3 support this, by highlighting the importance of certain personal and sociodemographic factors in Syrian refugees' help-seeking preferences. GPs should approach health promotion in more broad terms, taking into consideration its origins in cultural value systems and paying

attention to social processes that may play a role (Napier et al., 2014). Similarly, the GP may want to consider the important role of religion and individuals' partners when conducted both assessments and interventions.

Although stigma was not an important barrier indicated by Syrian refugees in paper 3, it is nevertheless important that GPs avoid pathologizing individuals. Clinicians must be conscious of the fact that:

> Classifying problems as 'psychiatric' may confer stigma and disqualify the moral autonomy and agency of the individual who is viewed as 'mad'. Insisting on a mental illness interpretation of a problem that was previously understood purely in religious or sociomoral terms can be liberating or debilitating depending on the cultural and social contexts and consequences.' (Kirmayer, 2012, p. 99)

Ultimately, future research and clinical practice alike needs to find solutions that not only allow refugees to survive but to thrive in their host countries. As Napier points out:

> Creation (or restoration) of wellbeing demands that patients have options that are real to them and that encourage them to live lives they have reason to value. (Napier et al., 2014, p. 27).

One of the paths towards such an approach may be cultural humility. The important role of culture in our interpretation of health suggests that not only the patient's cultural context ought to be considered, but also the practitioner's. Being culturally humble encourages the practitioner to recognize that there may be aspects of an individual that the practitioner does not understand. Such an approach can facilitate the practitioner's curiosity and willingness to better understand the patient and their own experience and perspective.

6. Conclusion

This thesis hopes to contribute to the development of a healthcare system that is appropriate for and respectful of a culturally diverse society.

GPs and patients seem to perceive both practical as well as interpersonal barriers to providing, and accessing, health care. While practical issues, such as financial and transport issues, may be solvable, inter-personal barriers are harder to tackle. A main take home message from this thesis is the facilitating effect of social connection, both between GP and patient, in the form a trusting relationship, but also regarding the patient's social network in the host country as well as feelings of connectedness with the host country. This suggests that a focus on a trusting relationship and a consideration of the patients' social network may act as a facilitator to being able to offer appropriate mental health care, as well as facilitate refugee patients' ability to access this care. Our findings furthermore give an important insight into how going to the GP can be understood in the integration/resettlement process, and what the characteristics are of individuals, who are more likely to seek professional help.

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8. Appendices

List of appendices

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Appendix 4	Consent form and survey distributed to participants in paper 2. Note that the survey was distributed online
Appendix 5	Letter of invitation, consent form, and survey distributed to participants in paper 3.

Appendix 1. Initial interviewguide (original Norwegian version) prior to pilot-testing and interviews with participants. Developed November-December 2018.

Introduksjon til intervju:

Studier på forskningsfeltet viser at flyktninger i Norge har en større risiko enn nordmenn for å oppleve noen psykiske lidelser, f.eks. depresjon og posttraumatisk stress-syndrom. I Norge er det fastlegenes oppgave å sikre at flyktningene får den hjelpen de trenger. Vi vil undersøke hvordan fastleger opplever, diagnostiserer, og arbeider med flyktninger som har psykiske lidelser.

Resultatene av studien vil adresseres til norske helsemyndigheter for å gi økt kunnskap om fastlegenes erfaringer, og vil samtidig danne grunnlag for et interaktivt kurs for helsepersonell og studenter.

Definisjon av flyktning: FNs flyktningkonvensjon: 'du er utenfor ditt eget hjemland, du ikke kan eller tør få beskyttelse i, eller returnere til, ditt eget hjemland, dette er fordi du frykter forfølgelse på grunn av rase, religion, nasjonalitet, medlemskap i en sosial gruppe, eller politiske meninger i ditt eget hjemland' (https://www.fn.no/Om-FN/Avtaler/Flyktninger/Flyktningkonvensjonen)

[Diskutere samtykke og hva skjer med informasjon, samle demografisk informasjon]

Er det noe du vil spørre om før vi går i gang? [Diskutere spørsmål]

Problemstilling	'Sub-questions'			
Describing experiences and attitudes of GPs towards working with refugees patients suffering from mental health problems in Norway, with a focus on identifying barriers and facilitators to their clinical encounters.	Erfaringer med flyktninger som har psykiske lidelser	Holdninger om arbeid med flyktninger	Fasiliterende forhold i arbeid med flyktninger	Utfordringer i arbeid med flyktninger

Førsteinntrykk

Kan du fortelle om det første møtet med denne pasienten? Hva skjedde? Hva tenke/kjente/følte du? Kan du beskrive din først inntrykk? Forandret første inntrykket seg i løpet av møtet?

Fasiliterende forhold

Hva gikk bra i arbeidet med pasienten? Hvilken behandling anbefalte du eller igangsatte du? Hva er ditt inntrykk av hvordan pasienten opplevede dette?

Hvorfor, tror du, at hun/han opplevde det slik?

Utfordringer

Var det noe du opplevde som vanskelig eller utfordrende ved konsultasjonen? I så fall – beskriv.

Hva skjedde? Hva følte/tenkte du? Hvordan ville du handlet det på en annen måte?
Følelse av støtte, selvsikkerhet/trygghet i konsultasjoner med flyktninger som har psykiskhelse problemer
Hva føler/tenker du om arbeidet med flyktninger som har psykiske problemer? På hvilken måte føler du deg forberedt å arbeider med dem? På hvilke måte føler du deg støttet i dette arbeidet? Hvordan kunne du bli mer forberedt? Støttet?
Trauma
Har du arbeidet med flyktninger som hadde trauma? Hvordan har du opplevd å arbeide med flyktninger med trauma? Kan du gi et eksempel fra slikt arbeid.
Bruk av tolk
Har du arbeidet med en tolk før? Hvordan har du opplevd å arbeide med en tolk i konsultasjoner med flyktninger som har psykisk lidelser? Kan du gi et eksempel fra slikt arbeid? Hva gikk bra? Hva gikk ikke så bra?
Sammenligning med flyktninger, asylsøker, og Nordmenn
Opplever du at du formulerer deg annerledes i møte med flyktninger enn med nordmenn? Beskriv. Opplever du en forskjell mellom flyktninger og asyl-søker? Mellom flyktninger fra forskjellige land? Beskriv – eksempel.
Opplever du en forskjell mellom flyktninger og asyl-søker? Mellom flyktninger fra forskjellige land? Beskriv – eksempel.
Alt i alt – hva opplever du er det viktigste du som fastlege bidrar med i arbeid med mennesker med flyktning bakgrunn?
Slutten: Er det noe mer du ønsker å legge til, som du tenker på og ikke har fått sagt?

Appendix 2. Final interviewguide, based on pilot and participant interviews.

Developed January – June 2019.

I. **Introduksjon**
   a. **Bakgrunn og hensikt**
      i. 'Resultatene fra undersøkelsen skal inngå i min PhD. Jeg ønsker å høre om hva slags erfaringer du har hatt med flyktninger som har psykiske lidelser. Det finnes ingen riktige eller gale svar, og det er like interessant å få høre om det som ikke har gått bra som det som har gått bra. Bruk gjerne eksempler, men del bare det som du er komfortabel med å dele.'
      ii. 'Har du hatt tid til å lese samtykkeskjemaet? Har du noen spørsmål?' (forklare lydopptak og innhente signert skjema)
         1. 'Vennligst ikke identifisere pasientene'
   b. **Klargjøre forskjell mellom flyktning og asylsøker.**

II. **Bakgrunnsopplysninger om informant**
   a. Deltakernummer, Kjønn, Fødselsland, alder, og hvor mange år arbeidet som lege totalt og i allmennmedisin
   b. Hvilke typer innvandrere har du mest av i din praksis?
   c. Hvor kommer flyktningene som du møter i din praksis fra?
   d. Hvor ofte arbeider du med flyktninger som har vansker med psykisk helse? Hver dag? Uke?

III. **Intervjuet**
   a. Opplever du en forskjell mellom det å arbeide med flyktninger eller Nordmenn?
   b. Opplever du en forskjell mellom det å arbeide med flyktninger og asylsøkere?
      i. Mellom disse gruppene, og det å arbeide med arbeidsinnvandrere?
      ii. Mellom flyktninger fra forskjellige land? Beskriv/eksempel.
         1. Påvirker denne forskjellen arbeidet ditt?
   c. Første situasjon
   d. Nå har jeg noen spørsmål som dreier seg om dine erfaringer og hvor du bruker konkrete eksempler.
   e. Vi vet at det å arbeide som lege med mennesker fra andre kulturer og som noen ganger kan være traumatisert kan være krevende. Jeg vil gjerne høre om konsultasjoner du har hatt med flyktnings pasienter som du opplevde som krevende eller utfordrende og som du kan ha opplevd å mestre i større eller mindre grad. **Det er imidlertid viktig at du ikke gir informasjon som kan bidra til å identifisere pasienter, for eksempel navn, bosted eller opprinnelsesland. Når du oppgir alder, ber vi deg bare om å oppgi om pasienten var yngre enn 25 år, mellom 25 og 40år, mellom 40 og 60 år eller over 60 år.**
      1. Kjønn og alder
      2. Fortell…
      3. Oppfølgingsspørsmål (ikke alltid nødvendig): Hvordan var første møtet? Førsteinntrykket ditt?
         a. Hvordan presenterte pasienten seg selv og problemet sitt? Hvilke vurderinger gjorde du underveis med henblikk på diagnoser? Var det vanskelig å

diagnostisere pasienten? Hva var det som eventuelt gjorde det vanskelig å diagnostisere?

4. Hva skjedde videre? Hvor mange konsultasjoner hadde du (omtrentlig) med pasienten om problemsstillingen?
5. Hva forsøkte du å få til med pasienten? Hva gjorde du? Hvilken former for behandling ble vurdert? Var det vanskelig å henvise til spesialisten?
6. Mente du at tilstanden ble tilfredsstillende behandlet? Hvorfor? Hvordan forklarte du dette til pasienten?
    a. Hvordan forholdt pasienten seg til dette?
    b. Hva skjedde videre? Hvordan kjentes det for deg når det ble på denne måten?
7. Opplever du at du tok disse erfaringer med deg hjem? At du ble gående og tenke på dem mye etterpå?
8. Opplevde du at denne hadde noe med pasientens spesifikke kulturelle bakgrunn å gjøre? Var det forskjellige enn en Nordmann?
9. Opplevde du at pasienten hadde tillit til deg? Og følte seg hørt/forstått/respektert? Opplever du at pasienten har forventinger til deg som vanskelig la seg oppfylle?

ii. Hadde du noen å rådføre deg med underveis? Søkte du hjelp fra/snakket du med noen om dette?

f. Hvordan opplever du at grunnutdanningen som lege og spesialisering etterpå har forberedt deg på denne type utfordringer?

i. Hva opplever du at du hadde trengt mer kompetanse på?
ii. Ville du håndtert dette annerledes i dag? Er det noes om kunne gjort denne utfordringen enklere å handtere?

g. Andre situasjon (hvis aktuell)

i. Kan du fortelle om en pasient hvor du mestret utfordringen som meldte seg?
    1. Hva tenker du er den viktigste forskjellen mellom disse to pasientkonsultasjonene?

h. Trauma - Dersom eksempelet over ikke var med pasienter med traume-bakgrunn.

i. Har du arbeidet med flyktninger som har hatt psykiske traumaer?
ii. Hvordan opplever du generelt å arbeide med flyktninger med traumebakgrunn?

i. Bruk av tolk

i. Har du brukt tolk? Hvordan har du opplevd dette? Eksempel.

IV. Slutten

a. Er det noe mer du ønsker å legge til, som du tenker på og ikke har fått sagt?
b. Avslutte lydopptak
c. Be om tillatelse til å siter informanten i formidling av resultatene fra undersøkelsen
d. Avtale om deltakeren ønsker artikkelen eller resultatene
e. Spørre om vi kan ta kontakt igjen dersom vi må avklare noe

Appendix 3. Consent forms for interviews with GPs (paper 1).

Forespørsel om å delta i forskningsprosjektet «Kliniske møter med flyktninger med psykiske helseplager»

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å undersøke hvilke utfordringer fastleger opplever i møte med pasienter som er flyktninger og som har psykiske lidelser. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Studier på forskningsfeltet viser at flyktninger i Norge har større risiko enn nordmenn for å oppleve enkelte psykiske lidelser, f. eks. depresjon og posttraumatisk stress-syndrom (PTSD). I Norge er det fastlegenes oppgave å sikre at flyktningene får den hjelpen de trenger. Prosjektet tar sikte på å få mer kunnskap om fastlegers erfaringer med å gi et godt behandlingstilbud til pasienter med flyktningebakgrunn og som har psykiske lidelser. Målsetningen med studien er å få kunnskap som kan brukes i utvikling av utdanning og kurstilbud innenfor migrasjonshelse for medisinstudenter, fastleger og behandlere innenfor psykisk helsevern.

Kriteriet for deltakelse er at du ved dags dato arbeider som fastlege i Norge.

Hvem er ansvarlig for forskningsprosjektet?
Studien skal inngå i PhD-arbeidet til stipendiat Samantha Harris og er en del av et omfattende forskningsprosjekt finansiert av Norges Forskningsråd (Helsevel). Prosjektet gjennomføres av Society and Workplace Diversity Group ved Det psykologiske fakultet, Universitetet i Bergen under ledelse av professor Gro Mjeldheim Sandal. Du kan lese mer om forskningsgruppen og prosjektet på forskningsgruppens nettside (https://www.uib.no/fg/saw).

Hva innebærer deltakelse i studien?
Deltakelse i studien innebærer et individuelt intervju om erfaringer som du som fastlege har hatt med flyktninger som har psykiske lidelser. Intervjuet kommer til å bruke en 'critical incident' tilnærming, som betyr at vi vil be deg om å fortelle om situasjoner som du har opplevd som utfordrende. Det er viktig at du ikke skal gi informasjon som identifiserer enkeltpasienter, men at du anonymisere informasjon om navn eller annet som kan identifisere pasienten (alder, bosted og opprinnelsesland Samtalen tar omtrent 90 minutter og det vil bli gjort lydopptak.

Det er frivillig å delta
Det er frivillig å delta i studien. Du kan la være å svare på spørsmål under intervjuet og du trenger heller ikke å dele mer enn det du er komfortabel med. Hvis du under eller etter intervjuet ikke lengre ønsker å delta, kan du når som helst trekke ditt samtykke uten å oppgi noen grunn Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Om du velger å trekke deg fra undersøkelsen, kan du kreve at informasjonen som du har gitt blir slettet fra transkripsjonene. Dette kan du bare gjøre fram til lydopptaket har blitt slettet. Etter dette er det ikke lenger mulig å identifisere enkeltpersoner eller å slette informasjon som den enkelte har gitt.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Lydopptaket blir slettet innen oktober 2019 etter at intervjuene har blitt transkribert og anonymisert. Inntil lydopptakene blir slettet vil de bli oppbevart i et låst sikkerhetsskap. Bare forskeren som gjennomfører intervjuet (Samantha Harris), hennes veiledere (professor Per Einar Binder og professor Gro Mjeldheim Sandal), og forskningsassistent Tuva Emilie Øyslebø, vil ha tilgang til lydopptaket.

Postadresse Postboks 7807, 5020 Bergen **Besøksadresse** Christiesgate 13 5015 Bergen

Telefon + 47 55 58 27 10 **E-post** post@psyfa.uib.no **Internett** www.uib.no

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket. Ved presentasjon av resultater fra undersøkelsen vil resultatene ikke kunne knyttes til enkeltpersoner. Resultatene vil bli presentert i forelesninger og i vitenskapelige artikler, nasjonalt og internasjonalt. De viktigste resultatene vil bli publisert på forskningsgruppens nettside etter at undersøkelsen er avsluttet.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke. På oppdrag fra Universitetet i Bergen har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket. Prosjektet skal etter planen pågå fram til 1.juni 2021.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- *Samantha Harris (stipendiat),* e-post: samantha.harris@uib.no, telefon: 55583135
- Personvernombud ved Universitet i Bergen: *Janecke Helen Veim*, e-post: janecke.veim@uib.no, telefon: 55 58 20 29/930 30 721
- NSD – Norsk senter for forskningsdata AS, på epost (personvemtjenester@nsd.no) eller telefon: 55 58 21 17.

Vi håper at du er villig til å delta i undersøkelsen.

Med vennlig hilsen

Gro Mjeldheim Sandal	Samantha Harris	Per Einar Binder
Professor, prosjektleder	Doktorgradsstipendiat	Professor, veileder

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet, og har fått anledning til å stille spørsmål. Jeg samtykker til:

☐ å delta i intervjuet

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 1.Juni 2021.

(Signert av prosjektdeltaker, dato)

Postadresse Postboks 7807, 5020 Bergen **Besøksadresse** Christiesgate 13 5015 Bergen

Telefon + 47 55 58 27 10 **E-post** post@psyfa.uib.no **Internett** www.uib.no

Appendix 4. Consent form and survey distributed to participants in paper 2.

Formål
Prosjektet tar sikte på å få mer kunnskap om fastlegers erfaringer med å gi behandlingstilbud til forskjellige pasientgrupper. Målsetningen med studien er å få kunnskap som kan brukes i utvikling av utdanning og kurstilbud for medisinstudenter, fastleger og andre behandlere.

Hva innebærer deltakelse i studien?
Deltakelse i studien innebærer å fylle ut et nettbasert spørreskjema. Spørreskjemaet inneholder en kort filmsnutt av en simulert klinisk konsultasjon mellom en fastlege og en pasient. Etter at du har sett filmsnutten, blir du spurt noen spørsmål om hvordan du hadde håndtert denne konsultasjonen. Deretter vil vi stille noen spørsmål om deg.

Det er frivillig å delta
Det er frivillig å delta i studien. Hvis du under eller etter studien ikke lenger ønsker å delta, kan du trekke ditt samtykke uten å oppgi noen grunn. Det vil ikke ha noen negative konsekvenser for deg. Det eneste du trenger å gjøre for å trekke deg er å ikke sende inn skjemaet. Etter at skjemaet er levert vil du ikke lenger kunne trekke deg siden det da vil være umulig å identifisere enkeltpersoner eller å slette informasjon som den enkelte har gitt.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Spørreundersøkelsen er anonym og vi samler ikke inn informasjon som kan brukes til å identifisere deg

Finansiell kompensasjon
Vi ønsker å tilby deg en økonomisk kompensasjon for at du deltar i form av et gavekort pålydende kr 500. Dette er noe du kan velge selv. Etter å ha trykket på 'avslutt' knappen på slutten av spørreskjemaet, blir du videresendt til et nytt skjema. Der kan du oppgi navn og adresse. I og med at du avslutter undersøkelsen før du oppgir den informasjonen, sikrer vi at svarene dine ikke kan knyttes til navnet ditt. Slik bevarer du anonymiteten din også når du får tilsendt gavekortet.

Hvem er ansvarlig for forskningsprosjektet?
Studien skal inngå i PhD-arbeidet til stipendiat Samantha Harris og er en del av et omfattende forskningsprosjekt finansiert av Norges Forskningsråd (Helsevel). Prosjektet gjennomføres av Society and Workplace Diversity Group under ledelse av professor Gro Mjeldheim Sandal ved det psykologiske fakultet, Universitetet i Bergen. Du kan lese mer om forskningsgruppen og prosjektet på forskningsgruppens nettside (https://www.uib.no/fg/saw).

Samtykke

Jeg har mottatt og forstått informasjon om prosjektet. Jeg samtykker til å delta i nettbasert spørreundersøkelsen:

(1) ❑ Ja

(2) ❑ Nei

Kliniske vurderinger om film konsultasjonen
Forestill deg at du har nettopp kommet til legekontoret hvor du jobber, og din første pasient er allerede kommet og venter på deg. Du er for tiden vikar for en kollega og har aldri møtt denne pasienten før. Du har noen minutter for å se gjennom journalen. Det du finner er følgende:

Navn: Mari Berg/Emil Olsen/Hodan Osman/Abdi Warsame
Alder: 31
Bakgrunn: født og vokst opp i Norge/flyktning fra Somalia
Gift: Ja
Barn: 2
Grunn for legekonsultasjon i dag: Hodepine. Pasienten har tidligere blitt undersøkt for hodepinen uten at det ble funnet noe somatisk grunnlag for dette.

Du skal nå få se en kort filmsnutt (4-5min) av konsultasjonen med denne pasienten, før du blir spurt om å svare på noen spørsmål om hvordan du hadde vurdert og behandlet denne pasienten.

[VIDEO]

Hvilke tentative diagnose (r) ville du ha valgt for denne pasienten basert på den informasjonen som du nå har fått? Du kan angi inntil 3 diagnoser.

(1) ❑ N01 Hodepine

(2) ❑ P01 Følelse angst/nervøs/anspent

(3) ❑ P02 Psykisk ubalanse situasjonsbetinget

(4) ❑ P03 Depresjonsfølelse

(5) ❑ P04 Irritabel atferd/følelse

(6) ❑ P06 Søvnforstyrrelse

(7) ❑ P19 Stoffmisbruk

(8) ❑ P25 Livsfaseproblem voksen

(9) ❑ P27 Engstelig for psykisk sykdom

(10) ❑ P28 Redusert funksjonsevne psykisk problem

(11) ❑ P29 Psykiske symptomer/plager IKA

(12) ❑ P72 Schizofreni

(13) ❑ P73 Affektiv lidelse

(14) ❑ P74 Angstlidelse

(15) ❑ P75 Dissosiativ/somatoform lidelse

(16) ❑ P76 Depressiv lidelse

(17) ❑ P78 Nevrasteni

(18) ❑ P82 Posttraumatisk stresslidelse

(19) ❑ P98 Psykose IKA

(20) ❑ P99 Psykisk lidelse IKA

(23) ❑ Annet, vennligst oppgi: _____

(22) ❑ Ingen

(21) ❑ Jeg vet ikke

Du har valgt følgende diagnos(er). Dersom du har valgt mer enn én, vennligst ranger dem i prioritert rekkefølge (du rangerer rekkefølgen ved å skyve boksene opp eller ned).

Hvor alvorlig ville du si at pasientens tilstand er?

1 (ikke alvorlig)	2 (lite alvorlig)	3 (litt alvorlig)	4 (veldig alvorlig)
(1) ❑	(2) ❑	(3) ❑	(4) ❑

Gitt informasjonen du fikk om denne pasienten, hvor sikker er du på den første diagnosen du valgte?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Den andre diagnosen (dersom relevant)?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Den tredje diagnosen (dersom relevant)?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Hvilke utredningsalternative (r) ville du ha valgt for denne pasienten basert på informasjonen som du nå har fått? Du kan angi inntil 3 utredningsalternativer.

(1) ❑ Blodprøver

(3) ❑ Tilby flere/lengre konsultasjoner

(4) ❑ Kontakt med andre aktører f.eks. familie, arbeidsplass, NAV, skole, etc.

(5) ❑ Drøfte med fastlege-kolleger

(6) ❑ Drøfte med nevrolog per telefon

(7) ❑ Drøfte med psykiater per telefon

(8) ❑ Drøfte med spesialist i klinisk psykologi per telefon

(9) ❑ Videre utredning hos meg (fastlege)

(10) ❑ Henvisning til DPS

(11) ❑ Henvisning til offentlig psykolog utenfor BUP

(12) ❑ Henvisning til offentlig psykiater utenfor BUP

(13) ❑ Henvisning til privat psykolog

(14) ❑ Henvisning til privat psykiater

(15) ❑ Henvisning til nevrolog

(16) ❑ Henvisning til andre spesialister

(17) ❑ Denne pasienten trenger ingen videre utredning

(20) ❑ Annet, vennligst oppgi: _____

(18) ❑ Jeg vet ikke

Du har valgt følgende utredningsalternative(r). Vennligst ranger dem i prioritert rekkefølge (du rangerer rekkefølgen ved å skyve boksene opp eller ned).

Gitt informasjonen du fikk om denne pasienten, hvor sikker er du på det første utredningsalternativet som du valgte?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Det andre utredningsalternativet (dersom relevant)?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Det tredje utredningsalternativet (dersom relevant)?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Hva hadde du valgt som behandlingsalternativ(er)? Du kan angi inntil 3 behandlingsalternativer.

(1) ❑ Flere/lengre konsultasjoner hos meg (fastlege)

(2) ❑ Samtaleterapi hos meg (fastlege)

(3) ❑ Informer pasienten om mulige kurstilbud om psykisk helse i regi av kommunen eller frivillige organisasjoner

(5) ❑ Sykemelding

(6) ❑ Medikamenter for somatiske plager, vennligst oppgi: _____

(8) ❑ Psykofarmaka, vennligst oppgi: _____

(10) ❑ Tvangsinnleggelse

(4) ❑ Denne pasienten trenger ingen videre behandling

(12) ❑ Annet, vennligt oppgi: _____

(11) ❑ Jeg vet ikke

Du har valgt følgende behandlingsalternativ(er). Dersom du har valgt mer enn én, vennligst ranger prioritert rekkefølge (du rangerer rekkefølgen ved å skyve boksene opp eller ned).

Gitt informasjonen du fikk om denne pasienten, hvor sikker er du på det første behandlingsalternativet du valgte?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Det andre behandlingsalternativet (dersom relevant)?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Det tredje behandlingsalternativet (dersom relevant)?

0 (helt usikker)	1	2	3	4	5	6	7 (helt sikker)
(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑

Nå blir du spurt noen bakgrunnsopplysninger om deg selv og hvordan du vurderer din egen kompetanse i arbeidet med forskjellige pasientgrupper.

Kjønn

(1) ❑ Mann

(2) ❑ Kvinne

Alder

(1) ❑ 20-29

(2) ❑ 30-39

(3) ❑ 40-49

(4) ❑ 50-59

(5) ❑ 60-69

(6) ❑ 70-79

Opprinnelsesregion

(1) ❑ Skandinavia

(2) ❑ Øst-Europa

(3) ❑ Europa ellers

(4) ❑ Afrika

(5) ❑ Latin-Amerika

(6) ❑ Nord-Amerika

(7) ❑ Asia

(8) ❑ Oceania

Hvilken spesialisering har du?

(1) ❑ Allmennmedisin

(4) ❑ Under spesialisering

(5) ❑ Ingen spesialitet

(6) ❑ Annen spesialitet _____

År med arbeidserfaring i ditt nåværende yrke

(1) ❑ Mindre enn 1 år

(7) ❑ 1-10 år

(2) ❑ 11-20 år

(3) ❑ 21-30 år

(4) ❑ 31-40 år

(5) ❑ 41-50 år

(6) ❑ Over 50 år

Hvor var du utdannet som lege?

(1) ❑ Skandinavia

(2) ❑ Øst-Europa

(3) ❑ Europa ellers

(4) ❑ Afrika

(5) ❑ Latin-Amerika

(6) ❑ Nord-Amerika

(7) ❑ Asia

(8) ❑ Oceania

Maksimal reisetid (ca.) til spesialisthelsetjeneste (f.eks. DPS) fra din nåværende praksis?

(1) ❑ <30 min

(2) ❑ 30 min

(3) ❑ 45 min

(4) ❑ 60 min

(5) ❑ 75 min

(6) ❑ 90 min

(7) ❑ Jeg vet ikke

Har du fått undervisning i innvandrerhelse (dvs. hvordan migrasjonsprosesser og migrantbakgrunn kan påvirke helsetilstand og forekomst av sykdom, samt tilgang til og kvalitet på helsetjenester) i løpet av studiene dine?

(1) ❑ Ja

(2) ❑ Nei

(3) ❑ Jeg husker ikke

Har du fått noen kurs om innvandrerhelse etter at du fullførte studiene?

(1) ❑ Ja

(2) ❑ Nei

(3) ❑ Jeg husker ikke

Føler du behov for kurstilbud innenfor innvandrerhelse feltet?

(1) ❑ Ja

(2) ❑ Nei

(3) ❑ Jeg ville ikke prioritere det

Er det noe du synes er viktig å nevne som vi ikke har tatt opp her?

Undersøkelsen blir nå avsluttet. **Takk for din deltakelse. Husk å trykke AVSLUTT-knappen!** Dersom du ønsker å få gavekortet i verdi av 500kr, ber vi deg om å oppgi kontaktinformasjonen din på det neste skjemaet. Da vil du få gavekortet tilsendt i posten. Ved å trykke på avslutt-knappen blir du videresendt til et nytt skjema som ikke er del av undersøkelsen. Etter det kan svarene dine ikke kobles til kontaktinformasjonen din.
Har du spørsmål vedrørende undersøkelsen, kan du ta kontakt med:
Samantha Harris (stipendiat), e-post: samantha.harris@uib.no, telefon: 55583135Personvernombud ved Universitet i Bergen: Janecke Helen Veim, e-post: janecke.veim@uib.no, telefon: 55 58 20 29/930 30 721NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Appendix 5. Letter of invitation, consent form, and survey distributed to participants in paper 3.

INVITASJON TIL Å DELTA I UNDERSØKELSE OM PSYKISK HELSE

Mange mennesker opplever psykiske helseplager en eller flere ganger i løpet av livet, enten selv eller hos familie og venner. Målsetningen med denne studien er å få mer kunnskap om hvordan personer fra ulike kulturer mener at slike vansker best mulig kan håndteres og mestres. Et siktemål med prosjektet er å gi en bedre forståelse for hvordan psykiske helsetjenester i Norge kan forbedres og tilpasses behovene til mennesker som kommer fra andre land.

HVA INNEBÆRER PROSJEKTET?

Undersøkelsen gjennomføres av Forskningsgruppen for kulturelt mangfold i samfunn og arbeidsliv ved Det psykologiske fakultet ved Universitetet i Bergen, og er finansiert av Norges Forskningsråd. Du kan lese mer om forskningsgruppen på nettsidene våre (https://www.uib.no/fg/saw).

Som deltaker i undersøkelsen vil du først bli bedt om å lese et kort avsnitt om en person. Deretter vil du få noen spørsmål om hvordan du mener at denne personen best mulig kan håndtere problemene sine. Du vil også bli bedt om å besvare noen spørsmål om deg selv og dine erfaringer med bruk av ulike helsetjenester.

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, trykker du på "jeg er villig til å delta i undersøkelsen" nederst på siden og du vil da bli overført til spørreskjemaet. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke og avslutte besvarelsen før du er ferdig.

HVA SKJER MED INFORMASJONEN SOM DU GIR?

Fordi vi ikke samler inn informasjon som gjør det mulig å identifisere akkurat deg og dine svar, er det ikke mulig å slette dem igjen etter at du har svart. All

informasjon som du gir vil bli behandlet strengt konfidensielt, og du skal ikke oppgi navn, fødselsnummer eller annen informasjon som kan knyttes direkte til deg. Resultatene vil bli presentert i forelesninger og i vitenskapelige artikler, nasjonalt og internasjonalt. Prosjektet vil pågå fram til 01.06. 2021. Etter at prosjektet er avsluttet, vil du finne en oppsummering av resultatene på forskningsgruppens hjemmeside.

GODKJENNING

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Universitetet i Bergen har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket. Regional komité for medisinsk (REK) og helsefaglig forskningsetikk har vurdert prosjektet, og har gitt forhåndsgodkjenning. 2018/1794-1. Dokument-id: 1078887 Dokument mottatt 25.09.2018.

KONTAKTOPPLYSNINGER

Vi håper at du er villig til å delta i undersøkelsen. Om du har spørsmål kan du kontakte doktorgrad-stipendiat Vilde Aarethun, telefon 55583186, epostadresse: vilde.aarethun@uib.no eller doktorgrad-stipendiat Dixie Brea, telefonnummer: 55583216, epostadresse: dixie.brea@uib.no.

Du må være fylt 18 år for å delta. Ved å trykke på knappen jeg er villig til å delta i undersøkelsen, bekrefter du samtidig at du har fylt 18 år.

Med vennlig hilsen
Gro Mjeldheim Sandal
Professor, prosjektleder

Samtykke

(1) ❑ Jeg er villig til å delta i undersøkelsen

På hvilken måte har du blitt invitert til å delta i undersøkelsen?

(1) ❑ Jeg mottok en epost, melding eller brev fra forskerne

(2) ❑ Jeg mottok en henvendelse fra ansatte på introduksjonsprogrammet

(3) ❑ Jeg mottok en henvendelse/invitasjon gjennom sosiale medier (f.eks. Facebook)

(4) ❑ Jeg mottok en henvendelse fra noen på min arbeidsplass eller skole

(5) ❑ Venner eller andre som jeg kjenner fortalte meg om undersøkelsen

(6) ❑ Annet

Alder

(1) ❑ 19 år eller yngre

(2) ❑ Mellom 20 og 29 år

(3) ❑ Mellom 30 og 39 år

(4) ❑ Mellom 40 og 49 år

(5) ❑ Mellom 50 og 59 år

(6) ❑ Mellom 60 og 69 år

(7) ❑ 70 år eller eldre

Hvis du er født utenfor Norge, hvor gammel var du da du kom til Norge?

(1) ❑ Jeg ble født i Norge

(2) ❑ 9 år eller yngre

(3) ❑ Mellom 10 og 19 år

(4) ❑ Mellom 20 og 29 år

(5) ❑ Mellom 30 og 39 år

(6) ❑ Mellom 40 og 49 år

(7) ❑ Mellom 50 og 59 år

(8) ❑ Mellom 60-69 år

(9) ❑ 70 år eller eldre

Kjønn

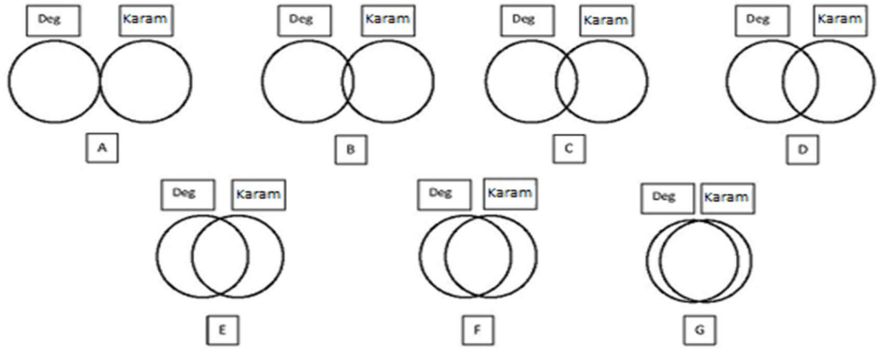
(1) ❑ Mann

(2) ❑ Kvinne

Nå ber vi deg om å lese følgende avsnitt og svare på noen spørsmål etterpå

Karam/Ghazal er en 27-år gammel servitør på en restaurant i Bergen. Han/hun er født i Oslo hvor foreldrene var innehavere av en restaurant. Han/hun har nå bodd i Bergen i 5 år. De siste ukene har han/hun følt seg trist hver dag. Karam/Ghazals tristhet har vært uavbrutt og han/hun kan ikke finne noen forklaring på den ut ifra ting som har skjedd eller årstiden. Det er vanskelig for ham å gå på jobb hver dag; han/hun pleide å trives med kollegaene sine og med arbeidet i restauranten, men nå kan han/hun ikke lenger finne noe glede i det. Faktisk er Karam/Ghazal lite interessert i de fleste aktivitetene som han/hun pleide å like tidligere. Karam/Ghazal er ikke samboende eller gift og bor i nærheten av sin bror/søster. Vanligvis liker de å gå ut sammen og med venner, men nå finner han/hun ikke glede i dette lenger. Karam/Ghazal har veldig dårlig samvittighet fordi han/hun er så trist og Han/hun føler at han/hun har sviktet broren/søsteren og vennene sine. Han/hun har prøvd å endre sine arbeidsrutiner og få nye hobbyer for å bli motivert igjen, men han/hun klarer ikke konsentrere seg om disse gjøremålene. Til og med broren/søsteren har nå sagt at Karam/Ghazal blir altfor lett distrahert og at han/hun er ute av stand til å ta avgjørelser. Siden disse problemene begynte, har han/hun sovet dårlig hver natt, han/hun har hatt vanskeligheter med å sovne og våkner mange ganger i løpet av natten. Da han/hun lå våken for noen netter siden og prøvde å få sove, begynte han/hun å gråte fordi han/hun følte seg så hjelpeløs.

Av sirklene nedenfor, vennligst velg den som beskriver best i hvor stor grad du har følt deg som Karam/Ghazal i de to siste månedene:



أنت = **Deg**
كرم = **Karam**

(1) ❑ A

(2) ❑ B

(3) ❑ C

(4) ❑ D

(5) ❑ E

(6) ❑ F

(7) ❑ G

Om du hadde følt deg slik som Karam/Ghazal**, hvor sannsynlig er det at du ville ha søkt hjelp fra følgende kilder?**

Marker det alternativet som best beskriver hvor usannsynlig eller sannsynlig det er at du ville søke hjelp fra kildene som er nevnt nedenfor.

	Svært usannsynlig	Usannsynlig	Noe usannsynlig	Noe sannsynlig	Sannsynlig	Svært sannsynlig	Jeg kjenner ikke til denne kilden eller det ville ikke vært mulig for meg å søke hjelp hos denne kilden
Partner (f.eks. kjæreste, samboer, ektefelle)	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Syriske venner	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Norske venner	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Mor	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Far	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Annen slektning/familiemedlem	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Psykiater/Psykolog	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Noen på min arbeidsplass	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑

	Svært usannsynlig	Usannsynlig	Noe usannsynlig	Noe sannsynlig	Sannsynlig	Svært sannsynlig	Jeg kjenner ikke til denne kilden eller det ville ikke vært mulig for meg å søke hjelp hos denne kilden
Hjelpetelefon	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Internett	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Fastlege	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Legevakten	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Religiøs leder (f.eks. imam eller prest)	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Tradisjonell behandler fra mitt opprinnelsesland	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Eldre i mitt nærmiljø	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Sosialarbeider/NAV	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Alternativ behandling (F.eks. akupunktør, homeopat, urter)	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Leder i min etniske gruppe eller fra samme land som meg	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Lærer på voksenopplæring/kontaktperson på introduksjonssenter	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Helsesøster/helsestasjon	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Forening eller frivillig organisasjon	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑

	Svært usannsynlig	Usannsynlig	Noe usannsynlig	Noe sannsynlig	Sannsynlig	Svært sannsynlig	Jeg kjenner ikke til denne kilden eller det ville ikke vært mulig for meg å søke hjelp hos denne kilden
Allah/Gud	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Fysioterapeut	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Jeg vil søke hjelp fra andre som ikke er oppført ovenfor	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑
Jeg ville ikke oppsøkt hjelp fra noen	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑

Av kildene over, hvem ville du søke hjelp hos først, som nummer to, og som nummer tre?

Jeg ville først søkt hjelp hos	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑	(14) ❑	(15) ❑	(16) ❑	(17) ❑	(18) ❑	(19) ❑	(20) ❑	(21) ❑	(22) ❑	(23) ❑	(24) ❑	(25) ❑
Jeg ville som nummer to søkt hjelp hos	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑	(14) ❑	(15) ❑	(16) ❑	(17) ❑	(18) ❑	(19) ❑	(20) ❑	(21) ❑	(22) ❑	(23) ❑	(24) ❑	(25) ❑
Jeg ville som nummer tre søkt hjelp hos	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑	(14) ❑	(15) ❑	(16) ❑	(17) ❑	(18) ❑	(19) ❑	(20) ❑	(21) ❑	(22) ❑	(23) ❑	(24) ❑	(25) ❑

Er Karam/Ghazal sitt problem alvorlig nok til at han burde bli sykemeldt?

(1) ❑ Ja

(2) ❑ Nei

Hvor lang sykemelding mener du at Karam/Ghazal trenger?

(1) ❑ 1-10 dager

(2) ❑ 11-20 dager

(3) ❑ 21-30 dager

(4) ❑ Mellom 1 og 2 måneder

(5) ❑ Mellom 2 og 3 måneder

(6) ❑ Mellom 3 og 4 måneder

(7) ❑ Mellom 4 og 5 måneder

(8) ❑ Mellom 5 og 6 måneder

(9) ❑ Mer enn 6 måneder

Dersom du følte deg som Karam/Ghazal, hva kunne vært grunner til å ikke ta kontakt med fastlegen?
Dette ville vært grunner for å ikke ta kontakt med fastlegen dersom jeg følte meg som Karam/Ghazal. Du kan oppgi flere grunner:

	Ja
Jeg har ikke en fastlege	(1) ❑
Jeg vet ikke hvem fastlegen min er	(1) ❑
Jeg stoler ikke på fastlegen	(1) ❑
Det ville vært skamfullt	(1) ❑
Tror ikke det ville hjulpet	(1) ❑
Norskkunnskapene mine ville hindret meg	(1) ❑
Jeg vet ikke hvordan jeg skal komme i kontakt med fastlegen	(1) ❑
Det ville vært for dyrt å gå til fastlegen	(1) ❑
Det tar for lang tid å få hjelp hos fastlegen	(1) ❑
Praktiske hindringer (f.eks. lang avstand, transportproblemer)	(1) ❑
Jeg tror ikke at min fastlege ville forstått meg	(1) ❑

	Ja
Jeg ville vært redd for å bli sendt videre til psykolog/psykiater	(1) ❑
Jeg ville ikke dratt til fastlegen av andre grunner enn de listet opp over	(1) ❑

Hvilket kjønn har din fastlege?

(1) ❑ Mann

(2) ❑ Kvinne

Hvilken bakgrunn har din fastlege?

(1) ❑ Norsk

(2) ❑ Ikke norsk

Dine erfaringer med det offentlige helsevesenet i løpet av det siste året.

Vennligst oppgi antall besøk for deg selv eller familiemedlemmer som du har ansvar for

	0	1	2-5	6-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Fastlege	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑
Psykolog eller psykiater	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑
Legevakt	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑
Har vært innlagt på sykehus	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑
Distriktpsykiatrisk senter (DPS)	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑
Fysioterapaut	(1) ❑	(2) ❑	(3) ❑	(4) ❑	(5) ❑	(6) ❑	(7) ❑	(8) ❑	(9) ❑	(10) ❑	(11) ❑	(12) ❑	(13) ❑

I hvilken grad møtte besøket hos denne helsetjenesten behovene dine?

	Nesten alle behovene mine ble møtt	Flere av mine behov ble møtt	Kun enkelte av mine behov ble møtt	Ingen av behovene mine ble møtt
Fastlege	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Psykolog eller psykiater	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Legevakt	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Har vært innlagt på sykehus	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Distriktspsykiatrisk senter (DPS)	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Fysioterapaut	(1) ❑	(2) ❑	(3) ❑	(4) ❑

Sett under ett, hvor tilfreds er du med helsetjenestene som du mottok?

	Svært tilfreds	For det meste tilfreds	Likegyldig eller noe tilfreds	Ganske misfornøyd
Fastlege	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Psykolog eller psykiater	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Legevakt	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Har vært innlagt på sykehus	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Distriktspsykiatrisk senter (DPS)	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Fysioterapaut	(1) ❑	(2) ❑	(3) ❑	(4) ❑

Hvis du skulle søke hjelp igjen, ville du oppsøke denne helsetjenesten på nytt?

	Nei, helt sikkert ikke	Nei, jeg tror ikke det	Ja, jeg tror det	Ja, helt sikkert
Fastlege	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Psykolog/psykiater	(1) ❑	(2) ❑	(3) ❑	(4) ❑

	Nei, helt sikkert ikke	Nei, jeg tror ikke det	Ja, jeg tror det	Ja, helt sikkert
Legevakt	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Har vært innlagt på sykehus	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Distriktspsykiatrisk senter (DPS)	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Fysioterapaut	(1) ❑	(2) ❑	(3) ❑	(4) ❑

Nedenfor finner du en liste over symptomer og problemer som folk noen ganger har. Vennligst oppi omtrent hvor mye hvert av disse symptomene har vært til besvær eller plage for deg den siste uka.

	Ikke i det hele tatt	Litt	En god del av tiden	Svært mye
Plutselig skremt uten grunn	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler du deg engstelig	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler du deg svimmel eller kraftløs	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Nervøs eller urolig	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Hjertebank	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Skjelving	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler deg anspent eller opphisset	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Hodepine	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Anfall av redsel eller panikk	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Rastløshet, kan ikke sitte rolig	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler deg slapp og uten energi	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Anklager deg selv for ting	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Har lett for å gråte	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Tap av seksuell interesse/opplevelse	(1) ❑	(2) ❑	(3) ❑	(4) ❑

	Ikke i det hele tatt	Litt	En god del av tiden	Svært mye
Dårlig appetitt	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Vanskelig for å sove	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Følelse av håpløshet mht. framtiden	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler deg nedfor	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler deg ensom	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Har tanker om å ta ditt eget liv	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Følelse av å være fanget	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Bekymrer deg for mye	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler ikke interesse for noe	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler at alt krever stor anstrengelse	(1) ❑	(2) ❑	(3) ❑	(4) ❑
Føler at du ikke er noe verd	(1) ❑	(2) ❑	(3) ❑	(4) ❑

Stort sett vil du si at din helse er:

(1) ❑ Utmerket

(2) ❑ Meget god

(3) ❑ God

(4) ❑ Nokså god

(5) ❑ Dårlig

Er du i et parforhold (gift, samboende eller i langvarig kjæresteforhold)?

(1) ❑ Ja

(2) ❑ Nei

Har du barn?

(1) ❑ Ja

(2) ❑ Nei

Hvilken beskrivelse passer best på området du bor i? Vi tenker her på norske forhold

(1) ❑ En storby

(2) ❑ En forstad eller utkanten av en storby

(3) ❑ En liten eller mellomstor by

(4) ❑ Et bygdesentrum

(5) ❑ Et spredtbygd strøk

Hvor knyttet til Norge føler du deg?

(1) ❑ Jeg føler en ekstremt nær tilknytning

(2) ❑ Jeg føler en veldig nær tilknytning

(3) ❑ Jeg føler en moderat tilknytning

(4) ❑ Jeg føler en svak tilknytning

(5) ❑ Jeg føler ingen tilknytning i det hele tatt

Hvor ofte føler du deg som en fremmed i Norge?

(1) ❑ Aldri

(2) ❑ Sjeldent

(3) ❑ Av og til

(4) ❑ Ofte

(5) ❑ Alltid

Når du tenker på fremtiden din, hvor ønsker du å bo?

(1) ❑ Jeg vil definitivt bo i Norge resten av livet

(2) ❑ Jeg vil sannsynligvis bo i Norge resten av livet

(3) ❑ Jeg er usikker på om jeg vil bli i Norge eller om jeg vil flytte til et annet land

(4) ❑ Jeg vil sannsynligvis flytte til et annet land

(5) ❑ Jeg vil definitivt flytte til et annet land

Hvor ofte føler du deg isolert fra det norske samfunnet?

(1) ❑ Aldri

(2) ❑ Sjeldent

(3) ❑ Av og til

(4) ❑ Ofte

(5) ❑ Alltid

I Norge, hvor vanskelig eller lett ville det være for deg å oppsøke en lege?

(1) ❑ Veldig vanskelig

(2) ❑ Ganske vanskelig

(3) ❑ Hverken vanskelig eller lett

(4) ❑ Ganske lett

(5) ❑ Veldig lett

I Norge, hvor vanskelig eller lett ville det være for deg å lete etter en jobb (finne passende utlysninger)?

(1) ❑ Veldig vanskelig

(2) ❑ Ganske vanskelig

(3) ❑ Hverken vanskelig eller lett

(4) ❑ Ganske lett

(5) ❑ Veldig lett

I Norge, hvordan skal man søke hjelp for en tilstand som kroniske ryggsmerter?

(1) ❑ Ringe etter en ambulanse

(2) ❑ Oppsøke legevakten

(3) ❑ Gå til fastlegen

(4) ❑ Spørre en leder på jobb

(5) ❑ Vet ikke

Hva er din husholdnings totale årsinntekt (før skatt og fradrag) fra alle inntektskilder? Hvis du ikke vet det nøyaktige beløpet, vennligst gi et anslag.

Din husholdning omfatter alle som du deler leilighet eller hus med, og som du **også** er i slekt eller familie med (personer som du er knyttet til gjennom blodsbånd, ekteskap, partnerskap eller adopsjon).

(1) ❑ Under 150.000 kr

(2) ❑ 150.000 kr – 249.999 kr

(3) ❑ 250.000 kr - 349.999 kr

(4) ❑ 350.000 kr - 449.999 kr

(5) ❑ 450.000 kr – 549.999 kr

(6) ❑ 550.000 kr – 749.999 kr

(7) ❑ 750.000 kr – 999.999 kr

(8) ❑ 1.000.000 kr og over

Er det slik at din husholdning per dags dato har eller ikke har råd til en uforutsett, men nødvendig, utgift på…

	Ja, har råd	Nei, har ikke råd
5.000 kroner	(1) ❑	(2) ❑
10.000 kroner	(1) ❑	(2) ❑
100.000 kroner	(1) ❑	(2) ❑
500.000 kroner	(1) ❑	(2) ❑

Hvor mange mennesker, inkludert deg selv, bor i din husholdning?
Din husholdning omfatter alle som du deler leilighet eller hus med, og som du **også** er i slekt eller familie med (personer som du er knyttet til gjennom blodsbånd, ekteskap, partnerskap eller adopsjon).

(1) ❑ 1

(2) ❑ 2

(3) ❑ 3

(4) ❑ 4

(5) ❑ 5

(6) ❑ 6

(7) ❑ 7

(8) ❑ 8

(9) ❑ 9

(10) ❑ 10

(11) ❑ 11

(12) ❑ 12

(13) ❑ 13

(14) ❑ 14

(15) ❑ 15

(16) ❑ Mer enn 15

Hvilken av beskrivelsene under passer best på det du har gjort de siste fire ukene?

(1) ❑ I lønnet arbeid (eller midlertidig fraværende)

(2) ❑ Under utdanning (som ikke er betalt av arbeidsgiver, eller midlertidig fraværende)

(3) ❑ Arbeidsledig og aktivt arbeidssøkende

(4) ❑ Arbeidsledig, ønsker en jobb, men er ikke aktivt arbeidssøker

(5) ❑ Varig syk eller funksjonshemmet

(6) ❑ Pensjonert

(7) ❑ Hjemmeværende, passer barn eller andre personer

(8) ❑ Annet

Har du en eller flere norske venner?

(1) ❑ Nei

(2) ❑ Ja, jeg har én norsk venn

(3) ❑ Ja, jeg har flere norske venner

Har du en eller flere syriske venner i Norge?

(1) ❑ Nei

(2) ❑ Ja, jeg har én syrisk venn i Norge

(3) ❑ Ja, jeg har flere syriske venner i Norge

Hvor ofte har du kontakt med (er sammen med/snakker med) nordmenn i løpet av en vanlig uke?

(1) ❑ Aldri

(2) ❑ Én gang i uken

(3) ❑ 2-3 ganger i uken

(4) ❑ 4-6 ganger i uken

(5) ❑ Hver dag

(6) ❑ Flere ganger om dagen

I løpet av de siste 12 månedene, hvor ofte har du spist middag med nordmenn som ikke er del av din egen familie?

(1) ❑ Aldri

(2) ❑ En gang i året

(3) ❑ En gang i måneden

(4) ❑ En gang i uken

(5) ❑ Nesten hver dag

Tenk på nordmennene du har i din adressebok eller på kontaktlisten på telefonen din. Hvor mange av dem har du hatt en samtale med – enten på telefon, chat eller tekstmelding – i løpet av de siste fire ukene?

(1) ❑ 0

(2) ❑ 1 til 2

(3) ❑ 3 til 6

(4) ❑ 7 til 14

(5) ❑ 15 eller mer

Mange mennesker hjelper hverandre med hverdagslige tjenester som skyss, låne litt penger, eller barnepass. I løpet av de siste 12 månedene, hvor ofte har du ytt slike tjenester til nordmenn?

(1) ❑ Aldri

(2) ❑ En gang i året

(3) ❑ En gang i måneden

(4) ❑ En gang i uken

(5) ❑ Omtrent hver dag

Samlet sett, i hvilken grad opplever du den kontakten du har med nordmenn som negativ eller positiv?

(1) ❑ Kun negativ

(2) ❑ For det meste negativ

(3) ❑ Blandet negativ og positiv

(4) ❑ For det meste positiv

(5) ❑ Kun positiv

Evaluer dine egne norskkunnskaper. Hvor godt kan du gjøre det følgende når du leser norsk?
Jeg kan lese og forstå hovedbudskapet i enkle avisartikler om kjente tema:

(1) ❑ Veldig godt

(2) ❑ Godt

(3) ❑ Nokså godt

(4) ❑ Ikke så godt

(5) ❑ Ikke godt i det hele tatt

Evaluer dine egne norskkunnskaper. Hvor godt kan du gjøre det følgende når du snakker norsk?
I en samtale kan jeg snakke om kjente tema og uttrykke personlige meninger.

(1) ❑ Veldig godt

(2) ❑ Godt

(3) ❑ Nokså godt

(4) ❑ Ikke så godt

(5) ❑ Ikke godt i det hele tatt

Hva er din høyeste fullførte utdanning? (ikke tell med introduksjonsprogrammet/voksenopplæring)

(1) ❑ Har ikke fullført noen utdanning

(2) ❑ Barneskole eller grunnskole 1-6 år

(3) ❑ Barneskole eller grunnskole 7-8 år

(4) ❑ Barneskole eller grunnskole 9-10 år

(5) ❑ Videregående skole 1-2 år

(6) ❑ Videregående skole 3 år

(7) ❑ Videregående skole 4 + år

(8) ❑ Universitet eller høgskole 1-2 år

(9) ❑ Universitet eller høgskole 3-4 år

(10) ❑ Universitet eller høgskole 5+ år

(11) ❑ Universitet eller høgskole Ph.D

Tusen takk for din deltagelse!

Dersom du ønsker å snakke med noen etter å ha deltatt i denne undersøkelsen, kan du f.eks. kontakte din fastlege eller din kommunes flyktninghelseteam.

frontiers in Psychology

ORIGINAL RESEARCH
published: 13 March 2020
doi: 10.3389/fpsyg.2020.00412

General Practitioners' Experiences of Clinical Consultations With Refugees Suffering From Mental Health Problems

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Refugees suffer from higher rates of certain mental health problems than non-refugee migrants and the native population of their host country. General practitioners (GPs) in Norway and many other European countries are the first contact person for settled refugees in need of non-emergency medical support. This includes psychiatric support, although GPs are not typically specialists in psychiatry. The aim of this study is to investigate how GPs experience working with refugees suffering from mental health problems, with a specific focus on perceived challenges and facilitators. We conducted semi-structured interviews with 15 GPs working in Norway (7 females). Participants ages ranged from 29 to 67 (M = 41.7 years, SD = 11.1) with work experience ranging from 2 to 39 years (M = 13.6 years, SD = 12.1). Interviews were analysed thematically using the qualitative data analysis computer software package NVivo 12. The main challenges presented by GPs relate to language barriers, mismatched expectations, different understandings of health and illness, and the GP feeling unprepared to work with this patient group. The main facilitating themes related to establishing trust and finding the work meaningful. The themes presented in this study highlight areas of interest for future research, and should inform training programmes to improve health care for both clinicians and refugee patients.

Keywords: general practitioner, refugee, mental health, barriers, challenges, facilitators, qualitative, interviews

OPEN ACCESS

Edited by:
Marc Dupuis,
Université de Genève, Switzerland

Reviewed by:
Artemisa Rocha Dores,
Politécnico do Porto, Portugal
Federica Biassoni,
Catholic University of the Sacred Heart, Italy

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Specialty section:
This article was submitted to Psychology for Clinical Settings, a section of the journal Frontiers in Psychology

Received: *13 November 2019*
Accepted: *24 February 2020*
Published: *13 March 2020*

Citation:
Harris SM, Binder P-E and Sandal GM (2020) General Practitioners' Experiences of Clinical Consultations With Refugees Suffering From Mental Health Problems. Front. Psychol. 11:412. doi: 10.3389/fpsyg.2020.00412

INTRODUCTION

General practitioners (GPs) experience a range of challenges that contribute to the perceived complexity of clinical consultations with refugees suffering from mental health problems. There are almost 26 million refugees on the planet today (UNHCR, 2019), who flee their home countries 'because of persecution, war or violence' and 'have a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group' (UNHCR, 2017). According to Statistics Norway (2019), people with a refugee background currently constitute 4.4% (over 230,000 people) of Norway's population. Studies have suggested that refugees experience higher rates of certain mental health problems such as anxiety, depression (Lindert et al., 2009), and post-traumatic stress disorder (PTSD) than non-refugee migrants or the native population of their host country (Fazel et al., 2005). This may also be the case for

schizophrenia and other non-affective psychoses (Hollander et al., 2016). Due to experiences pre, during, and post flight they are faced with a range of mental and physical health problems (Matlin et al., 2018; World Health Organization [WHO], 2018), which are a challenge for host countries to meet adequately (Matlin et al., 2018). In many European countries, including the country of our study, Norway, the GP acts as a gatekeeper to specialist health services. While GPs are not typically specialists in psychiatry, they are required to make important decisions regarding patients' mental health treatment. Clinicians have reported feeling they lack the resources or training to meet the demands placed on them by working with refugees suffering from mental health problems (Jensen et al., 2013; Wylie et al., 2018). This may be partly related to practical challenges such as language barriers, working with interpreters, patients' illiteracy, and time constraints (Robertshaw et al., 2017). However, implicit challenges such as different understandings of illness and expectations of treatment (Jensen et al., 2013; Wylie et al., 2018), patients' high expectations of health care professionals, and different cultural values (Robertshaw et al., 2017) may also play a role. Health care professionals working with patients with a different cultural background have previously reported feelings of distress, overload, and exhaustion as a result of this work (Terraza-Nunez et al., 2011).

Rothlind et al. (2018) developed a conceptual model of communication in intercultural primary care consultations, which gives an insight into the possible mechanisms underlying the perceived complexity of intercultural consultations. Their model is based on interviews with both patients with an immigrant background and their physicians, called 'circling the undefined' (**Figure 1**). They postulate that patients and their clinicians lack a shared understanding of issues that are fundamental to the consultation, such as what constitutes health and illness in the first place. They present themes such as 'fragmentising the story,' i.e., only fragments of a patient's history being available to the clinician due to time constraints, and 'expanding one's role,' i.e., the clinician taking on roles beyond their traditional job roles, such as that of a social worker. While not specifically based on refugees or mental health, this model provides an interesting conceptual framework for our findings.

Previous literature investigating the barriers faced by GPs in consultations with refugees with mental health problems disregard aspects of the consultation that GPs considered to be successful. Some factors that have previously been suggested to be instrumental in the recovery of patients with refugee and other immigrant backgrounds, for example, include a good relationship between clinician and patient (Kokanovic et al., 2010; Mirdal et al., 2012; Mollah et al., 2018), patients having received some psychoeducation, the patient having a stable living situation, and effective transdisciplinary interventions and coordination (Mirdal et al., 2012; Mollah et al., 2018). Focussing on what GPs present as already contributing to successful consultations could pave the way for the development of more feasible interventions that draw on the systemic structures as well as clinicians' strengths that are already available. Unfortunately, studies that have explored GPs' experiences of refugees suffering from mental health problems did so prior to the main influx of refugees to Europe (Begg and Gill, 2005; Jensen et al., 2013), which, according to the European Parliament (2019) peaked in 2015, or have not focussed specifically on patients with a refugee background (Furler et al., 2010; Priebe et al., 2011; Terraza-Nunez et al., 2011; Hjørleifsson et al., 2018; Mollah et al., 2018), mental health (Johnson et al., 2008; McKeary and Newbold, 2010; Robertshaw et al., 2017), or the experiences of GPs (Wylie et al., 2018). Our study sets out to fill this gap.

The findings from this study will highlight important areas of interest that should be explored further in large scale, generalisable studies and should go toward informing interventions for GPs as well as improvements to the health care system. The risks of ineffective mental health care for refugees (Steel et al., 2011), highlight the importance of addressing this issue not only for the clinicians but also for their patient's sake. The aim of the present study is to explore the experiences of general practitioners in Norway in clinical consultations with refugees, who present symptoms of mental health problems. The research question is: what were the main challenges and facilitators GPs perceived in clinical consultations with this patient group? We addressed this question through in-depth semi-structured interviews using a hermeneutic phenomenological approach (Langdridge, 2007; Finlay, 2011; Gadamer, 2013; Brinkmann and Kvale, 2014).

MATERIALS AND METHODS

We chose a hermeneutic phenomenological qualitative method that retains the thematic content of the interviews, to explore the GPs' first-person perspectives, and to be able to trace subtle nuances of their perceptions (Finlay, 2011; Gadamer, 2013). This approach generates descriptive knowledge and analytic concepts from everyday experience through dialogic engagement. Each participant told their own individual story, which may not necessarily speak for all GPs or reflect the patients' own experiences. By comparing the individual accounts, we wanted to identify both patterns of commonalities and differences in how GPs experienced clinical consultations with refugee patients, and formulate these as themes. The specific phenomenological element of our approach lies in the attitude toward, preparation for and presence in the interviews, and the use of imagination in the reading of the interviews, meaning the researcher attempts to see the experience from different perspectives to better understand it (Langdridge, 2007). The phenomenological approach does not try to explain but rather describe experiences (Laverty, 2003). The hermeneutical element in our approach implies that interpretation is necessary when we try to understand and point out the meaning of an utterance, and that the description of the participant's lived experiences needs to be understood within the participant's but also the researchers context (Finlay, 2011). The researcher then, in interpreting the participants' experiences, invariably draws on their own preconceptions and understandings of the world and can never be impartial (Finlay, 2011). Since the researcher becomes the lens through which the data are interpreted, we reflect on possible preconceptions and experiences that could shape

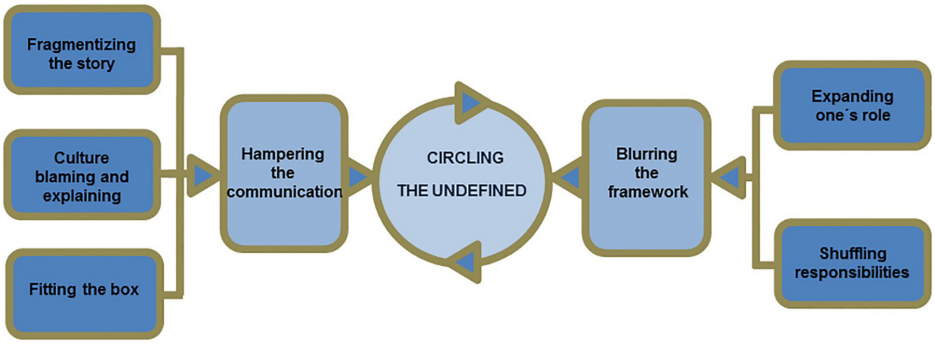

FIGURE 1 | Rothlind et al. (2018) conceptual model describing how clinicians and patients continue to 'circle the undefined' through their behaviours in intercultural consultations.

and influence how we understand the participants' narratives (van Manen, 2014).

Procedures

A reference group of people in relevant positions such as GPs, people with immigrant backgrounds, the Red Cross, the Bergen municipality, and psychologists gave feedback regarding the relevance of our research and helped with participant recruitment. We recruited participants through a combination of purposive and snow-ball sampling through the research group's network as well as from obligatory GP training courses in Norway.

Throughout data collection, the first author kept a reflective diary recording experiences, reactions, and awareness of assumptions or biases following Morrow's (2005) recommendations.

Participants

Participants were required to have worked in a general practitioner role in Norway (either full-time or as a substitute) with at least one experience treating someone with a refugee background who presented with symptoms of mental health problems. We included one accident and emergency doctor due to the participant's relevant experience with this patient group. Based on the authors' previous experience with qualitative interviews, as well as previous literature (Begg and Gill, 2005; Jensen et al., 2013; Mollah et al., 2018) an approximate sample of 15 participants was estimated ahead of time. During data collection, authors reconvened and agreed that given the depth of the interviews, a sample size of 15 would be sufficient to gather a varied and relevant depiction of participants' experiences. We approached participants via email or in person. GPs received consent forms after they had shown interest in taking part in the study, which outlined details of the study and their rights as participants. We aimed for diverse enough demographic characteristics to gain insight into a variety of experiences. Fifteen participants agreed to take part (7 female), who were working in both urban and rural areas around the country. The participants' ages ranged from 29 to 67 (M = 41.7 years, SD = 11.1). According to self-report, nine participants were born in Norway, three in Russia, one in Denmark, one in Iraq, and one in Kurdistan. The amount of work experience ranged from 2 to 39 years (M = 13.6 years, SD = 12.1). We offered participants to hold the interview in either Norwegian or English depending on their preference. Three participants chose to be interviewed in English. Participants were remunerated 500 NOK (Norwegian krone) for their time.

Interview Protocol

The first author conducted two pilot interviews to examine the relevance of the interview guide. Based on the pilot interviews some questions were reformulated, and we ensured that participants were familiar with the terms 'asylum-seeker,' 'refugee,' and 'economic migrant' before beginning the interview. Interviews were audio recorded. Interviews were semi-structured and followed an interview guide to ensure that they covered relevant and similar topics. The first author transcribed all interviews verbatim, before finishing data collection. This lead to a further revisiting and updating of the interview-guide to include new topics that appeared important throughout interviews, for example the extent to which education and training had prepared participants for working with refugee patients suffering from mental health problems. Transcriptions included information on who was speaking (researcher or participant), significant pauses, laughing or crying, and interruptions such as phones ringing. The interview began by collecting general background information about the participant (sex, country of birth, years of work experience in general medicine, amount and types of patient groups seen at the practice). This section was followed by an open question encouraging the participant to recount a consultation with a refugee patient, who displayed symptoms of mental illness. Possible follow-up questions aimed to explore the GP's first impression of the patient, diagnoses and treatment options considered by the GP, what happened next, how the GP felt during and following the consultation, the GP's perception of the relationship to the patient, as well as possible sources of

support for the GP. The follow-up questions were not asked at every interview in the same way, as the interviewer adapted the interview allowing the conversation to follow the GPs' narratives coherently. Following in-depth exploration of this first case, the interviewer aimed to cover the following topics if not already addressed spontaneously by the participant and if they were relevant: to what extent education and training had prepared the GP for this type of consultation, experiences providing care for refugees with trauma, and experiences using an interpreter. The interviews took approximately 60 min each.

Researchers

This study was conducted as part of the Clinical Encounters with Refugees Suffering from Mental Health Problems research project within the Society and Workplace Diversity Group at the University of Bergen. The first author is a research fellow at the University of Bergen with a master's degree in clinical mental health sciences from University College London and some clinical experience within mental health. Her cultural background is German and English. PB is a clinical psychologist as well as a professor of clinical psychology with many years of experience in qualitative methods. GS is a clinical psychologist and professor at the University of Bergen, as well as the project leader of the research group. She has many years of experience within the research field of migration and mental health. Both PB and GS are native Norwegians.

Ethics Statement

This study was approved by the Norwegian Centre for Research Data (NSD Notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki (World Medical Association, 2013). Audio recordings of interviews were stored on the secure desktop solution 'SAFE' (Secure Access to Research Data and E-infrastructure) (University of Bergen IT Desk, 2019), in line with the Norwegian code of conduct for information security in the health care sector. Participants received consent forms ahead of time and were encouraged to ask questions at any point.

Analysis

Interviews were analysed in line with Braun and Clarke's thematic analysis approach (Braun and Clarke, 2006; Clarke and Braun, 2018), following their six step guide to conducting thematic analysis including: familiarising self with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun and Clarke, 2006). The first author transcribed all interviews verbatim, which was considered the first stage of familiarisation with the data. Transcriptions were summarised and initial codes were noted. These were condensed according to potential overarching themes, which were reviewed by returning to the transcripts and summaries to ensure they captured the most relevant subjects discussed during the interviews. All authors turned back to the overall text to check whether voices and points of view should be added, conceptions and descriptions of themes could be developed further, or correctives to the preliminary line of interpretation represented. The authors who did not conduct the interviews, had a leading role in critically auditing the identification of thematic units. The themes were formulated and agreed upon by all authors. Finally, themes were rewritten and reported. The analysis was conducted using QSR International's NVivo 12 qualitative data analysis software (NVivo qualitative data analysis software, 2018).

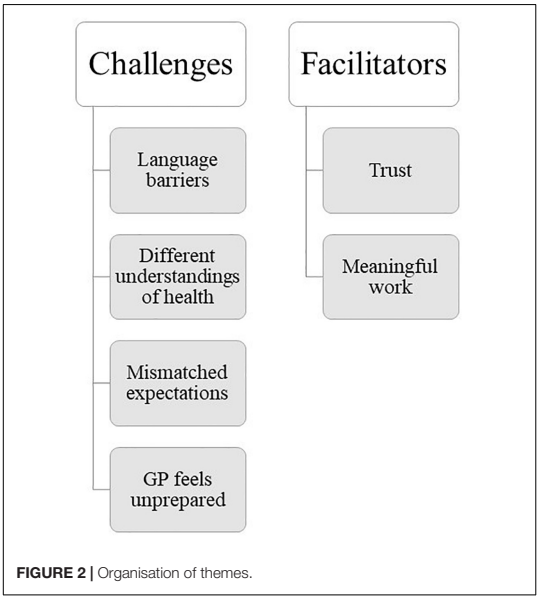

FIGURE 2 | Organisation of themes.

RESULTS

All GPs had relevant experiences with patients with a refugee background, who, according to participants themselves, displayed symptoms of mental health problems. We present six main themes based on GPs narratives, presented under the main headings 'challenges' and 'facilitators,' to indicate the GPs' own perceptions of whether this theme stood in the way of, or facilitated, the consultation (**Figure 2**). Note that initials are pseudonyms and do not have any relation to the participants' real names.

Challenges

Language Barriers Limit Our Ability to Give and Receive Help

This theme describes challenges surrounding language barriers and includes working with interpreters, which was often presented as time-consuming and difficult. Participants described communicating with their patients either in broken Norwegian or via an interpreter. Even when patients felt comfortable communicating in Norwegian a high level of language mastery was vital in order to discuss complex issues such as mental health adequately, which was often not possible. The language barrier

was presented as an obstacle to diagnosing, communicating treatment options, as well as building up a trusting relationship with the patient. One participant said:

> *PC: So we have problem number one, which is language, right. If you meet people who are having a very difficult time then having a shared language and a common platform is such a basic thing that makes it easier for both patient and clinician.*

On the flipside, speaking the same language, as well as being familiar with the patient's culture, was considered conducive to the consultation:

> *PK: I mean, in this case I knew the culture, let's say, the language, I knew everything. It made the job probably a million times easier. Both for me as a doctor but also for the patient and that also will affect the outcome.*

Speaking the same language allowed this GP to pick up on 'clues' during the consultation, which give indications of the patient's mental health. GPs pointed out that interpreters are rarely medically qualified making it difficult for them to present medical symptoms in a coherent way, which in turn influences the consultation outcome. Furthermore, participants pointed out that the quality of interpreters varies, and two participants described occasions where the patient spoke better Norwegian than the interpreter. One participant describes some of the challenges of working with interpreters:

> *PG: It depends on the quality of the interpreter. I have (pause) got the impression that the interpreter, the interpreters that we use in [our] municipality are not (pause) the same quality as those [this aforementioned] hospital uses. Many have taken only a Norwegian course, or Norwegian exam 2 or 3. I do not remember what they have taken, but it is rare that they have taken Bergen test for example or Level 3 at university so you notice a big difference. And then at the same time (pause) if the patient is sceptical of talking about these symptoms (pause) in front of an interpreter who has the same background as the patient, then it is not easy to identify these symptoms. I have a patient who has mental health problems, speaks poor Norwegian but a little, and he refuses to have an interpreter.*

This participant highlights a number of challenges. First, the interpreter may not always be able to provide the necessary support leaving GP and patient at square one. Second, participants may be sceptical of working with interpreters with the same cultural background as them, possibly due to the stigma associated with certain conditions and experiences within their common culture. It is important to add, however, that many participants also praised interpreters for the good work they do and recognised their importance in cross-cultural consultations.

It was also mentioned that diagnostic tests commonly used in primary care, such as the Montgomery-Åsberg depression rating scale (MADRS) (Montgomery and Åsberg, 1979), are aimed toward people with fluent Norwegian language skills and a western understanding of health. In many cases, GPs were limited to conducting diagnostic tests via interpreters. GPs further suggested that it may be difficult to conduct effective psychotherapy through an interpreter, and that refugee patients may consequently receive a poorer quality of mental health care. A few participants were of the opinion that the Norwegian health-care system itself is not suited to refugees with mental health problems, who lack the resources required for navigating the system, including adequate language skills.

When Worldviews Clash

This theme includes GPs' impressions that patients have different understandings of the body, what constitutes health or illness, and the causes of mental illness. Some patients seemed to believe that mental illness was caused by the supernatural, such as possession by spirits or 'jinn.' GPs, all of which were influenced by western medicine, did not have the same beliefs. The following participant describes the difficulties of dealing with these clashing conceptualisations:

> *PI: And for people from low-income countries, who have little or no education, it's more like we have such different horizons of understanding. We have such (pause) it's so terribly difficult to communicate over a like (pause) regardless of how carefully we explain they sort of often interpret signals from the body differently.*

This GP describes their experiences with some refugees, who may have low or no education. They mention 'different horizons of understanding' indicating that even when patient and clinician may be able to communicate verbally the meaning of their statements may be lost as a result of their different horizons of understanding health, illness, and the body. An additional challenge here was that some GPs felt like patients often did not see mental illness as a main problem in the first place:

> *PN: Because he did not see mental illness as a challenge, because the challenge was to deliver the children to school. The challenge was this bus that departs early. The challenge was that he could not pick up the children when he came back from school and there was no bus. Right? That was a challenge, right? The challenge was that he had no job. So, it is clear then that it becomes very difficult to explain: 'no, you have mental health problems that you have to solve first,' right?*

All GPs acknowledged mental illness as a condition to be taken seriously, and as something that could be treated. Some of their patients, however, either did not want to discuss mental health, did not see it as a problem, or did not expect the GP to be involved in matters regarding their mental health. One of the GPs with a Middle Eastern background pointed out how culture may influence the way in which patients approach mental health. This GP explained that there are very few psychiatrists in the Middle East, and that mental illness is a taboo topic, leading to fewer diagnoses. The participant added that *'depression is considered a usual (pause) or usual symptoms, not an illness. And then it is not easy to go a psychologist or to speak about mental health problems.'*

For some patients with a refugee background, mental health problems seemed, according to GPs, to be overshadowed by physical health problems. GPs recognised links between physical symptoms and traumatic experiences, stress, or mental illness, which they felt their patients often did not:

> *PL: (pause) I do not think he, well I tried to explain the connection that sometimes if one is exposed to [traumatic experiences] then it can worsen pain, for example. And he, I think he kind of went along*

with it a bit but I didn't quite get the feeling that he accepted that explanation. He was very focussed on that there must be something in that foot.

Great Expectations and Not Living up to Them

Participants suggested that refugees' expectations regarding the Norwegian health-care system, including the role of the GP, as well as possible treatment options and outcomes might not align with their own. Many participants felt like their patients expected of them to solve all their problems, preferably through the use of tablets or shots:

PL: And (pause) quite like (pause) yes, he most likely thinks that with pretty great certainty he says himself that it is, it must be, yes clearly something is wrong right? And then 'you have to give me a medicine,' that's often the demand I get, 'you have to take a picture or do something.' So (pause) then, yes. So there have been a lot of challenges because to reach a dialogue which makes him receptive to talking about what he has experienced. So what I have spent a lot of time on: building the relationship and building trust with him.

The GP in this case, seemed to feel as though it would be therapeutic for the patient to discuss what they had experienced, while the patient was convinced that his problem was purely physical, which ought to be solved through medication and medical tests. Other participants described similar discrepancies in expectations. Consequently, some were required to spend time during consultations explaining the Norwegian health-care system to their patients and clarifying what a GP is capable of helping with. One participant described the effect the mismatched expectations had on them:

PM: Yeah, the effect on me (pause) well, I (pause) I felt a bit (pause) I wouldn't say helpless, but I felt it was, I felt that it was very difficult to help him, because we didn't even have a shared understanding of what that help could be.

A few patients made GP appointments in order to discuss administrative issues such as letters they had received from the Norwegian Labour and Welfare Administration (NAV) or electricity bills. Many of the GPs expressed going beyond their traditional roles as GPs to provide adequate care for their refugee patients. However, one GP also warns of the consequences of being willing to go above and beyond for this patient group:

PH: So we took someone in privately to work in our garden and maybe invited him for dinner. And that was fine. But it can become very, it is very exhausting, because then you are both a doctor and you get to know, you also develop a private relationship, so there we sort of (pause) had a balancing act. We have (pause) my wife has taken, supported a few refugees here [in this place] among others a single mother with a small child who is adjusting very well. But you must, you must set boundaries there, you cannot become too involved.

I Was Not Prepared for It

Most participants agreed that their university education had not adequately prepared them for working with refugees suffering from mental health problems. Some GPs leaned on the information in the patient's medical files in order to make a more confident clinical decision, but files were often not available or non-existent. Similarly, GPs mentioned that in the case of a Norwegian patient they might involve the patient's social network to gather more information, which in the case of refugees was often difficult, either because they had no network or they were difficult to contact. One participant describes the first meeting with a refugee patient, who suffered from mental health problems:

PJ: I was not prepared for it. So, it was a big shock. I felt like I almost couldn't use anything of what I had learned during my education and that was very strange, because I had some expectations that during my placement and many other situations I would use the knowledge that I had, but here I felt as though I had very little knowledge.

Some participants reported feeling uncertain about their clinical decisions. In some cases this was related to the lack of information, which lead to a fear of making the wrong decision:

PA: It was well, what was difficult was that I felt sort of that I was making decisions based on lacking information. That was it. I was afraid of not doing the right thing in a way.

This participant later added:

PA: That is our world. We do things every day that we can't do. We just need to try to manage, right?

The participant seemed to feel like he was missing vital information in order to make a confident clinical decision, while also recognising this as a part of the job of a GP, to do things they are not prepared for. Some participants suggested that the education system could have done better in preparing them for the challenges related to working with this patient group, while a few felt like there was not much else the education system could have done to prepare them. In fact, many reported that while their education may not have specifically prepared them for these cases, their experiences had:

PL: I am educated in [another country]. So in that sense it is, I have some experience with non-Norwegian culture and that is living in another culture [. . .]. It demands a lot extra from you as a clinician to manage that in a good way, that's something you just have to learn in practice I think. That is how it is with a lot of things. I probably wasn't prepared for it when I finished my studies. What it was like to work with an interpreter, and work with, work with, yes very different values or other, in a way, thoughts about how the system should work and those with a different culture it is like, yes, you sort of learn as you go along.

However, GPs experiences varied, and none of the participants outlined having received specific instructions or guidelines on how to work with a refugee patient suffering from mental health problems, including how to effectively work with an interpreter.

Facilitators

Trust as a Bridge

Many of the challenges that GPs discussed seemed to be improved when patient and GP had established a trusting relationship. In the following case, a trusting relationship led to better communication:

PI: Yes, she, after a while we developed a trusting relationship and in a way she was able to speak to me about what had happened.

The most important factor in establishing a trusting relationship, however, was time. Most participants pointed out that building up a relationship often took a long time, required continuity of care, and taking the patient seriously. One participant described the process of building up such a relationship:

PE: Many patients feel that they do not have enough time to (pause) that it is in a way (pause) that it is a challenge with a GP because many GPs set aside 10 min or 15 min or 20 min. I think when I realise that I have such a patient (pause) something to do with such a patient, then at the first meeting I say that 'we'll set up a new appointment very soon, and we'll arrange a double appointment and then we'll become more familiar with one another and then we'll establish your needs' and (pause) I feel that in a way saying that I will try to help you within these frameworks here is very important. Importantly, I have at least experienced that it is a very important thing for them to hear, that they feel safe and seen and that even if we do not get to do so much, that they leave the consultation and feel that there is someone who has tried to help them at least, I think that is of great value.

While most GPs recognised the importance of a good alliance between clinician and any patient, they also acknowledge that this was harder to establish than with Norwegian patients:

PL: But it is probably also easier to do because of, it is easier to establish a relationship [with Norwegians] because of language and, there is no language barrier there. So (pause) then one can assume that it also contributes to having a (pause) it is easier to establish a trusting relationship then. So, if you imagine that you are trying to convey the message that, for example regarding the treatment of back pain, or treatment of pain through exercise or, or light activity, no tablets no pills, no such thing, and then to convey that message with an importance that the patient believes in then it is important to have a trusting relationship. And building that relationship is maybe a little easier when you do not have, when you are just one on one, do not have an interpreter in the room, where you always have an open dialogue, where you understand each other well. If you have an interpreter in the room it will probably be a little more difficult to build that trust in order to be able to convey such a message to the patient so that the patient accepts it.

This GP suggested that a trusting relationship between GP and patient seems to encourage the patient to adhere to treatment. This participant also discusses that an interpreter can stand in the way of establishing such a relationship, while another participant stated how interpreters could support the consultation. Overall, many participants pointed out that establishing a trusting relationship with a patient with a refugee background was possible and very valuable.

These Consultations Are Deeply Meaningful

While acknowledging the challenges associated with this type of work, most GPs felt like working with refugee patients was a meaningful and interesting part of their job, and participants highlighted that the desire to help their patients was not outweighed by the previously mentioned challenges. One GP recognised this type of work as a privilege:

PJ: I want a job where I get goose bumps, if I feel like 'oh this has touched me a lot.' Yes, because then I feel most alive and I need such a job, you see? So I think it makes a lot of sense to be given the privilege of hearing those stories, because I think to be allowed to witness something that is so personal I think is very, very meaningful and rewarding. It's a gift.

Within the same sentence, another GP presented the work as both 'hard work' as well as the reminder of why they became physicians:

PM: I've mostly come away from these meetings with a feeling that I actually did something worth doing today. I, you know, I was in the right spot. I was supposed to be there and I could probably do it better, but it was the right place for me to be, and it was a good day. So, that, I think that would be important for me to add, because otherwise the story is often presented as, you know, that's just hard work for physicians, but it is also a reminder why we became physicians, I think.

These and similar comments show that the GPs in these interviews, while recognising certain challenges, were often willing to go above and beyond in their job to support this patient group:

PE: But one becomes willing to go above and beyond for those, yes, in this practice here we are perhaps more preoccupied given where we work in [this place] and what we, in a way, want to represent, so we are interested in going above and beyond for those patient groups that need us.

DISCUSSION

Summary of Themes

This study explored GPs' perceived challenges and facilitators in clinical consultations with refugees suffering from mental health problems through individual semi-structured interviews. Resulting themes are presented under the overarching headings 'challenges' and 'facilitators,' to indicate participants' own opinions of whether the issue was a factor that helped or stood in the way of effective consultations.

Challenges included themes related to language barriers, different understandings of health and illness, mismatched expectations, and feelings of being unprepared. Facilitators included themes related to developing a trusting relationship and finding the work meaningful and interesting. Themes were interrelated and impacted on one another. For example, language barriers seemed to complicate other aspects of the consultation, for example clarifying what constitutes health and illness as well as the patient's expectations of health-care. Language barriers, different understandings of illness, and mismatched expectations of health-care seemed to make working with refugee patients more challenging than with Norwegian patients and contributed to GPs' feelings of being unprepared. Similarly, GPs discussed that it was easier to build trust, an important element of a successful consultation, with Norwegian patients often due to having a shared language. However, while time-consuming to

establish, a trusting relationship between clinician and refugee patient facilitated communication. Finally, many GPs found consultations with refugees meaningful and interesting, partly due to exactly those challenges presented above, which made them feel like they could make a valuable difference in their patients' lives.

Language barriers posed an important challenge both in our study and in previous literature (Jensen et al., 2013; Wylie et al., 2018). The 'circling the undefined' model highlights that information needs to be shared in order for clinician and patient to clarify those issues that are fundamental to the consultation, such as what constitutes health and illness (Rothlind et al., 2018). Their theme 'fragmentising the story' suggests that a large obstacle in sharing information is a lack of time. While language is not specifically referred to in Rothlind et al's model, our study suggests that language barriers may also pose a significant obstacle in the process of sharing information. Working with interpreters is meant to support the sharing of information between clinician and patient, however, our participants suggested that working with interpreters had both advantages and disadvantages. Previous literature suggests similar. When interpreters are introduced into the consultations they create a triadic therapeutic alliance, which when successful may enhance the consultation, but when unsuccessful may stand in the way of a healthy therapeutic alliance between clinician and patient (Miller et al., 2005). Miller et al. (2005) suggest that interpreters with a refugee background, who have been appropriately trained for working in a clinical setting should be employed and can be a great asset to intercultural consultations. However, language barriers seemed to go beyond verbal communication and affected other diagnostic procedures. According to our participants, diagnostic tools used in primary care in Norway are rarely culturally validated or even translated into other languages. Participants reported using standard assessment tools, such as the MADRS (Montgomery and Åsberg, 1979) translated through an interpreter during the consultation. This procedure is not considered a reliable, valid, and acceptable way of translating diagnostic questionnaires (Hambleton and de Jong, 2003), and could arguably lead to misdiagnoses. This highlights the importance of employing appropriately trained interpreters, as well as making culturally validated diagnostic tools readily accessible in primary care.

Some GPs in both our and previous studies (Jensen et al., 2013), found that their understandings of the causes of mental illness differed from those of their patients, who sometimes believed in possession of evil spirits, or 'jinn.' Furthermore, they reported that some of their patients did not speak openly about mental illness and often presented symptoms in terms of physical problems, known as 'somatisation' (Kirmayer, 2001), which complicated diagnostic decision making. It has previously been reported that ways of explaining and presenting mental illness seem to differ between cultures and languages. In Arabic, for example, it may be more common to describe sadness in terms of having a 'blind' or 'squeezed' heart, while in Kurdish, low mood may be portrayed in terms of being short of breath or the world becoming dark (Hassan et al., 2015). The observation that refugees somatise their distress is not a new insight (Fuller, 1993; Kokanovic et al., 2010; Farley et al., 2014). However, it has been suggested that it may be a generalisation made by people in Western cultures (Kirmayer, 2001). Kirmayer (2001) claims that 'if there is any validity to this generalisation, it can only be because Westerners (who themselves comprise extremely diverse and divergent cultural groups) share some distinctive values or practices that contribute to the obverse of somatisation, which has been termed psychologisation' (p. 23). This idea is also to some extent echoed in Rothlind et al. (2018) theme 'culture blaming and explaining,' which suggests that clinicians and patients in intercultural consultations may have the tendency to (erroneously) attribute each other's behaviours to culture, which prevents them from exploring each other's perspectives and motivations more thoroughly. While not openly stated by any of the participants in our study, it is possible that they, as well as we, also have the tendency to engage in 'culture blaming and explaining.'

Our participants experienced that their patients often had high expectations of them, of being cured quickly, and of receiving pharmacological treatment. Especially the expectation of receiving pharmacological treatment has been mentioned in previous literature (Jensen et al., 2013). When left unaddressed, this mismatch of expectations may lead to dissatisfaction and low compliance with treatment. While not in the context of refugees and mental health, Ali et al. (2006) study provides an interesting insight into the effects of mismatched expectations in intercultural consultations. They suggest that patients living in the United Kingdom with a different cultural background, who were fluent in English and familiar with the United Kingdom health-care system, compared to those who were not, were more satisfied with their treatment. The authors explain this in terms of expectations claiming that patients who are familiar with the health-care system have more realistic expectations of treatment. This is supported by Rothlind et al.'s (2018) 'circling the undefined' model, which suggests that part of the perceived complexity of intercultural consultations is a result of clinician and patient having a silent agreement on their expectations from treatment, which may not align. The model also describes a mismatch between what clinicians and patients expect their own roles and responsibilities to be, often leading to confusion and conflict.

Most GPs in our study stated that they felt their education had not adequately prepared them for working with refugees suffering from mental health problems. Other studies found that clinicians lack a uniform procedure to deal with such consultations (Wylie et al., 2018), lacked support or resources (Begg and Gill, 2005), and sufficient education and supervision (Fuller, 1993). While participants in our study pointed out that their education may not have prepared them for this work theoretically, they believed that their practical experience had. Some participants also argued that education alone could not prepare them. Nevertheless, the majority of participants agreed that preparation with regards to, for example, the proper use of interpreters would have been helpful. Similarly, the 'circling the undefined' model outlines that roles and responsibilities become blurred, and the clinician may find themselves taking on roles their education had not prepared them for, such as

a social worker, psychologist, and/or language teacher, among other things, which could lead to stress and less job-satisfaction (Rothlind et al., 2018). Importantly, it has been shown that the hindering effect of the lack of knowledge was decreased after taking cross-cultural mental health training (Bäärnhielm et al., 2014), highlighting the importance of such training in improving GPs confidence and competence in working with this patient group.

Alongside the challenges presented above, participants also reported factors that they felt contributed to, what they considered, successful clinical consultations with refugees suffering from mental health problems. Participants suggested that a trusting relationship encouraged patients to share more personal experiences, which helped the GP gather a clearer idea of the patient's experiences and symptoms and identify appropriate treatment options. Trust was presented in one study on refugee-background young people accessing mental health services as both a challenge and a facilitator (Colucci et al., 2015) and has also been mentioned in similar studies with immigrant patients in a general health context (Priebe et al., 2011; Mirdal et al., 2012; Robertshaw et al., 2017). While our participants discussed trust in a mostly facilitating context, these studies suggest that while the presence of trust can be invaluable, the absence of trust can be detrimental. Trust is, of course, not an element that is unique to the relationship between GP and patient with a refugee background. However, the importance of trust may be even more conducive and the lack of trust may be even more detrimental in a cross-cultural consultation. Furthermore, our participants pointed out that establishing a trusting relationship took time, something GPs often lacked due to time constraints on consultations.

Most of our participants found it important to highlight that they thought working with refugees with mental health problems is meaningful and interesting. This was partly due to exactly those challenges presented above, which made GPs feel like they were able to make a valuable difference in patients' lives. Similarly, primary health care workers and administrative staff at a specialist refugee health care service in Australia reported that despite challenges associated with their work, they were committed and enthusiastic about working with refugees (Farley et al., 2014). As far as we are aware, this topic has not been addressed in previous research exploring GPs experiences of providing care to refugees with mental health problems in a non-specialist health care setting, and is therefore an important contribution to the literature. It is important to remember, however, that while GPs in the current study find their work meaningful, they are nevertheless limited by both the challenges mentioned above as well as challenges on a systemic level that need to be addressed. Schwartz and Sharpe (2006) point out that the health-care system does not foster the quality of 'practical wisdom,' which is the ability to know what to do as well as wanting to do it because it is in line with one's values as opposed to just aiming to meet targets or being motivated by financial incentives. They suggest that doctors who achieve practical wisdom, who see their work as both meaningful and interesting, and whose work provides them with the opportunities to act in line with their own values, may consequently experience higher work satisfaction and may be able to provide higher quality care to their patients.

Reflexivity and Limitations

Working with ambiguous texts, such as these interviews, is a process that is vulnerable to observer bias and researchers may 'see what they expect or (subconsciously) want to see' in the data (Binder et al., 2016, p. 4). To address this in a hermeneutic phenomenological approach the researcher engages in a self-reflective dialogue regarding their own preconceptions and how these influence the research procedure (Laverty, 2003; Finlay, 2011; Gadamer, 2013). Following Morrow's (2005) recommendations, the first author kept a reflective diary recording experiences, reactions, and awareness of assumptions or biases. Some relevant reflections are presented below.

All authors had western backgrounds, which were similar to the majority of the participants. It is reasonable to assume, therefore, that they shared a relatively similar understanding of illness based on western medicine. These similarities may have facilitated the examination, but this assumption may also have led to over reliance on these perceived similarities when interpreting participants' statements (Merriam et al., 2001). Furthermore, none of the researchers were GPs themselves: PB and GS are experienced psychologists, and SH has worked with people with mild to moderate mental health problems. However, the authors' experiences of working with clients in a clinical setting may have allowed them to judge the most relevant themes to cover in the interviews with GPs, while their differences may have allowed them to interpret GPs' narratives through a different lens than someone within general medicine. Not sharing characteristics, role, or experience with participants can make the author an 'outsider' (Dwyer and Buckle, 2009). Being an 'insider' is said to ensure the trust and acceptance of the participants, allowing one to reach deeper and more meaningful narratives, but being an 'outsider' has its own advantages. An 'outsider,' for example, is not influenced by their own experiences and is therefore more open-minded to being guided by the participants' own experiences (Dwyer and Buckle, 2009).

In a discussion about dominance, Kvale describes the qualitative interviewer as using emotional rapport as a 'Trojan horse' to get behind defence walls of the interview subjects, who in turn may share information they later regret sharing (Kvale, 2006). The researcher holds power by setting the terms of the interview, deciding which questions to ask, and determining to some extent the direction of the interview. GPs may be used to being in a position of power in relation to their patients, but their role may not be as clear when sitting opposite a researcher. The researcher's influence on the participants and power over the interview was an important realisation, which led to actively informing the participants to only share as much as they felt comfortable with.

The study has some limitations that should be taken into consideration when interpreting the results. First, participants were given the choice of speaking Norwegian or English during their interviews. The majority of participants chose to hold the interviews in Norwegian. Norwegian is not the interviewer's (SH) first language and may consequently

have led to linguistic misunderstandings. Therefore, SH was shadowed by an experienced qualitative researcher, who speaks fluent Norwegian, during the first three interviews to ensure the quality of the interview procedure and evaluate the language barrier between interviewer and participants. SH was able to communicate easily and was understood well by participants. Obvious misunderstandings were addressed during the interviews, and any linguistic misunderstandings arising after interviews were clarified with the help of the Norwegian speaking co-authors and research assistant during the transcription and analysis phase. The advantage of allowing the participants to share their experiences in the language they are most comfortable with outweighs, in our opinion, the disadvantage of Norwegian not being the interviewer's first language.

Secondly, since participation in the study was voluntary we may have recruited mostly participants who were sympathetic to the topic of our research. Our theme related to finding the work meaningful and interesting may be a consequence of this. Furthermore, given the socio-political sensitivity of the topic of immigration and mental health, social desirability may have influenced the participants' responses. However, we successfully recruited a group of otherwise diverse participants, in terms of age, experience, gender, and ethnicity, which allowed the collection of a variety of narratives.

Finally, the interview guide, data collection, and analysis had an unavoidable subjective dimension, and were therefore influenced by the experiential horizon of the authors. Given the hermeneutic phenomenological approach of this study, however, this is not necessarily a disadvantage. The author is the lens through which the data are interpreted (Laverty, 2003), and through reflexivity we aimed to expand and transform as much as possible of the subjective dimension into an opportunity for exploration.

Conclusion and Future Avenues

According to our participants, the main challenges they experienced in consultations with refugees suffering from mental health problems related to language barriers, having different understandings of illness, having different expectations of health care, and GPs feeling unprepared for this work. A trusting relationship between patient and GP was said to facilitate consultations, and many GPs found working with refugees with mental health problems meaningful and interesting. Considering both facilitating factors alongside challenges in futures studies may lead to a more balanced view on how to develop interventions to improve mental health care for refugees, which focus not only on what needs to be improved but also draws on clinicians' strengths and encourages those aspects of consultations that are already contributing to successful outcomes. Furthermore, it is vital that we explore systematically what effect patients' backgrounds have on diagnoses and treatment options offered by clinicians, including the validity of frequently used diagnostic tools. These findings should be integrated with patients' own experiences to inform and tailor interventions accordingly. As a result of globalisation, in the wake of war, and more recently even climate change, migration is becoming a steadily increasing phenomenon. The importance of understanding how we can better address the challenges associated with providing health-care for immigrants, including refugees, must quickly become a priority in medical educational curricula. The way we choose to address these issues will hold important implications for public health and the well-being of both clinicians and people with a refugee background seeking help for mental illness.

DATA AVAILABILITY STATEMENT

The datasets generated for this study will not be made publicly available because there is confidential information in the data. Requests to access the datasets should be directed to the corresponding author.

ETHICS STATEMENT

The study was reviewed and approved by the Norwegian Centre for Research Data (NSD). The participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

SH, P-EB, and GS contributed to the conception and design of the study, conducted the analysis, and edited the manuscript. SH conducted all interviews. SH wrote the first draft of the manuscript. All authors contributed to manuscript revision, read and approved the submitted version.

FUNDING

This project was funded by the Norwegian Research Council (Project number: 273645).

ACKNOWLEDGMENTS

We want to thank Tuva Emilie Øyslebø for her invaluable contributions to proofreading and editing the interview transcripts. Furthermore, we would like to thank Vivian Woodfin, who attended the first three interviews alongside the first author to ensure the quality of the interview procedure.

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Conflict of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Title: General practitioners' management of depression symptoms in Somali refugee and Norwegian patients: A film vignette experiment

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Key Words: refugees, mental disorders, clinical variation, clinical uncertainty, general practitioners

Acknowledgements

First, we want to thank our participants for taking part. Thank you also to Dr Tommy Thorsen from the Bergen municipality for his help with participant recruitment. Thank you to our reference group, who helped keep this research relevant for stakeholders. Particularly, Dr Ali Watti, Dr Khuluud Abdi Jibril, and Morsal Saba, who helped with the development of the scripts. Thank you to the amateur actors, who professionally and patiently played their roles. Thank you to Tane Holm Høisæter and Ingrid Losnegaard from Media City for contributing with their expert film-making skills. Finally, thank you also to the reviewers, Pascal Schlechter, MSc, and Dr. Katrijn Delaruelle, for their helpful comments on a previous version of this manuscript.

Funding

This project was funded by the Norwegian Research Council (Project number: 273645).

Competing Interests

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

Abstract

OBJECTIVES

Refugees in comparison with non-refugee patients may face higher unmet mental healthcare needs. The mechanisms underlying these disparities are still poorly understood. The GP plays a vital role in refugees' mental health (MH), managing complaints within primary care and acting as gatekeeper to specialist services. However, GPs have reported feeling uncertain about working with refugee patients. Somalis make up one of the largest refugee groups in Norway and use primary care services more than the majority population for physical health, although not for MH. The current study examines GPs' management of MH complaints in Somali refugee vs. Norwegian vignette characters and the role of clinical uncertainty.

DESIGN

We distributed an online experimental survey to GPs in Norway (N=133), who were randomized to watch a simulated consultation with a female Norwegian, female Somali, male Norwegian, or male Somali vignette character, presenting the same symptoms of depression. GPs indicated which diagnoses, assessments, and treatments they would endorse for the patient and their level of certainty.

OUTCOME MEASURES

We calculated Simpson indices to measure inter-rater reliability and 2x2 ANOVAs as well as Bayesian estimation to examine clinical certainty.

RESULTS

GPs' clinical decisions about Somali and Norwegian vignette characters were similar, with a few exceptions. There was less consensus regarding the first prioritized diagnosis for Somali characters (Simpson index=0.129) vs. Norwegian characters (Simpson index=0.209), ($p=0.011$, one-tailed). Somalis more frequently received PTSD diagnoses, while Norwegians received diagnoses of feeling depressed. GPs endorsed sick leave more often for Norwegian

characters and medication for physical complaints for Somali characters. There were no substantial differences in GPs' self-reported certainty.

CONCLUSIONS

We found few and relatively small effects of patient background and gender on GPs' clinical decisions. Nevertheless, the validity of certain diagnoses and prescription of sick leave need to be considered by clinicians and in future research.

Article summary

Strengths and limitations of this study

- The experimental design has limited external validity and may not translate directly to a true consultation setting.
- Findings may be less relevant regarding clinical decisions made by other health professionals, or clinical decisions made about patient populations other than Somali refugees.
- However, the experimental approach provides practically unconfounded comparisons of vignette characters' gender and background.
- By specifying the patient's background, we were able to improve the relevance of the findings for GPs and service users with a Somali background.
- The power analysis followed by both frequentist analyses as well as Bayesian estimation provides a statistically robust basis on which to draw the conclusions.

Introduction

Since the beginning of the so-called “refugee crisis” in 2015, much attention has been paid to delineating the difficulties refugee populations face regarding health and healthcare [1-5]. Previous literature from European countries suggests that there are persistent inequalities between refugee/migrant and non-migrant groups, with migrants facing higher levels of unmet healthcare needs particularly regarding mental health (MH) [4]. However, the underlying mechanisms of these disparities are still poorly understood.

The general practitioner (GP) plays an important role in refugees’ MH care, resolving most MH problems within general practice as well as acting as gatekeeper to secondary services. The Norwegian public healthcare system is characterised by universal health coverage for all legal residents, including refugees, and individuals make only modest co-payments of maximum 2460NOK (€247) annually for different services. Services covered by universal health care include primary care, hospital care, and mental healthcare. As a result, all residents are encouraged to seek help from their GP for both physical and mental health problems [6].

There are currently more than 27,000[1] Somali refugees in Norway (Statistics Norway, personal communication, October 1, 2021). Refugee groups, in general, have reported poorer MH [1, 2, 5, 7-10], and lower use of health services than the majority population [11, 12]. However, this pattern may not apply to Somali refugees, who have self-reported good physical and mental health [13, 14], are more likely to make use of GP services than other sub-Saharan migrants in Norway for somatic complaints [15], and have higher contact rates to emergency services than the majority population [16]. Despite higher contact rates regarding somatic health complaints, Somali women in particular may have lower use of secondary mental health services [17]. This pattern does not necessarily mean that they do not experience psychological distress, however [18]. Lower contact rates to MH services may

[1] Number retrieved by internal employee from Table "08144: Personer med flyktningbakgrunn, etter statistikkvariabel, flyktningstatus, år, region og landbakgrunn".

be the result of high levels of stigma attached to mental illness [19], the belief that mental health problems do not exist among Somalis [20], and that mental illness ought to be treated through spiritual approaches [21]. Additionally, lower contact rates to specialist mental health services may reflect lower referrals from GPs [22].

A UNHCR report on the culture, context, and mental health of Somali refugees has suggested that health professionals find it challenging to provide healthcare to Somalis with a refugee background suffering from MH problems, due to their psychosocial problems and distinct cultural and religious conceptualizations of MH [19], which may include the belief that mental illness is the result of spiritual possession or of being a bad Muslim [20, 21]. While the knowledge that a patient has undergone forced migration may increase empathy towards refugees among host country residents, it may also increase anxiety and feelings of threat [23]. GPs may, therefore, experience distinctly different psychological responses to refugee patients in comparison with non-refugee patients. This is supported by findings indicating that health professionals evaluate forcibly displaced patients differently from majority population and other patients with foreign descent, for example being less optimistic about their recovery [24] and feeling less confident about providing care to them [25-28]. Similarly, Somali women with a refugee background may be perceived as being more at risk for violence [29], such as female genital mutilation [30], which may influence GPs' clinical decisions about this patient group. The role of gender in clinical decisions about diagnoses and treatments has been previously documented among non-migrant patients [31-33], and it has been shown that migrant women, compared to men, may receive fewer follow-ups for common mental disorders in Norway [34]. However, less is known about gender differences in the management of mental health problems among individuals with a refugee background.

There is evidence suggesting that some migrant groups may be handled or managed differently in primary care. Somali and Iraqi migrants, for example, have been referred more often for laboratory tests for physical health complaints in emergency primary healthcare

services for non-urgent purposes, in comparison with German and Polish migrants, as well as the majority population in Norway [16]. Whether this is due to a real difference in their need for laboratory tests is unclear. Still, it is noteworthy that the overuse of diagnostic tests has previously been identified as an indicator of clinical uncertainty on the part of the practitioner [35, 36]. In the UK, it was found that the apprehension some GPs experienced in working with individuals from other 'ethnicities' (this is not further clarified in the article) could be debilitating to their practice [28]. Improved cultural competence has been shown to improve health professionals 'transcultural self-efficacy', or the confidence with which they approach inter-cultural clinical consultations [37]. Furthermore, cultural competence contributes to health professionals attributing more trustworthiness to asylum-seeking patients [24]. Feeling a lack of cultural competence, for example through lacking training or courses, may therefore play a role in the experience of clinical uncertainty in inter-cultural consultations.

Clinical uncertainty is inherent to clinical practice [38], but may be exacerbated in consultations with vulnerable patient groups and is further 'complicated by cultural differences and psychological challenges' [39]. GPs have previously reported mismatched expectations of treatment as well as different understandings of mental health, as particularly pertinent barriers to providing effective mental healthcare to refugee patients [27, 40-42]. These barriers may furthermore contribute to GPs' feelings of being unprepared and uncertain about their clinical decisions [27]. This is supported by evidence that GPs in the UK and US experienced greater clinical uncertainty diagnosing depression among minority groups [43]. Clinical uncertainty is particularly relevant in primary care consultations, where clinicians are often confronted with undifferentiated illness presentations, and in MH consultations [38, 44]. Uncertainty can exist at the individual level as well as the aggregate level, which has been referred to as micro- and macro-uncertainty, respectively [45]. Micro-uncertainty refers to self-reports of clinicians' uncertainty, while macro-uncertainty refers to a lack of consensus across clinicians [45]. However, medical curricula and the culture of

medicine place little weight on acknowledging, accepting, and managing uncertainty in a clinical context [38, 46].

Since uncertainty is unavoidable, the 'key dilemma', [47], is how clinicians make decisions when faced with the reality of uncertain situations. When faced with situations with insufficient information and high uncertainty, health professionals are likely to rely on heuristics when making decisions [48]. In a clinical setting, this means that a clinician may rely on what they assume about, for example, the patient's background and gender, to conclude which diagnoses, assessments, and treatments are most appropriate. This type of decision-making has the advantage of being efficient, however, it is also prone to human error and bias [48]. The risks of clinical uncertainty, therefore, include higher variation in the clinical decisions made about different patients, and ultimately, disparities in treatment offered, even when individuals present with comparable complaints.

Studies that present the disparities between migrant and majority populations are typically observational and cannot fully consider potentially confounding variables [49, 50]. Experimental approaches may be the only feasible way to examine the unconfounded impact of patient characteristics on clinicians' decisions [51]. In the present study, we examine differences in the diagnoses, assessment, and treatment options chosen by GPs regarding female and male Norwegian and Somali refugee vignette characters presenting with the same symptoms of depression in simulated primary care consultations. We predicted that there would be less consensus among GPs (higher macro uncertainty) regarding the most appropriate diagnoses, assessments, and treatments considered for the Somali group vs. the Norwegian group. Furthermore, we hypothesized that participants would self-report lower rates of certainty (higher micro uncertainty) in consultations with the Somali characters. Finally, we hypothesized that we would observe an interaction of patient gender and background regarding both macro- and micro-uncertainty.

Methods and Materials

SAMPLING AND RECRUITMENT

The sample included 133 individuals currently working, or having previously worked, as GPs in Norway. Participants were recruited through snowball sampling, and via Bergen municipality's newsletter, through convenience sampling from August to November 2020.

We conducted a power analysis [52] for the 2x2 ANOVA examining self-reported certainty, which indicated a required sample of 128 participants in total to achieve a power of 0.80 for detecting a medium effect size of f=0.25 at a 5% alpha error level. We chose an effect size of 0.25, because we felt that smaller effects were unlikely to have a large practical consequence, although it must be kept it mind that also small effect sizes may have implications on a population level. A total of 192 participants took part in the study, however only 137 completed the entire survey. Participants who did not meet the inclusion criteria, i.e., had never worked as GPs, were excluded (n=4). The remaining 133 participants were included in the final analyses. A CONSORT flow diagram can be found in Figure S1 of the supplementary material. Participant characteristics are presented in Table S1 of the supplementary material.

Eighty participants (60.2%) reported either not having taken, or not remembering having taken, a course on migration and health during their education, and 97(72.9%) gave the same answer regarding such a course after finishing their education. However, 89 participants (66.9%) indicated that they felt the need for a course in migration and health.

PROCEDURE

The survey was distributed online via the survey platform Survey Xact [53]. Using simple randomization, participants were allocated to one of four groups within the survey, each watching one of four film vignettes depicting a simulated primary care consultation with a single character who was either a Somali male ("Abdi Warsame"), Norwegian male ("Emil Olsen"), Somali female ("Hodan Osman"), or Norwegian female ("Mari Berg").

Participants indicated up to three possible diagnoses, assessments, and treatments they would endorse for the vignette character and ranked the options according to priority. These will be referred to as D1, D2, D3, A1, A2, A3, T1, T2 and T3, where the letters are short for diagnosis, assessment, and treatment, respectively, and the numbers represent first, second, and third priority. Participants also indicated their level of certainty in each of these clinical decisions on an 8-point Likert scale where 0 = 'very uncertain' and 7 = 'very certain'. The diagnostic options were based on the International Classification of Primary Care (ICPC) codes [54]. The assessment and treatment options were developed by the authors, of whom ED is a medical doctor and specialist in Family Medicine.

FILM VIGNETTES

Symptoms presented by the vignette characters were based on DSM-V and ICD-10 criteria for depression [55, 56]. However, similar to Lawton et al.'s study [57], symptoms were presented in a relatively ambiguous manner so that a range of diagnoses, assessment and treatment options could be considered appropriate. To improve the realism of the scripts, we included small gender differences in the expression of symptoms based on previous literature [58]. Consequently, the female vignettes highlighted feelings of depression more in line with diagnostic criteria, including guilt and self-blame, while the male vignettes highlighted being in a bad mood and feeling irritable. Authors SH, PB, and GS attended all film sessions to ensure the same symptoms were presented in the same order and that the actors' body language was comparable.

The vignettes were filmed at Media City Bergen. Actors (Figure S2) were recruited from the Bergen amateur dramatic society (BADS) and the research group's network. All actors were fluent in Norwegian. However, the Somali actors both spoke with a Somali accent, making similar, small linguistic mistakes in Norwegian. The actors' ages ranged from 26 to 32. The GP character, who was briefly visible in all four clips, was played by the same actor. Each participant received background information about the vignette character before the consultation (Box S1).

PATIENT AND PUBLIC INVOLVEMENT

The scripts were developed by authors SH, PB, ED, and GS, as well as two medical doctors from a reference group of stakeholders, of which one has a Somali background. The survey was piloted among 12 medical students, who suggested to include information that the patient's symptoms had no known somatic causes.

ETHICAL CONSIDERATIONS

This study was approved by the Norwegian Centre for Research Data (NSD Notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki [59]. Participation was voluntary, anonymous, and confidential. To claim a gift card worth 500 NOK (€48), participants had the choice of being redirected to another website following completion of the survey, which could not be linked to their responses on the survey.

STATISTICAL ANALYSES

Main analyses were preregistered. Preregistration, data, and materials are publicly available on the Open Science Framework (osf.io/qexrj) [60].

Simpson indices

As a measure of inter-rater agreement with respect to the diagnosis, assessment and treatment options chosen by the participants, we calculated the Simpson indices of the distributions of corresponding responses. If the distribution of responses in any given task (say, D1) is 100% for one of the response options and 0% for all others, the inter-rater agreement may be considered perfect. In that case, the Simpson index, which is defined as

$$S = \sum_{i}^{K} {p_i}^2, \quad (1)$$

where p_i is the relative frequency of responses for response option i and K is the number of available response options, is 1. If the distribution is entirely flat, however (i.e. p_i = 1/K), one

may say that there is no inter-rater agreement. In this case, the Simpson index equals 1/K. Hence, the Simpson index can be considered a measure of inter-rater agreement that ranges from 1/K (minimal agreement) to 1 (maximal agreement). Couched in terms of probabilities, it can be shown that the Simpson index represents the probability that two randomly chosen responses sampled from the theoretical probability distribution are identical.

To test for statistically significant differences between the Simpson indices for different groups we used bootstrapping [61] since the theoretical distribution of the Simpson index under the null hypothesis is unknown. More specifically, we used the percentile bootstrap and one-tailed tests.

Frequentist ANOVA and Bayesian estimation

To examine whether GPs' self-reported certainty about their clinical decisions depends on the background and gender of the vignette characters, as well as any interaction of these two factors, we conducted 2x2 independent samples ANOVAs.

In addition to the frequentist ANOVAs, we used corresponding Bayesian estimation [62], which provides richer information, including distributions of credible values for the means and differences of means. Note that credible intervals, 95% highest density intervals (HDI) in Bayesian analysis, in contrast to traditional confidence intervals, indicate the range within which our true value is most likely to lie. We performed the estimation using the hierarchical model (as well as the accompanying R-script) described in Kruschke [62], which uses vague priors for the main and interaction deflections. The model assumes that the standard deviation of the error is normally distributed and equal in all groups, and the prior used for this parameter was a uniform distribution ranging from 0.01 to 10 times the standard deviation in the data. For the overall level across all groups, the prior was a normal distribution centered at the grand mean with at standard deviation 5 times the standard deviation in the data. The deflections from the overall level corresponding to each of the two factors, as well as the interaction deflections were assumed to be normally distributed and

centered at zero, and the prior for the corresponding standard deviations was a gamma distribution with a mode corresponding to half of the standard deviation in the data and a standard deviation twice that of the data.

All analyses were conducted using R [63]. The Bayesian ANOVA was conducted following the procedures outlined in Kruschke [62], using JAGS version 4.3.0 [64].

MISSING DATA

Participants were asked to rank clinical decisions, indicating *up to* 3 choices, which led to missing data in the second and third rankings. While the second ranked choices still fulfil the required number of observations for the above-mentioned power analysis (N>128), the third ranked choices, although they were included in the analysis, no longer have the power required to identify an effect of f>0.25 (N=89 for D3, N=98 for A3, and N=74 for T3).

Results

CLINICAL DECISIONS AND MACRO-UNCERTAINTY

Figure 1 shows the distributions of the diagnoses assigned to the Somali and Norwegian vignette characters.

XXXXXFigure 1 about hereXXXXX

Somali characters were the only group to receive a diagnosis of 'P82 PTSD' for D1. The Norwegian characters were more often given a diagnosis of 'P03 Feeling depressed' than the Somali group for D1. There was no strong statistical evidence of a difference in diagnoses chosen for D2 and D3.

Simpson indices and p-values are reported in Table 1. As can be seen in Figure 1, the Somali group had a broader spread, i.e., flatter distribution, than the Norwegian group, indicating less consensus across GPs regarding the most appropriate D1 for the Somali characters. No statistically significant difference regarding the Simpson indices was found for D2 or D3.

Table 1. Simpson indices and p-values for ranked diagnoses, assessment, and treatment options for Somali vs. Norwegian groups. A higher Simpson index indicates higher consensus.

Clinical decision	Somali	Norwegian	p-value
D1	0.129	0.208	0.011
D2	0.214	0.263	0.193
D3	0.289	0.453	0.052
A1	0.277	0.301	0.334
A2	0.284	0.349	0.117
A3	0.472	0.387	0.810
T1	0.183	0.213	0.146
T2	0.298	0.313	0.291
T3	0.456	0.325	0.905

Figure 2 shows the distributions of the assessments assigned to the Somali and Norwegian vignette characters. We found no statistically significant differences between assessment options chosen or Simpson indices (Table 1) regarding A1, A2, or A3.

XXXXXFigure 2 about hereXXXXX

The corresponding distributions of treatment options are shown in Figure 3. Somali characters were more often prescribed medication for physical complaints than Norwegian characters, while Norwegian characters were given more sick leave (Figure 3). However, when examining the four vignette characters separately (Figure 4), it appears that the female, Norwegian vignette character received the highest frequency of sick leave in comparison with the other three vignette characters, and may, therefore, account for the difference between the Norwegian and the Somali group in Figure 3.

XXXXXFigure 3 about hereXXXXX

XXXXXFigure 4 about hereXXXXX

There was no strong evidence for differences between the Simpson indices for the Somali and Norwegian vignette characters regarding T1, T2, or T3 (Table 1).

We did not find any statistically significant interaction effect of vignette character gender and background regarding Simpson indices, i.e. macro-uncertainty, of clinical decisions made by GPs.

There was no statistical evidence that GPs perceived the severity (1=not severe, 4=very severe) of the Somali vignette characters (*M*=2.86, *SD*=0.35) symptoms differently from that of the Norwegian ones (*M*=2.92, *SD*=0.37), (*t*(128)=1.01, *p*=0.316).

MICRO-CERTAINTY

GPs' mean certainty ratings did not differ between the Somali and Norwegian vignettes for diagnoses and assessments. We found, however, that GPs' mean certainty ratings for T1 were lower for the Somali characters (*M*=5.9, *SD*=1.3) than for the Norwegian ones (*M*=6.3, *SD*=0.9). While this difference is statistically significant ($F(1,129) = 4.318$, $p = .040$), it is small (0.39) and can be considered as having limited practical consequence. We did not find any interaction of the patient gender and migrant background regarding GPs' self-reported certainty ratings (Table S2).

We also used corresponding Bayesian estimation to examine posterior distributions[2] of the differences in GPs' self-reported uncertainty regarding clinical decisions made about the Somali vs. the Norwegian characters as well as examining the interaction of patient gender and migrant background. In all cases, except T1, a zero difference fell within the 95% HDI. All modes of the posteriors only deviated from zero by amounts smaller than 1 unit, including that for T1 (*Mode*=0.387). Hence, any real differences larger than one unit on the 8-point certainty scale are implausible in all cases. Furthermore, findings suggested that any interaction of patient gender and background was likely to have been small.

Discussion

Overall, the findings suggest that clinical decisions made by GPs about the Somali and the Norwegian vignette characters presenting symptoms of depression were similar, with a few differences found. The findings furthermore suggest that any clinical variation observed is unlikely to be due to differences in GPs' self-rated clinical uncertainty.

[2] The posterior probability of a given event is the updated probability assigned after new data is taken into account.

We found a slightly larger spread in the first ranked diagnosis considered for the Somali vs. Norwegian vignette characters (i.e., higher macro-uncertainty). This suggests that there was less consensus among GPs regarding which diagnosis (ranked first priority) was most suitable for the Somali vs. the Norwegian characters. Despite having found higher macro-uncertainty regarding the first ranked diagnosis for the Somali vs. the Norwegian characters, we did not find differences in micro-certainty, meaning GPs reported feeling similarly certain about the diagnoses they chose for the Somali vs. the Norwegian characters despite different degrees of consensus across GPs. We did not find less GP consensus regarding assessment or treatment options chosen for the Somali vs. the Norwegian vignette characters. We did, however, find differences in the type of treatment options that were ranked first for both groups. The most striking of these differences was the relatively high frequency of participants that endorsed sick leave as a treatment for the Norwegian vs. the Somali vignette characters. We discovered that the Norwegian female vignette character was more often given sick leave in comparison with the other three characters. This is in line with findings showing that women are more likely to receive sick leave than men in cases of depression [31]. However, this was not the case for the Somali, female vignette character, despite all vignette characters having explicitly stated that they are employed. Sick leave prescription has previously been associated with a patient's ability to evoke sympathy [65]. This begs the question whether the female Norwegian character evoked more sympathy among GPs than the Somali female and the male vignette characters.

GPs also considered medical treatment for physical complaints more often for the Somali characters vs. the Norwegian characters. Finally, in contrast to our hypotheses, we did not find that GPs reported higher uncertainty for any clinical decisions, apart from first ranked treatment, and this difference was very small. Nor was there any strong indication of an interaction of patient gender and background regarding certainty ratings. This was further supported by Bayesian estimation.

The higher frequency of PTSD diagnoses for the Somali characters is in line with findings from a previous vignette study [22]. This pattern may suggest the presence of heuristic decision making on the part of the GP. Previous research has consistently found a higher prevalence of PTSD among refugees than among majority populations as well as non-refugee migrants [66-68]. This knowledge, as well as knowledge about the types of perilous events that refugees encounter [23], may have informed GPs' diagnostic decisions. While it has been argued that doctors *should* be influenced by their knowledge of refugee health when making clinical decisions [51], this also leads to the concerning conclusion that some epidemiological data regarding the prevalence of PTSD among refugees may be based on diagnoses that are given despite insufficient evidence of PTSD symptoms. Since observational studies [66-68] cannot take into consideration the impact patient characteristics may have had on health professionals' clinical decisions, our findings make an important contribution and indicate that the validity of PTSD diagnoses should receive specific focus in future research. Furthermore, health professionals need to be aware of the risk of over- and misdiagnosing clinical mental disorders among refugees based on their own expectations of this patient group [2, 23].

Our findings also partly mirror the macro-uncertainty/micro-certainty phenomenon, originally observed by Baumann and colleagues [45], who described the relative self-reported clinical certainty despite a lack of consensus across health professionals. They concluded that this phenomenon indicates the presence of overconfidence. In a genuine clinical setting, overconfidence may lead to an unwillingness to take in new, conflicting evidence and instead leads to focusing on information that confirms one's original hypothesis [45]. This may contribute to an illusion of certainty, in that each GP feels relatively certain of his or her clinical decision, despite a lack of consensus across GPs. However, it is important to note that we did not find a large conflict of macro-and micro-certainty. Nevertheless, GPs should remain open to conflicting evidence that may alter what diagnosis, and hence treatment, they believe is most suitable for the patient.

Finally, we found that GPs more often endorsed physical health medication for Somali characters vs. Norwegian characters. This may be the result of GPs' expectations that patients with a refugee background are less open to discussing MH, and therefore more sceptical of MH treatment, and/or may result from the expectation that refugee patients tend to want a 'quick fix' [27]. It may also be an indication of GPs' self-perceived poor cultural competence. This is indicated by the majority of participants (66.9%), who claimed they would benefit from a course in migration and health. As a result, the choice may indicate a premature closure, which refers to the tendency to stop inquiring once a possible solution for a problem is found [38, 69]. This may occur when practitioners are confronted with data they find difficult to interpret or synthesize and make a clinical decision in order to reduce unpleasant psychological tension [38].

LIMITATIONS AND STRENGTHS

The current study should be considered considering the following limitations. While the experimental design of our study has several strengths, it also has limited external validity and may not translate directly to a true consultation setting, where patients and doctors are likely to enter a negotiation influencing the clinical decisions. While the Somali vignette characters had authentic Somali accents and made small linguistic mistakes in Norwegian, we were unable to simulate true language and cultural barriers as this would have made comparison between vignette characters impossible and jeopardized the experimental design of the study. Next, we distributed a link to the survey through various channels. We were only able to register the number of respondents who opened the survey, without knowing how many people had received a link to the survey. Consequently, we were unable to ascertain the response rate. Additionally, convenience sampling and the inclusion of inactive GPs, may have biased the representativeness of the sample. Social desirability may also have been a limitation. Participants were informed that the survey aimed to gather information regarding GPs' experiences providing healthcare to different patient groups. Although we did not mention that this referred specifically to patients with a migrant

background, participants particularly in the Somali vignette character group may have understood the purpose of the study and adjusted their answers to avoid seeming prejudiced, although it is unclear in what way this may have biased the results. However, due to the anonymity of the survey, social desirability may have been less of a risk than in interview studies for example [70]. Considering that GPs were our target group, findings should be interpreted with caution regarding the clinical decisions of other health professionals, such as psychologists. However, there are certain parallels between the experiences of psychologists and GPs working with refugee patients [27, 71]. For example, it has been suggested that psychologists too report feeling somewhat poorly prepared to work with this patient group [27, 71]. Psychologists' clinical decisions in sessions with refugee patients should, therefore, be examined in future research. Similarly, our findings may not be as relevant regarding clinical decisions made about other refugee/migrant populations. Findings may furthermore have been more useful and generalizable with the use of several vignettes, ideally with patients of different foreign descent, per participant. Finally, while the Somali vignette characters were presented as refugees, we did not clarify the difference between a refugee, asylum-seeker, and undocumented migrant. While we assumed that GPs were aware of the difference, different understandings of the legal rights of refugees may have influenced GPs clinical decisions.

The study also has the following strengths. The experimental approach we used provides practically unconfounded comparisons of vignette characters' gender and background [51]Despite limitations of external validity, our focus on making sure the actors presented symptoms in the same order and presented the same body language [72] strengthened the comparability of the characters. This is further supported by our finding that GPs did not differ in their perceived severity of the vignette characters' conditions. Finally, having conducted a power analysis followed by both frequentist analyses as well as Bayesian estimation provides a statistically robust basis on which to draw the conclusions we have drawn.

Conclusion

Our findings suggest that GPs may be influenced by patient background and gender when making clinical decisions regarding the management of mental health. However, this is unlikely to be the result of differences in perceived clinical uncertainty. Future research should examine alternative explanations for the variation in GPs clinical decisions, such as their expectations of the types of perilous experiences refugees are likely to have had as well as their expectation of patients' treatment preferences. Future research should furthermore pay careful attention to the validity of PTSD diagnoses, disparities in sick leave, and physical health medication given to refugee patients.

Contributorship statement

The conceptualisation was developed by SH, PB, GS, and ED. Data curation, formal analysis, programming including implementation of computer code, and visualization were conducted by SH and VE. GS acquired funding. SH, GS, and PB oversaw investigation, i.e., conducting the research and data collection. The methodology was developed and designed by all authors. SH and GS administered the project, taking care of management and coordination of research activity planning and execution. SH, GS, and ED took care of resources, including provision of study materials. GS, PB, VE, and ED oversaw supervision. SH wrote the original draft, and all authors contributed to reviewing and editing of the manuscript.

Competing Interests

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

Funding

This project was funded by the Norwegian Research Council (Project number: 273645).

Data sharing statement

The preregistration, data, and materials for the current study are publicly available on the Open Science Framework (osf.io/qexrj).

Ethics statement

This study was approved by the Norwegian Centre for Research Data (NSD Notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki [66].

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Figures

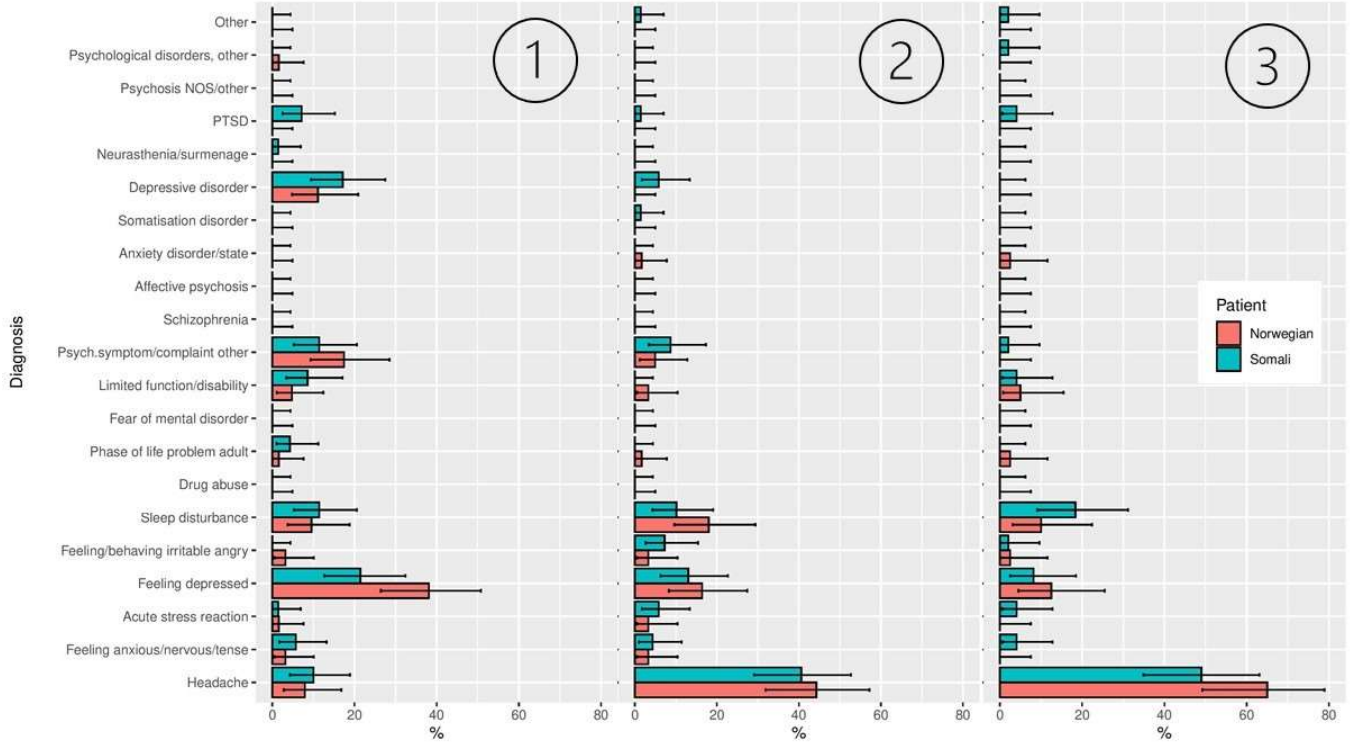
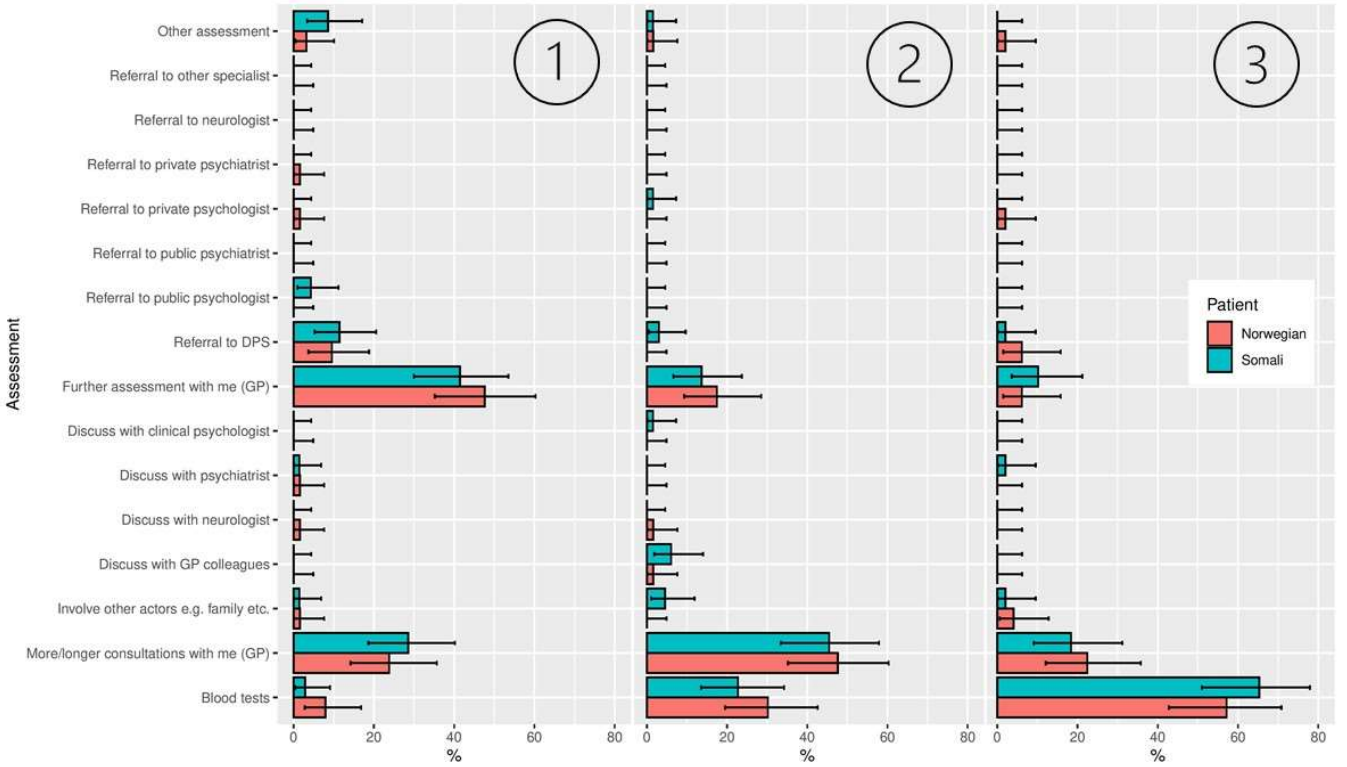
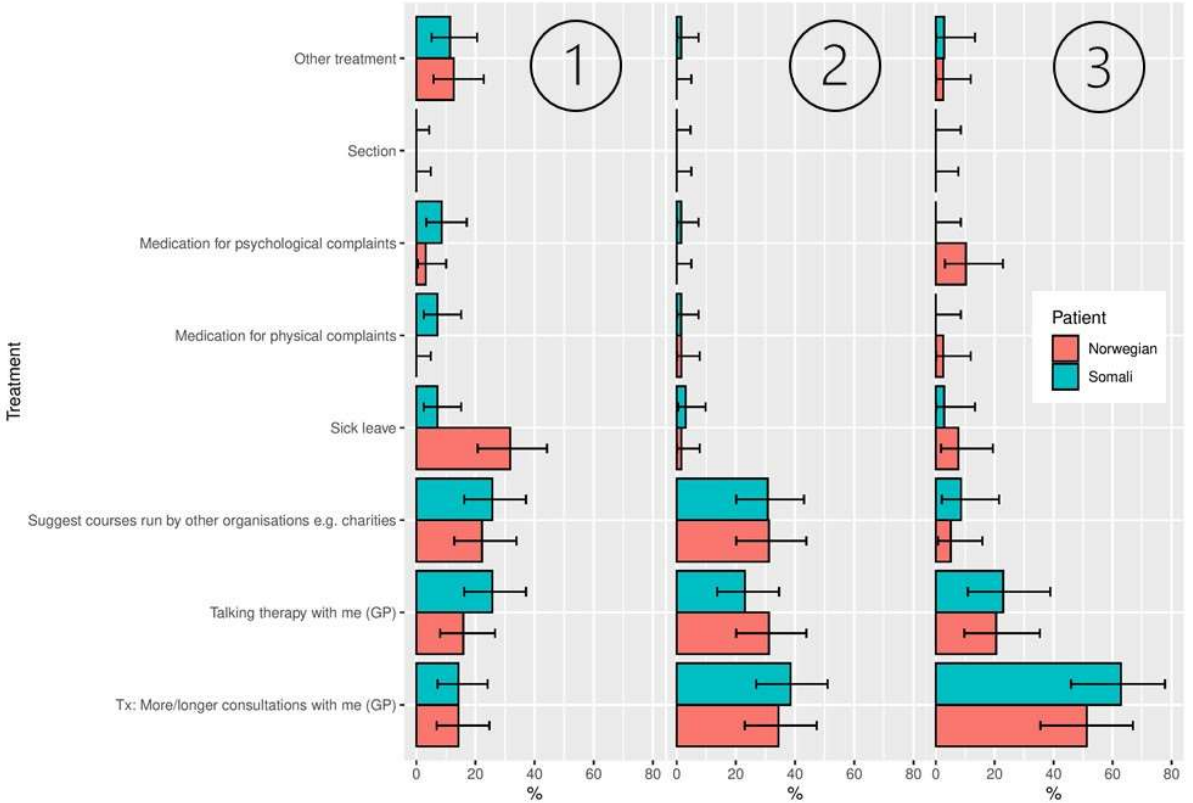


Figure 1. Distributions of diagnoses chosen, plotted separately for Norwegian and Somali vignette characters. First, second, and third ranked priorities are displayed from left to right. The error bars show 95% HDI of the posterior based on a uniform prior.



759

760 **Figure 2.** Distributions of assessment options chosen, displayed by vignette character background. First, second, and third ranked priority are
761 displayed from left to right. The error bars show 95% HDIs of the posterior based on a uniform prior. Note that 'Referral to DPS' refers to
762 referrals to the regional psychiatric centre/community mental health services (in Norwegian: distriktpsykiatrisk senter). These centres are part of
763 secondary services and provide specialist psychiatric care.



764

765 **Figure 3.** Distributions of treatment options chosen, displayed by vignette character background. First, second, and third ranked priority are
766 displayed from left to right. The error bars show 95% HDIs of the posterior based on a uniform prior.

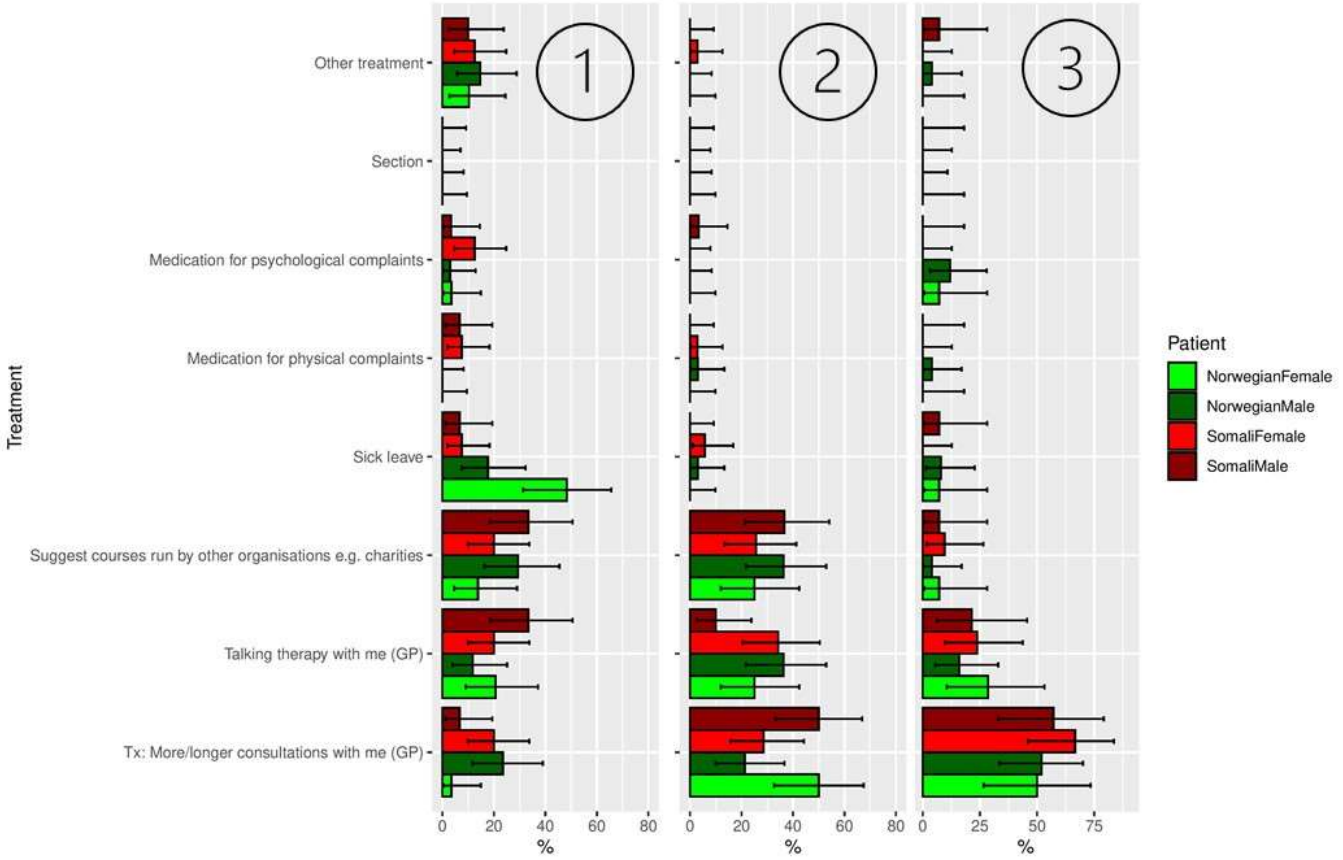


Figure 4. Distributions of treatment options chosen, displayed by vignette character. First, second, and third ranked priority are displayed from left to right. The error bars show 95% HDIs of the posteriors based on a uniform prior.

Integration is correlated with mental health help-seeking from the general practitioner: Syrian refugees' preferences and perceived barriers

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Keywords: integration, help-seeking, mental disorders, Syrian, refugees, general practice

Acknowledgements

This project was funded by the Norwegian Research Council (Project number: 273645). We would first like to thank all the contact persons who helped with the development of the survey and facilitated data collection. Special thanks to Dr Samar Issa Albarghouthi and Dr Ali Watti for drawing on their personal and professional experiences to support both the design and implementation of the survey. Thanks also to our reference group and colleagues from the Society and Workplace Diversity group for their invaluable feedback and support throughout this process. Last, but certainly not least, thanks to our hard-working research assistants (both former and current) Tuva Emilie Øyslebø, Kristin Skjærseth, Iphigenia Hellen, and Jaleb Clovis Nugame.

Declaration of Interest

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

Abstract

Despite a seemingly higher need, refugees in Europe tend to underuse mental health (MH) services. To better understand this underuse, it is important to understand refugees' willingness and ability to seek help from their general practitioner (GP) when experiencing MH problems. We employed a combined vignette and survey design to explore how the GP fits into the larger context of help-seeking preferences among a sample of Syrian refugees in Norway (n = 92), and what barriers they perceive in accessing help from the GP. We also examined how indicators of integration relate to seeking help from the GP. We take an exploratory approach. Participants were presented a vignette of an individual with symptoms in line with ICD-10 and DSM-5 criteria for depression. Participants were somewhat likely to seek help from the GP; however, seeking help from one's relationship with Allah/God and one's partner was preferred. Furthermore, while the GP was rated a somewhat likely help-seeking source, most participants indicated an average of two barriers to seeking help from the GP. Finally, social ties to the majority population in the form of social integration and feelings of connectedness with the host country (psychological integration) were positively correlated with likelihood of seeking help from the GP. Taken together, these findings suggest that the GP is considered a viable source of help among Syrians with a refugee background in the current sample, but that this may be influenced by perceived barriers and social as well as psychological integration. Addressing these barriers and promoting psychosocial integration with the host country are key to facilitating access and usage amongst refugees in need of MH services.

1.0 Introduction

Despite a seemingly higher need for mental health (MH) support, refugees in Europe tend to underuse MH services (Satinsky et al., 2019). To better understand this underuse, it is important to better understand factors that influence refugees' willingness and ability to seek help from their general practitioner (GP) when experiencing MH problems. Throughout Europe, GPs are often the first line of contact for people seeking mental and physical healthcare (WHO, 2008;Lu et al., 2020). GPs are trained to manage mild to moderate cases of MH problems (within primary care) and play a large role in determining appropriate preliminary diagnoses, assessments, treatments, and referrals for patients. Importantly, GPs are also often the first line of contact for patients with a refugee background.

One of the largest groups of refugees to arrive in Europe during the 2015-2016 refugee crisis originated from Syria. Syrian refugees who migrated to Europe and neighbouring countries in the Middle East have reported experiences including civil war, torture, cultural integration issues, the loss of family and community support, discrimination and adverse political climate, loneliness and boredom, prohibition to work, and disruption of education for their children (Miller and Rasmussen, 2010;Kirmayer et al., 2011;Sijbrandij et al., 2017). Such stressors can place refugees at considerable risk of developing symptoms of depression, anxiety, post-traumatic stress disorder (PTSD) and related somatic health symptoms (de Jong et al., 2003;Fazel et al., 2005;Steel et al., 2009;Hassan et al., 2016;Ben Farhat et al., 2018;Poole et al., 2018).

Considering MH and help-seeking in Syria may place refugees' engagement with health services in Europe into context. However, studies examining the MH burden in Syria are highly heterogeneous. A recent systematic review of the burden of mental disorders and access to MH and psychosocial support services in Syria and among Syrian refugees in neighbouring countries found that levels of depression ranged from 11-49% (Hendrickx et al., 2020). Similarly, another systematic review and meta-analysis recently estimated the prevalence of mental disorders at 21.1% in conflict-affected settings (Charlson et al., 2019). However, mental healthcare in Syria has been neglected for decades (Kakaje et al., 2021), and studies on access and barriers to MH and psychosocial support in Syria are quite limited (Hendrickx et al., 2020). It has been suggested that stigma associated with psychological and psychiatric disorders stands in the way of the use of MH services among Syrians in Syria (Hassan et al., 2015;Aarethun et al., 2021). Importantly, Syrians with a refugee background may seek help differently in Norway than Syria (Aarethun et al., 2021). This could relate to the different role of the GP in these countries. In Norway, patients, who want to see a specialist funded by the state are required to seek help via their GP (Helsenorge.no, 2019). In Syria, however, patients are typically able to access specialist services directly, experiencing fewer delays and waiting times (Aarethun et al., 2021). Furthermore, the GP may be seen as a source of help for physical problems rather than MH problems. It is also worth noting that some services that are available in Norway, such as social workers, may not be a relevant source of help in Syria and may therefore not be considered.

Refugees' underuse of health services in high-income countries may, in part, be due to barriers to access and use. In Germany and Austria, Syrian refugees have identified barriers to help-seeking, such as stigma and shame, not speaking the language of the host country, and lacking information about health services (Kohlenberger et al., 2019;Renner et al., 2020;Zehetmair et al., 2021). Similarly, refugees in Turkey have identified barriers such as not knowing where or how to get help, financial concerns, unavailability of appointments,

fear of being hospitalized, and finding the process inconvenient or time-consuming (Fuhr et al., 2020). Such barriers may stand in the way of refugees accessing health care. The barriers perceived by Syrian refugees in a Norwegian context, however, have not been examined previously. The Norwegian public healthcare system is characterised by universal health coverage for all residents, although individuals make modest co-payments for different services. Services covered by universal health care include primary care, hospital care and mental healthcare. Enrolment in universal healthcare is automatic, meaning that all residents have the right to state funded primary healthcare. Due to differences between countries' healthcare systems, we must assume that barriers perceived in other countries are not necessarily transferrable to the Norwegian context. Although it must be noted that refugees' expectations about the healthcare system in Norway may be influenced by their experiences in other countries.

Help-seeking is also influenced by factors besides barriers to accessing care. Andersen's behavioural model of health services use (BM) (Andersen, 2008;Andersen et al., 2014) presents how contextual and individual factors, as well as health behaviours and outcomes, interact and influence the use of health care services (referred to as personal health services in the model). However, the experience of illness as well as preferences for seeking help are embedded in larger cultural and social systems (Kirmayer et al., 2015). As an individual's cultural context changes, help-seeking preferences and behaviours are likely to change as well. This is supported by interviews with Syrian refugees (Aarethun et al., 2021). Similarly, preference for cultural traditions of the host country (including willingness to marry a Norwegian person, participating in social activities with Norwegians, etc.) was associated with semiformal (e.g. internet forum) and formal (i.e. medical doctor) as opposed to informal help-seeking sources among immigrants in Norway (Markova et al., 2020). This is in line with Wikberg and Eriksson (2008), who claim that the more integrated an individual feels, the more likely they are to accept the host country's dominant care models. While previous studies have considered culture in relation to the BM (Guo et al., 2015), it may not suffice to include culture as a static variable, in the form of cultural values for example, without acknowledging the unique circumstances caused by shifting cultural contexts. This gap may be addressed by examining the concept of integration, defined as 'the degree to which immigrants have the knowledge and capacity to build a successful, fulfilling life in the host society' (Kymlicka, 1995;Harder et al., 2018), in relation to help-seeking. Note, that the term 'integration' does not imply that immigrants must surrender their own cultural identity and traditions to successfully integrate (Berry, 2001). Harder and colleagues (2018) propose their multidimensional measure of immigrant integration spanning the domains of psychological, social, linguistic, economic, navigational, and political integration.

Harder's multidimensional measure of immigrant integration, or Immigration Policy Lab (IPL), can be used to measure integration overall or in its individual facets (linguistic, psychological, etc.), in contrast to several other measures, such as the Vancouver acculturation inventory (Ryder et al., 2000) and the cultural competence scale (Lay and Nguyen, 1998;Safdar et al., 2003;Safdar et al., 2021) which examine similar facets, but combine these into an overall score. Furthermore, Harder's measure examines the current social situation of the participants, including amount of contact with members of the host society, while the Acculturation orientation scale (Safdar et al., 2021) and Vancouver acculturation inventory (Ryder et al., 2000) focus on individuals' preferences, including how important social contact with ingroups and outgroups is to participants. For the current study, we felt it was more helpful to employ a measure, which considers the participants' current situation rather than their preferences. Furthermore, as Harder et al. point out in the

supplementary material of their paper, by 'directly measuring the frequency of a social interaction, the question has face validity for measuring social integration' (Harder et al., 2018). Importantly, other scales assume that participants have friends in the resettlement country. Since this is not necessarily the case for all refugees, we have included single item measures to examine number of Norwegian and Syrian friends in Norway. Single item measures have been used previously to measure number of friends among refugee groups (Hynie et al., 2019;Ahmad et al., 2021). In a relatively hard to reach population, such as Syrian refugees in Norway, it is important that surveys remain short and concise. Harder's measure captures 'key aspects of integration with a small number of widely applicable questions' and 'can be used at low cost and facilitate comparability' (p.11484). Their measure can therefore be used as a 'common measure of integration, which would allow for the accumulation of knowledge through comparison across studies, countries, and time' (p. 11483, Harder et al., 2018). Harder's measure has furthermore been validated among relevant populations, including refugees as well as immigrants both in Europe and the United States (Harder et al., 2018).

The important role of integration in other domains besides help-seeking has been described previously, which lends support to the potential importance of this concept in help-seeking. A lack of social integration, for example, may be associated with decreased health-related quality of life, functional impairment, and severity of depression symptoms, anxiety, and PTSD (Schick et al., 2016). Similarly, while the beneficial impact of inter-ethnic friendships on the integration and wellbeing of migrant youths (Windzio, 2015;Reynolds and Crea, 2017) and adults (Wessendorf and Phillimore, 2019) has been supported in previous research, the role of friendships in migration research has been largely treated as a side issue (Décieux and Mörchen, 2021). Research conducted in Germany has suggested that social capital may facilitate integration of Syrian refugees into the labour market, and that different types of social capital may affect the outcome of the integration process (although the presence of social capital does not invariably lead to the successful utilization of that capital) (Gericke et al., 2018). The importance of social integration has also been addressed by the German Institute for Economic Research, who suggest that social integration is vital in improving refugees' trust in key state institutions (Schmidt et al., 2020). Consequently, we incorporate elements of Harder's integration measure (2018) into Andersen's BM (2008;2014) to guide the current study.

The present exploratory study focuses on the Norwegian context. While some specialist MH services exist for refugees, the majority that are officially settled in Norway are encouraged to contact their GP, who acts as a gatekeeper to specialist services (Helsenorge.no, 2019). Like the rest of Europe, Syrian refugees in Norway have reported higher rates of MH problems. A recent cross-sectional study found that 33% of Syrian refugees in Norway reported symptoms indicative of anxiety or depression, and 7% reported symptoms of post-traumatic stress disorder (PTSD) (Strømme et al., 2020). These rates are substantially higher than the 12-month prevalence of 10-15% for anxiety or depression (Norwegian Institute of Public Health, 2016), and 1-1.7% for PTSD (for men and women respectively) among the Norwegian majority population (Lassemo et al., 2017). The aims of the current exploratory study are [1] to describe how the GP fits into the larger context of help-seeking preferences among Syrian refugees in Norway, and what barriers participants identify to accessing help from the GP, [2] to examine how the likelihood of seeking help from the GP relates to indicators of integration as well as other social, psychological, and demographic variables guided by the BM.

Furthermore, we focus on the GP as a source of help and the individual characteristics presented in the behavioural model (BM) as factors that may impact willingness to seek help from the GP. It is likely that throughout an individuals' life span either they or someone close to them will experience symptoms of depression. As a result, laypeople's beliefs about seeking help for depression have important implications for the behaviour of people suffering from depression.

According to the BM, the personal characteristics that influence help-seeking include predisposing (demographic, social, beliefs), enabling (financial resources, organisation), and need (perceived and evaluated) (Andersen, 2008;Andersen et al., 2014). While predisposing and enabling factors are sometimes difficult to disentangle (Babitsch et al., 2012), a predisposing factor can be thought of as something that would influence a person's willingness to seek help, while an enabling factor would influence their ability to receive help. Based on previous literature that has used the BM, we include age, gender, relationship status (Johnson et al., 2010;Babitsch et al., 2012), and education (Johnson et al., 2010;Magaard et al., 2017) as predisposing demographic factors. In addition, we include perceived benefit of seeking help from the GP under predisposing beliefs, as this taps into the attitudes, values, and knowledge about health and health services (Andersen et al., 2014). Here, we also incorporate Harder's social integration index and number Syrian and Norwegian friends, because this maps onto the social predisposing factors described in the BM (Andersen, 2008;Andersen et al., 2014). We chose to include psychological integration under predisposing factors, as we felt it best related to beliefs about health and healthcare (Andersen, 2008;Andersen et al., 2014), although it could also be argued that psychological integration can be seen as an enabling factor. We include Harder's economic integration index under enabling financing, similar to Johnson and colleagues (Johnson et al., 2010). We examine lack of access to the GP under enabling characteristics, as it either facilitates or impedes health services use (Andersen, 2008;Andersen et al., 2014), and does not predispose an individual to seek health help. We incorporate the indices for navigational and linguistic integration within a separate box entitled 'Knowledge' within enabling factors, as these did not fit within another category of the model but have been shown to have important implications regarding help-seeking (Kirmayer et al., 2011;Hassan et al., 2016;Satinsky et al., 2019). Navigational integration, referring to an individual's ability to manage basic needs in the host country, best matched the element 'organization' in the BM, which includes the existence of, and ability to access, a regular source of care. Furthermore, language proficiency, which is closely related to linguistic integration, has previously been included as an enabling factor (Li et al., 2016). Finally, we include perceived severity of the problem under perceived need, because it captures participants' own perception of the severity of the symptoms. Severity of depression has previously been shown to relate to help-seeking (Magaard et al., 2017), although it is unclear whether this is the case when responding to a vignette. Evaluated need from the original model is excluded as participants were not evaluated by a health professional. Our adapted conceptual model is presented in Figure 1.

XXXFigure 1 hereXXX

2.0 Materials and Methods

2.1 Participants and Procedure

The current study was embedded in a larger survey study on refugees and MH. Our target population were Syrian refugees over the age of 18. We recruited participants through a purposive sampling strategy (Palinkas et al., 2015). Participants were mainly contacted

through adult education programs[1] in two large Norwegian cities. Most participants completed the survey onsite, either on their own mobile devices, or on an iPad provided by the researchers. Participants were also given the option to respond to a paper version of the questionnaire, and to complete the survey in Arabic or Norwegian. An Arabic speaking research assistant was available for support onsite. A link to the survey was furthermore advertised on the research group's official website and shared via personal and professional networks. Data were collected throughout 2019, and the final responses were collected on the 14th of February 2020. Recruitment of participants was planned to continue beyond this time frame but had to be terminated due to the COVID-19 pandemic and the ensuing lock down.

A total of 478 participants opened the survey link. Participants who consented to take part (*N*=275) (57.5%) were randomized to one of two survey versions after answering demographic questions. Sixty-eight participants consented but dropped out prior to randomization. Of those that were randomized, 101 were randomized to the current study on help-seeking. Despite stating that we were recruiting participants from Syria with a refugee background, 4 individuals born in Norway participated. These were excluded from the final analysis. Similarly, participants were excluded if they did not respond to the help-seeking questions ($n = 5$), leaving a final sample of $n = 92$. Among these, there were some missing datapoints, but 82 completed the entire survey.

The final sample included 55 men and 37 women. Participants' ages were collected in 10-year age brackets. Most participants were between 30-39 years old (35.9 %) followed by the 20-29 age group (37.0 %). According to data from Statistics Norway (personal correspondence, 2021), of the 32,168 Syrians that moved to Norway between 2000 and 2021, 78% arrived as refugees and 22% arrived as family reunification cases. A vast majority of these individuals immigrated in 2015 and 2016. Consistent with this, we found that most of our participants indicated that their age of arrival corresponded to their present age group (58.7 %) followed by having moved one age bracket up since arrival (39.1 %). This suggests that our sample comprises recently settled refugees, in line with the pattern of immigration to Norway from Syria (Statistics Norway, 2017). Based on our sample size, (given α=0.05, two-tailed), we had a power of 0.80 to detect a medium effect size of $r = 0.31$, a power of 0.99 to detect a medium to large effect of $r = 0.45$, and a power of 0.15 to detect a small effect size of $r = 0.11$ (Faul et al., 2007).

A minority of respondents reported being employed (21.7 %), and most lived in a household with very low (33.7 %) or extremely low (25.5 %) annual incomes. The educational level of the respondents varied; many were educated at university / college level (51.1 %), and about equal proportions of respondents indicated high school (14.1%) or elementary school (21.7 %) as their highest completed level of education. Most of our sample were in a relationship (married or cohabiting) (64.1%) and about half (46.7%) had children. Participants' demographic characteristics are presented in SM Table 1 in the supplementary material.

Given the high prevalence of depressive symptoms and related MH problems in refugee populations, it is likely that some of our participants experienced depressive symptoms at the time of the survey. We included common psychiatric disorders, general self-rated health, and

[1]The adult education programs are part of a broader service offered to migrants by the Norwegian authorities and provide training for individuals to qualify for further study or employment in Norway. This includes the introductory program, which is mandatory for refugees, as well as other courses to improve individuals' job and further education opportunities.

identification with the vignette character in the current study to examine the relationship between these variables and what participants report they would do in case they felt like the vignette character.

2.2. Measures

2.2.1. Help-seeking. To measure help-seeking preferences, participants were presented with a vignette describing an individual, who was experiencing symptoms in line with DSM-V and ICD-10 criteria of depression (World Health Organization, 1993;American Psychiatric Association, 2013). The vignette is the same as used by Aarethun and colleagues (2021) and Markova and colleagues (2016;2020), which is based on Erdal and colleagues (2011). Female participants were presented with a female vignette character and males with a male vignette character. The vignettes were otherwise identical (SM 2).

After reading the vignette, participants indicated how likely they were to seek help from different sources, if they felt like the vignette character (6-point Likert scale where 1=Very unlikely, 6=Very likely, and 7= NA). Participants could select from a list of different sources, based on categories used by Markova and colleagues (2020) and the General Help-seeking Questionnaire (Wilson et al., 2005). Next, the participants were asked to indicate their first, second, and third most preferred help-seeking sources.

2.2.2. Barriers to seeking help from the GP. Based on barriers commonly mentioned in the literature (D'Avanzo, 1992;Wong et al., 2006;Bhatia and Wallace, 2007;O'Donnell et al., 2007) we developed a list of potential barriers for seeking help from the GP. Similar barriers have since been described in more recent studies (Satinsky et al., 2019;Byrow et al., 2020). The list of possible barriers is presented in the results section.

2.2.3. Integration indices

We employed the integration indices as described in the supplementary material of Harder and colleagues (2018). We followed the IPL-12 (Immigration Policy Lab-12) version of the measure for all indices apart from social and psychological integration, for which we included additional items from the IPL-24. Note that we excluded the index for political integration, as it had no clear link to help-seeking preferences.

2.2.4. Social integration. The social integration index consisted of three items, such as 'In the last 12 months, how often did you eat dinner with *Norwegians* who are not part of your family?' (1=Never, 5=Almost every day). The index had 'acceptable' internal consistency ($\alpha = 0.64$) according to previous literature (Taber, 2018).

2.2.5. Psychological integration. The psychological integration index consisted of four items, such as 'How connected do you feel with Norway?' (5=I feel an extremely close connection, 1=I do not feel a connection at all). The index had good internal consistency ($\alpha = 0.83$).

2.2.6. Linguistic integration. Linguistic integration was measured by two items as follows: 'Communicating in *Norwegian* has many components, like reading, writing, and speaking skills. Please evaluate your own skills in *Norwegian*': 'I can read and understand the main points in simple newspaper articles on familiar subjects' and 'In a conversation, I can speak about familiar topics and express personal opinions' (5=Very well, 1=Not well at all) ($r = 0.83$).

2.2.7. Navigational integration. We initially based navigational integration on the two items included in the IPL-12 (Harder et al., 2018): 'In this country, how difficult or easy would it be for you to do each of the following? A) See a doctor. B) Search for a job (find

proper listings)' (1=Very difficult, 5=Very easy). However, the items were uncorrelated in our sample (r =0.07). Therefore, we employ only the single item regarding finding a doctor, which was most relevant to the scope of this paper.

2.2.8. Economic integration. The economic integration index used in the current study consists of one item examining household income equalised by household size. Originally, this item is to be combined with occupational status, but these two items were uncorrelated in our sample (r=0.09), and we thus focus on equalized household income only.

2.2.9. Number of Norwegian and Syrian friends. Number of Norwegian and Syrian friends was examined through the items 'Do you have one or more Norwegian friends' and 'Do you have one or more Syrian friends?' (1=No, 2= Yes, I have one friend, 3= Yes, I have several), which was dichotomized for the analysis (1=No, 2=Yes, I have one or several friends).

2.2.10. Perceived severity. Perceived severity was measured by asking participants whether they felt the vignette character's condition was severe enough to warrant sick leave (Yes/No).

2.2.11. Identification with the vignette character. We measured identification with the vignette character by asking participants to what extent two progressively overlapping circles represent them and the vignette character. Circles A, for example, represented two separate circles (coded as 1), while circles G were almost entirely overlapping (coded as 7).

2.2.12. Self-rated health. Participants' general self-reported health (GSRH) was measured through the single item: 'Overall, would you say your health is:' with the response options ranging from (5) Excellent to (1) Very Poor. This question has previously been used to measure self-rated health among Syrian refugees migrating to Norway (Haj-Younes et al., 2020) and has been validated among Arabic speaking refugee populations (Dowling et al., 2017).

2.2.13. Common mental disorders. Common mental disorders were measured using the HSCL-25 (Derogatis et al., 1974). Participants were asked to report to what extent a range of experiences applied to them over the last 14 days (1=Not at all, 4= A lot). The Norwegian and Arabic translations of this survey have been validated in Norwegian and Arabic samples (Sandanger et al., 1998;Selmo et al., 2019). In our sample, mean HSCL score for men was 2.20 (SD=0.71) and 2.04 (SD=0.67) for women. Of these, 63% of women and 75% of men scored above the clinical cut-off of 1.75 (Ventevogel et al., 2007). While we are cautious to determine an optimal clinical cut-off in the current sample, it appears that a substantial number of participants reported symptoms indicative of psychological distress.

2.3. Ethical considerations

This study was approved by the Norwegian Centre for Research Data (NSD Notification form: 602214). All participants gave written consent in accordance with the Declaration of Helsinki (World Medical Association, 2013) at the start of the survey. Participation was voluntary, anonymous, and confidential.

3. Results

3. 1 The GP as a source of help

Participants' likelihood of seeking help from different sources is presented in Table 1. The GP ranked as the fourth most likely source of help, preceded by Allah/God, participants' partner, and mother. To further explore the likelihood of seeking help from the GP in comparison to

other positively rated help-seeking sources, we conducted a series of paired samples Wilcoxon signed rank tests. Due to the number of tests and the exploratory nature of our analyses, we employed a more stringent alpha level of 0.01. These tests revealed that the likelihood score of seeking help from the GP was significantly lower than that of seeking support from Allah/God ($T = 5453.5$, $p < .001$) and one's partner ($T = 2721.5$, $p = 0.009$). However, we found no significant difference between the mean likelihood rating of seeking help from the GP and one's mother ($T = 3578.5$, $p = 0.530$), a psychologist/psychiatrist ($T = 4132$, $p = 0.811$), other family members ($T = 4209.5$, $p = 0.460$), Syrian friends ($T = 4322.5$, $p = 0.124$), father ($T = 3306$, $p = 0.279$), the internet ($T = 4870$, $p = 0.011$), or Norwegian friends ($T = 4707$, $p = 0.012$). The likelihood score of seeking help from the GP was significantly higher than seeking help from a social worker ($T = 5038.5$, $p = <.001$).

XXXTable 1 hereXXX

Figure 2 presents participants' top three help-seeking choices, based on the question 'where would you seek help first, second, or third'. The most frequent first choices were partner, Allah/God, and mother. The most frequent second choices were mother, partner, and psychologist/psychiatrist followed closely by the GP. Finally, the third choices were spread more evenly, with the internet ranking as the most common third choice, followed closely by mother and none, which was chosen similarly as often as psychologist and other family member. Figure 2 extends the findings from the paired Wilcoxon rank tests and suggests that there is a preference for seeking help from Allah/God and one's partner over seeking help from one's GP.

XXXFigure 2 hereXXX

3.2. Barriers to seeking help from the GP

Barriers to seeking help from the GP are presented in Figure 3. Of 92 participants, 87 identified at least 1 barrier. On average, participants reported 2 barriers ($SD = 1.8$). The most frequently chosen barriers were 'language barriers', 'I don't think it would help', 'the waiting times are too long', and 'I don't think my GP would understand'.

XXXFigure 3 hereXXX

We created a measure of lack of perceived benefit by combining the barriers 'I don't think it would help', 'I don't think my GP would understand', and 'I don't trust my GP'. Lack of perceived benefit of seeking help from the GP was negatively correlated with likelihood of seeking help from the GP, (r_s (87) = -0.35, $p < 0.001$). We did not find, however, lack of access in the form of not having a GP, not knowing who the GP is or how to contact them, to be central barriers in our sample. The final element of access, waiting times – endorsed by 27 of 87 participants –, was positively correlated with seeking help from the GP ($r_s(87) = 0.22$, $p = 0.038$). The fact that individuals had the experience of long waiting times suggests that they had access to their GP, and the positive correlation indicates that long waiting times did not systematically deter participants from considering the GP as a viable source of help. Given the emphasis placed on stigma and shame in previous research, it is notable that very few participants ($n = 3$) indicated that seeking help form the GP would be shameful.

3.4. The role of integration in the Behavioural Model

Our second aim was to examine several socio-demographic variables based on previous literature and their relation to endorsing seeking help from the GP, as well as address integration's role in the model. Correlations between all variables are presented in Table 2. In

terms of socio-demographic variables, we found that neither gender nor education were related to endorsing help-seeking from the GP.

Higher psychological (r_s (83) = 0.24, p = 0.028) and social integration (r_s(81) = 0.32, p = 0.003) were both positively correlated with likelihood of seeking help from the GP. We did not find any significant associations between having Norwegian friends, Syrian friends, economic, linguistic, or navigational integration and reported likelihood of seeking help from the GP. It is worth noting, however, that while there was no significant correlation between number of Norwegian friends and likelihood of seeking help from the GP, both psychological and social integration were significantly correlated with Norwegian friends (see Table 2), suggesting that the effect of Norwegian friends may be indirect.

3.5. Perceptions of severity and participants' own health status

Neither perceived severity of the condition (r_s(87) = -0.02, p = 0.875), participants' own self-reported health status (r_s(83) = -0.15, p = 0.157), mean HSCL score (r_s(81) = -0.03, p = 0.818), nor their identification with the vignette character (r_s (86) = -0.05, p = 0.651) was correlated with endorsing seeking help from the GP. While we did not include these variables in the conceptual model, these results suggest that individuals are not influenced by their current health status when considering potential sources of help for the future. Furthermore, these variables act as validity checks, in that HSCL score is correlated with identification with the vignette character (r(84) = 0.57, p <.001), as well as self-reported health (r(84) = -0.52, p <.001).

XXXTable 2 hereXXX

4. Discussion

4. 1. Summary of results. The findings of the current exploratory study suggest that Syrians with a refugee background considered seeking help from the GP as somewhat likely if they experienced symptoms in line with depression. Formal sources of help, such as the GP and psychologist/psychiatrist, were preceded by Allah/God and one's partner as preferred sources of help. Furthermore, participants indicated experiencing an average of two barriers to seeking help from the GP. The most prevalent barriers included language barriers, not thinking it would help, long waiting times, and feeling like the GP would not understand. We found that psychological and social integration, i.e., feelings of connectedness with Norway and having a Norwegian social network, were correlated with higher reported likelihood of endorsing the GP as a viable source of help.

4.2. Previous literature and implications

4.2.1. The role of the GP as a source of help. Our findings suggest that Syrians with a refugee background in the current sample preferred to seek help from Allah/God and their partner over the GP or psychologist/psychiatrist, but that the GP and psychologist/psychiatrist were nevertheless considered viable help-seeking sources. This has been found among Syrian refugees in Istanbul, who reported a preference for seeking help from informal sources, such as family, but also endorsed seeking help from professional sources (Fuhr et al., 2020). Participants in the latter sample also reported religious leaders as a common source of help (Fuhr et al., 2020), while our sample ranked religious leaders as very unlikely help-seeking sources and Allah/God as a very likely source of help. Our findings, therefore, suggest there may be an important difference between turning to one's relationship with Allah/God for help and seeking help from religious leaders. We must also consider that some sources of help,

such as social workers, may not be relevant in Syria, which may explain why participants considered social workers as a relatively unlikely source of help in the current study. Nevertheless, all refugees receive information about MH and formal help-seeking sources as part of the introductory program, which would have raised awareness about social workers and their role in Norwegian society.

It is important to remember that help-seeking sources are not mutually exclusive (Kirmayer et al., 2011), and individuals may consider seeking help from both formal as well as informal sources simultaneously. Adopting both dominant care models as well as the care models of the home country has the advantage of affording individuals more options (Atallah, 2017). However, Atallah (2017) draws particular attention to the conflict that may arise when the dominant care model of the patient's home and host country do not align. The current study finds no evidence for a conflict on the side of the participants, but we must acknowledge that a conflict may exist on the side of the practitioner. Practitioners in Norway are not expected to consider or recommend religious coping, despite evidence that religious coping has a range of benefits for mental well-being (Koenig, 2018).

4.2.2. Barriers to seeking help. Commonly identified barriers to help-seeking, like language and waiting times (Kohlenberger et al., 2019;Fuhr et al., 2020;Renner et al., 2020;Zehetmair et al., 2021), are in line with our results. Our findings also mirror reports from GPs working with refugee patients with MH problems (Harris et al., 2020). Language barriers in particular have been identified by GPs as obstacles to providing mental healthcare to refugees (Harris et al., 2020). Similarly, GPs have reported feeling as though refugee patients had different understandings of what constitutes and causes health and illness, resulting in a lack of understanding one another (Harris et al., 2020). The barrier 'I don't think my GP would understand' chosen by participants in the current study mirrors this experience and suggests that language barriers as well as different understandings of health and illness may be perceived by both patients with a refugee background and their GPs.

Lack of perceived benefit was also indicated as an important barrier by our sample. Perceived benefit has previously been identified as one of the most important predictors of help-seeking intentions among adolescents (O'Connor et al., 2014). High perceived benefit may lead other barriers to become less important, and if confirmed in future research, may suggest that health promotion programmes, which focus on removing barriers should also promote the benefits of seeking help for MH problems (O'Connor et al., 2014).

However, other common barriers identified previously, such as stigma, shame, not knowing how to contact the GP, financial concerns, and fear of being hospitalized were not mirrored in our findings (Kohlenberger et al., 2019;Fuhr et al., 2020;Renner et al., 2020;Zehetmair et al., 2021). With regards to shame and stigma, focus group interviews with Syrian refugees in Norway suggest that while stigma and shame influenced where individuals might seek help, they also acknowledged that stigma surrounding professional healthcare was diminished in Norway, making it easier and less stigmatized to seek professional MH help (Aarethun et al., 2021).

Finally, our findings suggest that current health status is not associated with considering the GP as a source of help; however, our findings do suggest that current health status is associated with other forms of help-seeking behaviour[2]. This is in line with previous

[2] Additional analyses suggest that mean HSCL score was negatively correlated with seeking help from, for example, one's partner and mother.

literature, which suggests that severity and duration of depression as well as chronic somatic disorders are related to help-seeking behaviours (Magaard et al., 2017).

4.2.3. Role of social networks and feelings of connectedness. Intergroup contact and feelings of connectedness with the host country have previously been found to relate to wellbeing among refugees (Schick et al., 2016;Tip et al., 2019). Less attention has been paid to psychological integration. Our results extend previous findings and address this gap in the literature, suggesting that social ties and feelings of connectedness, measured through the social and psychological integration indices (Harder et al., 2018), play an important role in considering seeking MH help from the GP. This further ties in with the importance of social capital, which has been shown to play a role in other domains, such as gaining access to the job market (Gericke et al., 2018). Gericke and colleagues (2018) distinguish between different types of social capital: bridging, referring to social contact with individuals outside of your community, vs bonding social capital, marked by closed-off communities. They suggest that bonding social capital may put individuals at a disadvantage regarding accessing career-related information and social mobility. Furthermore, the authors highlight the difference between horizontal social capital, between people with similar access to resources and knowledge, and vertical social capital, which describes contacts who belong to different social levels (Gericke et al., 2018). By the same virtue, Syrians with a refugee background in the context of the current study may benefit from having close ties to the Norwegian majority population, i.e., vertical, bridging social capital, with regard to the help-seeking sources they consider, and, consequently, are afforded more options regarding where to seek help. However, it is important to note that our sample had little variation regarding financial and employment situation. Consequently, our findings suggest that within an economically relatively deprived sample, social and psychological integration play an important role in participants' consideration of professional sources of help, and do not necessarily imply that economic, navigational, or linguistic integration are not also important factors.

4.3. Strengths & Limitations

This study makes an important contribution by recognizing that help-seeking preferences are dynamic and contingent on time and context, rather a static characteristic. Similarly, much of the previous literature has framed help-seeking among refugee and non-refugee migrants in terms of barriers and factors that put them at a disadvantage to majority populations. While we also present barriers, our findings highlight social ties and feelings of connectedness as facilitators to help-seeking. Having collected data from Syrian refugees, our findings are particularly relevant to this patient group. Refugees are a highly heterogeneous group and 'lumping them together' is neither appropriate nor informative (Fuller, 1993). However, it should be noted that by the same token our findings may be less relevant for other patient groups. This may also be the case for important intragroup heterogeneity. For example, we did not consider ethnic identification within this participant group. Disregarding the differential culture of Kurds, for example, can gloss over important cultural differences that may play a role in help-seeking. Next, given the cultural differences presumed to exist with regard to our understandings of mental illness (Kirmayer et al., 2011), we chose to present a vignette, which did not mention the term depression but instead described only the symptoms. This allowed us to gain an insight into individuals' help-seeking preferences for such symptoms without entangling our study in a larger discussion around the cross-cultural validity of 'Western' nosology. The use of this vignette furthermore allowed Aarethun and colleagues' (2021) findings to complement the findings of the current study.

The study also had certain limitations that suggest caution should be exercised when interpreting the findings. We examined help-seeking preferences of Syrians with a refugee

background regarding a fictional vignette character, which may not reflect participants' true help-seeking behaviours. Nevertheless, the preferences indicated in the current study may present what individuals are likely to endorse in situations where family and friends seek advice from them. Given the importance of certain informal help-seeking sources among this sample, this information is highly relevant. It is also important to note that help-seeking may differ by migrant background. Quota refugees and family reunification refugees in Norway are screened by a doctor, where many cases of MH problems are identified and managed. We chose not to collect information regarding specific reasons for arrival, as we felt this was too intrusive. However, if participants were to a large extent quota or family reunification refugees, it is possible that many are familiar with the Norwegian healthcare system. This may have impacted their willingness to consider the GP as a viable source of help, and therefore influenced our results. Similarly, we did not collect specific data regarding time spent in Norway, which has been shown to be an important variable regarding help-seeking in previous literature (Satinsky et al., 2019). Time spent in the host country is often employed as a proxy for integration or acculturation. The use of proxies, however, may be imprecise and implies that integration and other relevant processes progress similarly for all migrants over time. Our study improves this approach by examining integration directly. It is, however, important to note that we employed several single item measures. Both navigational and economic integration were intended to be measured through several items, but due to a lack of correlation between items we reduced these to single measure items. This is sample specific and should be corrected in future research. Finally, the social integration measure had a lower than desired reliability in the current sample. Nevertheless, the measure correlated meaningfully with other variables, such as seeking help from the GP, Norwegian friends and psychological integration, which may act as a form of validity check.

4.4. Conclusion

Our findings suggest that participants in the current study consider some formal help-seeking sources, such as the GP and psychologist/psychiatrist, for symptoms of depression. However, our findings also suggest that certain informal sources, such as one's partner and Allah/God, may be preferred. Given that help-seeking sources are not mutually exclusive, it is likely that individuals would seek help, or advise someone else to seek help, from a combination of both formal and informal help-seeking sources. However, most participants indicated an average of two barriers to seeking help from the GP. These included, for example, language barriers as well as feeling that the GP would not be able to help. This suggests important areas for interventions and future study. Our study also shows that social ties with the majority population as well as feelings of connectedness with the host country are correlated with considering seeking MH support from the GP. The current study thereby contributes to our understanding of help seeking as dynamic and contingent on cultural context. In line with calls for more nonconfirmatory research, which may facilitate making hypothesis tests more informative (Scheel et al., 2020), we encourage the use of our findings as inspiration and basis for future hypotheses. Measures of integration, particularly social and psychological integration, which acknowledge the consequences of shifting cultural contexts, should be considered in future research. Furthermore, future studies should consider longitudinal designs to examine the development of help-seeking preferences, and/or behaviours, over time. Future studies should also consider gender differences in help-seeking. Finally, given our focus on Syrians with a refugee background and a vignette displaying depression symptoms, future research ought to examine a variety of migrant groups as well as employ vignettes with different mental disorders.

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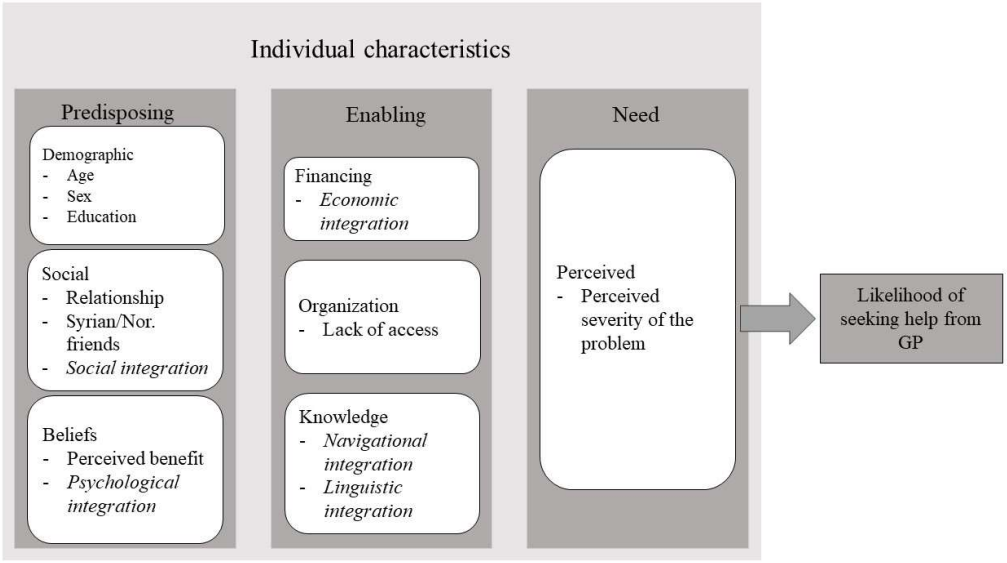

826

827 **Figure 1.** Conceptual model of the current study based on Andersen's behavioural model of
828 health services use and Harder's multidimensional measure of immigrant integration (in
829 italics).

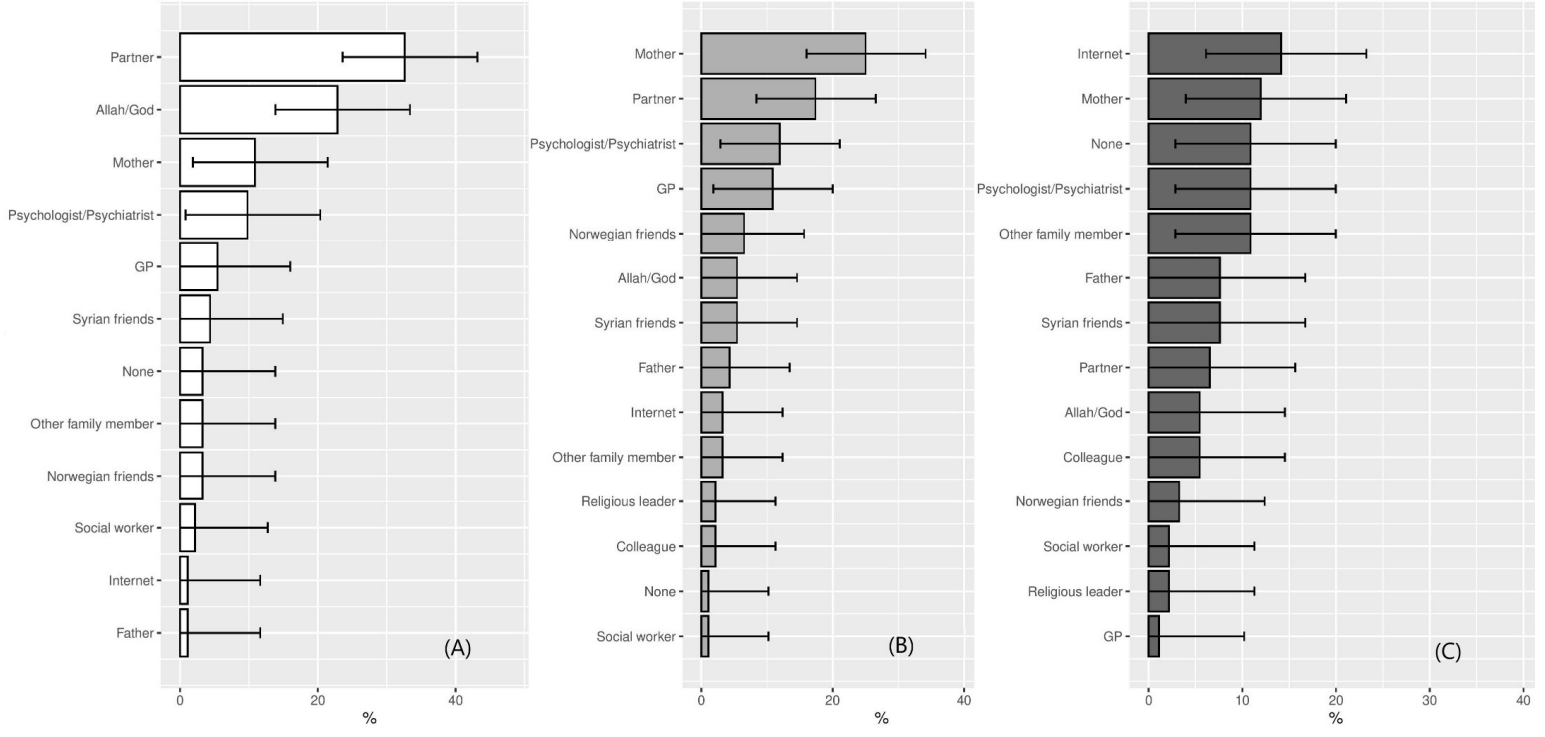

Figure 2. First (pane indicated with a 1), second (pane indicated with a 2), and third (pane indicated with a 3) help-seeking choices (N=92). Note that none of the participants chose 'religious leader' and 'colleague' as their first choice. The following help-seeking options were removed from the figure, as they were not chosen by participants at all: Helpline, A&E, Traditional healer, Elder, Alternative healer, Leader from community, Teacher, Nurse, Charity, Physiotherapist, and Other.

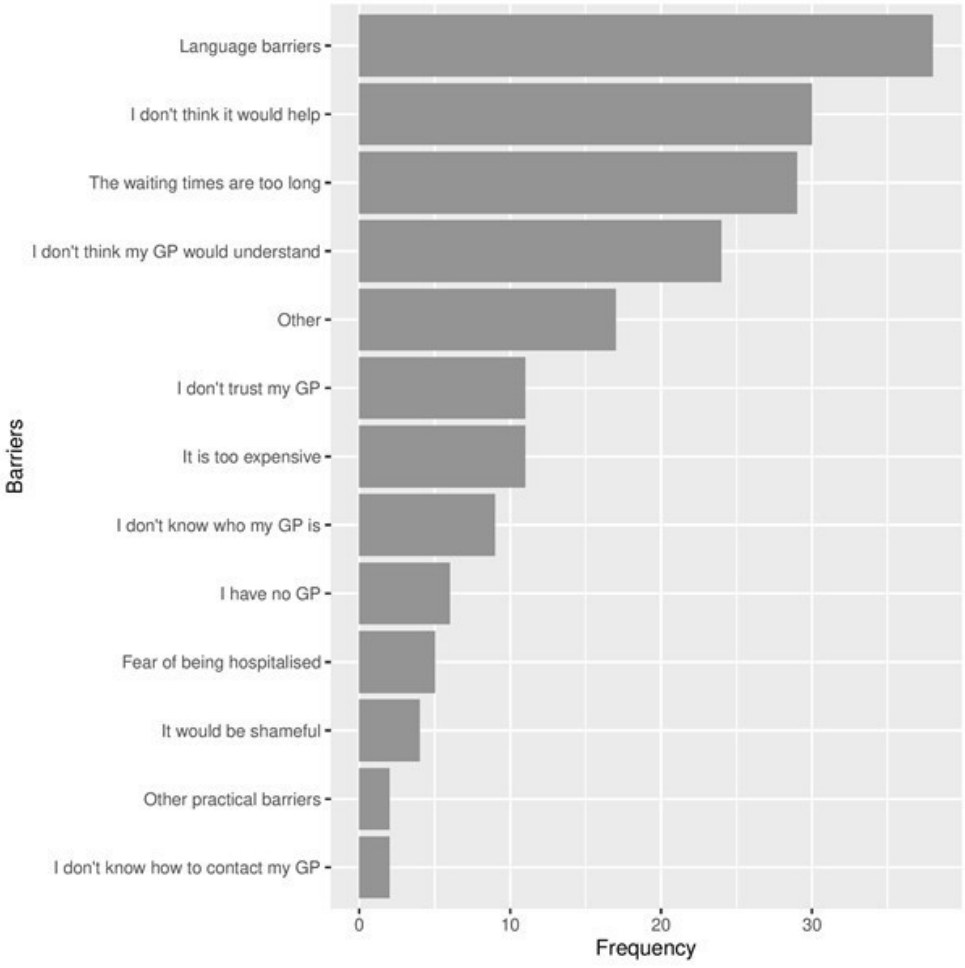

Figure 3. Barriers reported by participants to seeking help from the GP (*N*=87). Note that participants could select several or no barriers.

Table 1. Participants' likelihood of seeking help from different sources ordered by highest (top) to lowest (bottom) total mean likelihood score, standard deviation (SD), median, and interquartile range (IQR).

		Total	
Help-seeking source	*N*	Mean (SD)	Median (IQR)
Allah/God	86	5.13(1.56)	6(5-6)
Partner	79	4.56(1.82)	5(4-6)
Mother	85	4.05(1.94)	5(2-6)
GP	89	3.98(1.76)	4(2-6)
Psychologist/Psychiatrist	91	3.88(1.84)	4(2-5)
Other family member	89	3.80(1.77)	4(2-5)
Syrian friends	86	3.55(1.81)	4(2-5)
Father	82	3.54(2.09)	4(1-6)
Internet	90	3.33(1.68)	4(2-5)
Norwegian friends	87	3.30(1.74)	4(2-5)
Social worker/NAV	89	3.08(1.80)	3(1-5)
Nurse	91	3.01(1.64)	3(2-4)
Physiotherapist	86	2.85(1.73)	2(1-5)
Elders in my community	88	2.84(1.60)	3(1-4)
None	89	2.75(1.77)	2(1-4)
Colleague/someone at work	90	2.74(1.65)	2(1-4)
Teacher/contact from introductory programme	90	2.71(1.65)	2(1-4)
Telephone helpline	81	2.53(1.56)	2(1-4)
A&E	88	2.52(1.67)	2(1-4)
Alternative treatment*	85	2.42(1.68)	2(1-4)
Other	82	2.39(1.71)	2(1-3)
Charity	86	2.38(1.57)	2(1-3)
Religious leader (e.g., imam or priest)	88	2.33(1.59)	2(1-4)
Traditional healer from my country of origin	86	2.05(1.35)	2(1-3)
Leader from my community or country of origin	86	1.81(1.12)	1(1-2)

Note. Responses were indicated on a 6-point Likert scale, where 1=very unlikely and 6=very likely, 7=NA. Responses are based on a sample size of $N = 92$. N in the table presents participants who chose a likelihood rating between 1-6. Not all sources of help may have been relevant for all participants.
*Alternative treatment was specified as: e.g. acupuncture, homeopathy, herbal treatment.

Table 2. Spearman's rank (in grey) and Pearson Correlations among Study Variables.

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.
1. Seeking help from GP	-															
2. Gender	-0.02	-														
3. Age	0.27*	-0.16	-													
4. Education	0.05	-0.10	0.03	-												
5. Relationship	-0.26*	-0.17	0.01	0.01	-											
6. Syrian friends	0.11	-0.05	-0.04	0.13	-0.03	-										
7. Norwegian friends	0.09	0.03	0.23*	-0.04	-0.25*	0.07	-									
8. Lack of benefit	-0.35*	-0.06	-0.17	0.07	0.02	-0.06	-0.19	-								
9. Severity	-0.02	0.18	0.00	0.00	-0.10	0.10	0.10	-0.15	-							
10. Vignette character identification	-0.05	0.04	-0.16	-0.23*	0.13	0.00	-0.09	0.04	-0.08	-						
11. Health	-0.15	0.01	-0.15	0.05	-0.11	-0.02	0.27*	-0.06	0.19	-0.34*	-					
12. HSCL	-0.03	-0.11	-0.16	0.03	0.16	0.00	-0.25*	0.30*	-0.16	0.57**	-0.51**	-				
13. Social integration	0.32**	-0.10	0.28*	0.03	-0.23*	0.13	0.56**	-0.20	0.06	-0.08	0.20	-0.15	-			
14. Psychological integration	0.24*	0.05	0.12	-0.21	-0.15	-0.22*	0.27*	-0.20	-0.02	-0.18	0.26*	-0.35*	0.34*	-		
15. Linguistic integration	-0.07	-0.16	-0.06	0.28*	-0.05	0.01	0.07	0.19	-0.06	-0.01	-0.06	0.06	0.12	-0.09	-	
16. Economic integration	-0.06	-0.14	0.01	0.19	0.00	-0.03	-0.01	0.01	-0.07	0.04	-0.09	0.10	0.10	0.07	0.27*	-
17. Navigational integration	0.07	-0.16	0.04	0.06	0.00	-0.10	0.10	-0.18	0.14	-0.25*	0.28*	-0.30*	0.01	0.21	0.18	0.05

Note. Gender (1=male, 2=female), Relationship (1=Yes, 2=No), Syrian/Norwegian friends (1=No, 2=Yes, I have one or several). * $p < .05$, ** $p < .01$.

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	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
2008 H	Brønnick, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.

	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
2009 V	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Konwledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners
2009 H	Skorpen, Aina Øye, Christine	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes
	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour
	Wageningen, Heidi Karin van	The role of glutamate on brain function

	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
2010 V	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevold	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools
H	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
	Bjørkelo, Brita	Whistleblowing at work: Antecedents and consequences
	Reme, Silje Endresen	Common Complaints – Common Cure? Psychiatric comorbidity and predictors of treatment outcome in low back pain and irritable bowel syndrome
	Helland, Wenche Andersen	Communication difficulties in children identified with psychiatric problems
	Beneventi, Harald	Neuronal correlates of working memory in dyslexia
	Thygesen, Elin	Subjective health and coping in care-dependent old persons living at home
	Aanes, Mette Marthinussen	Poor social relationships as a threat to belongingness needs. Interpersonal stress and subjective health complaints: Mediating and moderating factors.
	Anker, Morten Gustav	Client directed outcome informed couple therapy

	Bull, Torill	Combining employment and child care: The subjective well-being of single women in Scandinavia and in Southern Europe
	Viig, Nina Grieg	Tilrettelegging for læreres deltakelse i helsefremmende arbeid. En kvalitativ og kvantitativ analyse av sammenhengen mellom organisatoriske forhold og læreres deltakelse i utvikling og implementering av Europeisk Nettverk av Helsefremmende Skoler i Norge
	Wolff, Katharina	To know or not to know? Attitudes towards receiving genetic information among patients and the general public.
	Ogden, Terje, dr.philos.	Familiebasert behandling av alvorlige atferdsproblemer blant barn og ungdom. Evaluering og implementering av evidensbaserte behandlingsprogrammer i Norge.
	Solberg, Mona Elin	Self-reported bullying and victimisation at school: Prevalence, overlap and psychosocial adjustment.
2011 V	Bye, Hege Høivik	Self-presentation in job interviews. Individual and cultural differences in applicant self-presentation during job interviews and hiring managers' evaluation
	Notelaers, Guy	Workplace bullying. A risk control perspective.
	Moltu, Christian	Being a therapist in difficult therapeutic impasses. A hermeneutic phenomenological analysis of skilled psychotherapists' experiences, needs, and strategies in difficult therapies ending well.
	Myrseth, Helga	Pathological Gambling - Treatment and Personality Factors
	Schanche, Elisabeth	From self-criticism to self-compassion. An empirical investigation of hypothesized change prosesses in the Affect Phobia Treatment Model of short-term dynamic psychotherapy for patients with Cluster C personality disorders.
	Våpenstad, Eystein Victor, dr.philos.	Det tempererte nærvær. En teoretisk undersøkelse av psykoterapautens subjektivitet i psykoanalyse og psykoanalytisk psykoterapi.
	Haukebø, Kristin	Cognitive, behavioral and neural correlates of dental and intra-oral injection phobia. Results from one treatment and one fMRI study of randomized, controlled design.
	Harris, Anette	Adaptation and health in extreme and isolated environments. From 78°N to 75°S.
	Bjørknes, Ragnhild	Parent Management Training-Oregon Model: intervention effects on maternal practice and child behavior in ethnic minority families
	Mamen, Asgeir	Aspects of using physical training in patients with substance dependence and additional mental distress
	Espevik, Roar	Expert teams: Do shared mental models of team members make a difference
	Haara, Frode Olav	Unveiling teachers' reasons for choosing practical activities in mathematics teaching

2011 H	Hauge, Hans Abraham	How can employee empowerment be made conducive to both employee health and organisation performance? An empirical investigation of a tailor-made approach to organisation learning in a municipal public service organisation.
	Melkevik, Ole Rogstad	Screen-based sedentary behaviours: pastimes for the poor, inactive and overweight? A cross-national survey of children and adolescents in 39 countries.
	Vøllestad, Jon	Mindfulness-based treatment for anxiety disorders. A quantitative review of the evidence, results from a randomized controlled trial, and a qualitative exploration of patient experiences.
	Tolo, Astrid	Hvordan blir lærerkompetanse konstruert? En kvalitativ studie av PPU-studenters kunnskapsutvikling.
	Saus, Evelyn-Rose	Training effectiveness: Situation awareness training in simulators
	Nordgreen, Tine	Internet-based self-help for social anxiety disorder and panic disorder. Factors associated with effect and use of self-help.
	Munkvold, Linda Helen	Oppositional Defiant Disorder: Informant discrepancies, gender differences, co-occuring mental health problems and neurocognitive function.
	Christiansen, Øivin	Når barn plasseres utenfor hjemmet: beslutninger, forløp og relasjoner. Under barnevernets (ved)tak.
	Brunborg, Geir Scott	Conditionability and Reinforcement Sensitivity in Gambling Behaviour
	Hystad, Sigurd William	Measuring Psychological Resiliency: Validation of an Adapted Norwegian Hardiness Scale
2012 V	Roness, Dag	Hvorfor bli lærer? Motivasjon for utdanning og utøving.
	Fjermestad, Krister Westlye	The therapeutic alliance in cognitive behavioural therapy for youth anxiety disorders
	Jenssen, Eirik Sørnes	Tilpasset opplæring i norsk skole: politikeres, skolelederes og læreres handlingsvalg
	Saksvik-Lehouillier, Ingvild	Shift work tolerance and adaptation to shift work among offshore workers and nurses
	Johansen, Venke Frederike	Når det intime blir offentlig. Om kvinners åpenhet om brystkreft og om markedsføring av brystkreftsaken.
	Herheim, Rune	Pupils collaborating in pairs at a computer in mathematics learning: investigating verbal communication patterns and qualities
	Vie, Tina Løkke	Cognitive appraisal, emotions and subjective health complaints among victims of workplace bullying: A stress-theoretical approach
	Jones, Lise Øen	Effects of reading skills, spelling skills and accompanying efficacy beliefs on participation in education. A study in Norwegian prisons.

2012 H	Danielsen, Yngvild Sørebø	Childhood obesity – characteristics and treatment. Psychological perspectives.
	Horverak, Jøri Gytre	Sense or sensibility in hiring processes. Interviewee and interviewer characteristics as antecedents of immigrant applicants' employment probabilities. An experimental approach.
	Jøsendal, Ola	Development and evaluation of BE smokeFREE, a school-based smoking prevention program
	Osnes, Berge	Temporal and Posterior Frontal Involvement in Auditory Speech Perception
	Drageset, Sigrunn	Psychological distress, coping and social support in the diagnostic and preoperative phase of breast cancer
	Aasland, Merethe Schanke	Destructive leadership: Conceptualization, measurement, prevalence and outcomes
	Bakibinga, Pauline	The experience of job engagement and self-care among Ugandan nurses and midwives
	Skogen, Jens Christoffer	Foetal and early origins of old age health. Linkage between birth records and the old age cohort of the Hordaland Health Study (HUSK)
	Leversen, Ingrid	Adolescents' leisure activity participation and their life satisfaction: The role of demographic characteristics and psychological processes
	Hanss, Daniel	Explaining sustainable consumption: Findings from cross-sectional and intervention approaches
	Rød, Per Arne	Barn i klem mellom foreldrekonflikter og samfunnsmessig beskyttelse
2013 V	Mentzoni, Rune Aune	Structural Characteristics in Gambling
	Knudsen, Ann Kristin	Long-term sickness absence and disability pension award as consequences of common mental disorders. Epidemiological studies using a population-based health survey and official ill health benefit registries.
	Strand, Mari	Emotional information processing in recurrent MDD
	Veseth, Marius	Recovery in bipolar disorder. A reflexive-collaborative exploration of the lived experiences of healing and growth when battling a severe mental illness
	Mæland, Silje	Sick leave for patients with severe subjective health complaints. Challenges in general practice.
	Mjaaland, Thera	At the frontiers of change? Women and girls' pursuit of education in north-western Tigray, Ethiopia
	Odéen, Magnus	Coping at work. The role of knowledge and coping expectancies in health and sick leave.
	Hynninen, Kia Minna Johanna	Anxiety, depression and sleep disturbance in chronic obstructive pulmonary disease (COPD). Associations, prevalence and effect of psychological treatment.

	Flo, Elisabeth	Sleep and health in shift working nurses
	Aasen, Elin Margrethe	From paternalism to patient participation? The older patients undergoing hemodialysis, their next of kin and the nurses: a discursive perspective on perception of patient participation in dialysis units
	Ekornås, Belinda	Emotional and Behavioural Problems in Children: Self-perception, peer relationships, and motor abilities
	Corbin, J. Hope	North-South Partnerships for Health: Key Factors for Partnership Success from the Perspective of the KIWAKKUKI
	Birkeland, Marianne Skogbrott	Development of global self-esteem: The transition from adolescence to adulthood
2013 H	Gianella-Malca, Camila	Challenges in Implementing the Colombian Constitutional Court's Health-Care System Ruling of 2008
	Hovland, Anders	Panic disorder – Treatment outcomes and psychophysiological concomitants
	Mortensen, Øystein	The transition to parenthood – Couple relationships put to the test
	Årdal, Guro	Major Depressive Disorder – a Ten Year Follow-up Study. Inhibition, Information Processing and Health Related Quality of Life
	Johansen, Rino Bandlitz	The impact of military identity on performance in the Norwegian armed forces
	Bøe, Tormod	Socioeconomic Status and Mental Health in Children and Adolescents
2014 V	Nordmo, Ivar	Gjennom nåløyet – studenters læringserfaringer i psykologutdanningen
	Dovran, Anders	Childhood Trauma and Mental Health Problems in Adult Life
	Hegelstad, Wenche ten Velden	Early Detection and Intervention in Psychosis: A Long-Term Perspective
	Urheim, Ragnar	Forståelse av pasientaggresjon og forklaringer på nedgang i voldsrate ved Regional sikkerhetsavdeling, Sandviken sykehus
	Kinn, Liv Grethe	Round-Trips to Work. Qualitative studies of how persons with severe mental illness experience work integration.
	Rød, Anne Marie Kinn	Consequences of social defeat stress for behaviour and sleep. Short-term and long-term assessments in rats.
	Nygård, Merethe	Schizophrenia – Cognitive Function, Brain Abnormalities, and Cannabis Use
	Tjora, Tore	Smoking from adolescence through adulthood: the role of family, friends, depression and socioeconomic status. Predictors of smoking from age 13 to 30 in the "The Norwegian Longitudinal Health Behaviour Study" (NLHB)
	Vangsnes, Vigdis	The Dramaturgy and Didactics of Computer Gaming. A Study of a Medium in the Educational Context of Kindergartens.

	Nordahl, Kristin Berg	Early Father-Child Interaction in a Father-Friendly Context: Gender Differences, Child Outcomes, and Protective Factors related to Fathers' Parenting Behaviors with One-year-olds
2014 H	Sandvik, Asle Makoto	Psychopathy – the heterogenety of the construct
	Skotheim, Siv	Maternal emotional distress and early mother-infant interaction: Psychological, social and nutritional contributions
	Halleland, Helene Barone	Executive Functioning in adult Attention Deficit Hyperactivity Disorder (ADHD). From basic mechanisms to functional outcome.
	Halvorsen, Kirsti Vindal	Partnerskap i lærerutdanning, sett fra et økologisk perspektiv
	Solbue, Vibeke	Dialogen som visker ut kategorier. En studie av hvilke erfaringer innvandrerungdommer og norskfødte med innvandrerforeldre har med videregående skole. Hva forteller ungdommenes erfaringer om videregående skoles håndtering av etniske ulikheter?
	Kvalevaag, Anne Lise	Fathers' mental health and child development. The predictive value of fathers' psychological distress during pregnancy for the social, emotional and behavioural development of their children
	Sandal, Ann Karin	Ungdom og utdanningsval. Om elevar sine opplevingar av val og overgangsprosessar.
	Haug, Thomas	Predictors and moderators of treatment outcome from high- and low-intensity cognitive behavioral therapy for anxiety disorders. Association between patient and process factors, and the outcome from guided self-help, stepped care, and face-to-face cognitive behavioral therapy.
	Sjølie, Hege	Experiences of Members of a Crisis Resolution Home Treatment Team. Personal history, professional role and emotional support in a CRHT team.
	Falkenberg, Liv Eggset	Neuronal underpinnings of healthy and dysfunctional cognitive control
	Mrdalj, Jelena	The early life condition. Importance for sleep, circadian rhythmicity, behaviour and response to later life challenges
	Hesjedal, Elisabeth	Tverrprofesjonelt samarbeid mellom skule og barnevern: Kva kan støtte utsette barn og unge?
2015 V	Hauken, May Aasebø	«*The cancer treatment was only half the work!»* A Mixed-Method Study of Rehabilitation among Young Adult Cancer Survivors
	Ryland, Hilde Katrin	Social functioning and mental health in children: the influence of chronic illness and intellectual function
	Rønsen, Anne Kristin	Vurdering som profesjonskompetanse. Refleksjonsbasert utvikling av læreres kompetanse i formativ vurdering

	Hoff, Helge Andreas	Thinking about Symptoms of Psychopathy in Norway: Content Validation of the Comprehensive Assessment of Psychopathic Personality (CAPP) Model in a Norwegian Setting
	Schmid, Marit Therese	Executive Functioning in recurrent- and first episode Major Depressive Disorder. Longitudinal studies
	Sand, Liv	Body Image Distortion and Eating Disturbances in Children and Adolescents
	Matanda, Dennis Juma	Child physical growth and care practices in Kenya: Evidence from Demographic and Health Surveys
	Amugsi, Dickson Abanimi	Child care practices, resources for care, and nutritional outcomes in Ghana: Findings from Demographic and Health Surveys
	Jakobsen, Hilde	The good beating: Social norms supporting men's partner violence in Tanzania
	Sagoe, Dominic	Nonmedical anabolic-androgenic steroid use: Prevalence, attitudes, and social perception
	Eide, Helene Marie Kjærgård	Narrating the relationship between leadership and learning outcomes. A study of public narratives in the Norwegian educational sector.
2015 H	Wubs, Annegreet Gera	Intimate partner violence among adolescents in South Africa and Tanzania
	Hjelmervik, Helene Susanne	Sex and sex-hormonal effects on brain organization of fronto-parietal networks
	Dahl, Berit Misund	The meaning of professional identity in public health nursing
	Røykenes, Kari	Testangst hos sykepleierstudenter: «Alternativ behandling»
	Bless, Josef Johann	The smartphone as a research tool in psychology. Assessment of language lateralization and training of auditory attention.
	Løvvik, Camilla Margrethe Sigvaldsen	Common mental disorders and work participation – the role of return-to-work expectations
	Lehmann, Stine	Mental Disorders in Foster Children: A Study of Prevalence, Comorbidity, and Risk Factors
	Knapstad, Marit	Psychological factors in long-term sickness absence: the role of shame and social support. Epidemiological studies based on the Health Assets Project.
2016 V	Kvestad, Ingrid	Biological risks and neurodevelopment in young North Indian children
	Sælør, Knut Tore	Hinderløyper, halmstrå og hengende snører. En kvalitativ studie av håp innenfor psykisk helse- og rusfeltet.
	Mellingen, Sonja	Alkoholbruk, partilfredshet og samlivsstatus. Før, inn i, og etter svangerskapet – korrelater eller konsekvenser?
	Thun, Eirunn	Shift work: negative consequences and protective factors

	Hilt, Line Torbjørnsen	The borderlands of educational inclusion. Analyses of inclusion and exclusion processes for minority language students
	Havnen, Audun	Treatment of obsessive-compulsive disorder and the importance of assessing clinical effectiveness
	Slåtten, Hilde	Gay-related name-calling among young adolescents. Exploring the importance of the context.
	Ree, Eline	Staying at work. The role of expectancies and beliefs in health and workplace interventions.
	Morken, Frøydis	Reading and writing processing in dyslexia
2016 H	Løvoll, Helga Synnevåg	Inside the outdoor experience. On the distinction between pleasant and interesting feelings and their implication in the motivational process.
	Hjeltnes, Aslak	Facing social fears: An investigation of mindfulness-based stress reduction for young adults with social anxiety disorder
	Øyeflaten, Irene Larsen	Long-term sick leave and work rehabilitation. Prognostic factors for return to work.
	Henriksen, Roger Ekeberg	Social relationships, stress and infection risk in mother and child
	Johnsen, Iren	«Only a friend» - The bereavement process of young adults who have lost a friend to a traumatic death. A mixed methods study.
	Helle, Siri	Cannabis use in non-affective psychoses: Relationship to age at onset, cognitive functioning and social cognition
	Glambek, Mats	Workplace bullying and expulsion in working life. A representative study addressing prospective associations and explanatory conditions.
	Oanes, Camilla Jensen	Tilbakemelding i terapi. På hvilke måter opplever terapeuter at tilbakemeldingsprosedyrer kan virke inn på terapeutiske praksiser?
	Reknes, Iselin	Exposure to workplace bullying among nurses: Health outcomes and individual coping
	Chimhutu, Victor	Results-Based Financing (RBF) in the health sector of a low-income country. From agenda setting to implementation: The case of Tanzania
	Ness, Ingunn Johanne	The Room of Opportunity. Understanding how knowledge and ideas are constructed in multidisciplinary groups working with developing innovative ideas.
	Hollekim, Ragnhild	Contemporary discourses on children and parenting in Norway. An empirical study based on two cases.
	Doran, Rouven	Eco-friendly travelling: The relevance of perceived norms and social comparison
2017 V	Katisi, Masego	The power of context in health partnerships: Exploring synergy and antagony between external and internal ideologies in implementing Safe Male Circumcision (SMC) for HIV prevention in Botswana

	Jamaludin, Nor Lelawati Binti	The “why” and “how” of International Students’ Ambassadorship Roles in International Education
	Berthelsen, Mona	Effects of shift work and psychological and social work factors on mental distress. Studies of onshore/offshore workers and nurses in Norway.
	Krane, Vibeke	Lærer-elev-relasjoner, elevers psykiske helse og frafall i videregående skole – en eksplorerende studie om samarbeid og den store betydningen av de små ting
	Søvik, Margaret Ljosnes	Evaluating the implementation of the Empowering Coaching™ program in Norway
	Tonheim, Milfrid	A troublesome transition: Social reintegration of girl soldiers returning ‘home’
	Senneseth, Mette	Improving social network support for partners facing spousal cancer while caring for minors. A randomized controlled trial.
	Urke, Helga Bjørnøy	Child health and child care of very young children in Bolivia, Colombia and Peru.
	Bakhturidze, George	Public Participation in Tobacco Control Policy-making in Georgia
	Fismen, Anne-Siri	Adolescent eating habits. Trends and socio-economic status.
2017 H	Hagatun, Susanne	Internet-based cognitive-behavioural therapy for insomnia. A randomised controlled trial in Norway.
	Eichele, Heike	Electrophysiological Correlates of Performance Monitoring in Children with Tourette Syndrome. A developmental perspective.
	Risan, Ulf Patrick	Accommodating trauma in police interviews. An exploration of rapport in investigative interviews of traumatized victims.
	Sandhåland, Hilde	Safety on board offshore vessels: A study of shipboard factors and situation awareness
	Blågestad, Tone Fidje	Less pain – better sleep and mood? Interrelatedness of pain, sleep and mood in total hip arthroplasty patients
	Kronstad, Morten	Frå skulebenk til deadlines. Korleis nettjournalistar og journaliststudentar lærer, og korleis dei utviklar journalistfagleg kunnskap
	Vedaa, Øystein	Shift work: The importance of sufficient time for rest between shifts.
	Steine, Iris Mulders	Predictors of symptoms outcomes among adult survivors of sexual abuse: The role of abuse characteristics, cumulative childhood maltreatment, genetic variants, and perceived social support.
	Høgheim, Sigve	Making math interesting: An experimental study of interventions to encourage interest in mathematics

2018 V	Brevik, Erlend Joramo	Adult Attention Deficit Hyperactivity Disorder. Beyond the Core Symptoms of the Diagnostic and Statistical Manual of Mental Disorders.
	Erevik, Eilin Kristine	User-generated alcohol-related content on social media: Determinants and relation to offline alcohol use
	Hagen, Egon	Cognitive and psychological functioning in patients with substance use disorder; from initial assessment to one-year recovery
	Adólfsdóttir, Steinunn	Subcomponents of executive functions: Effects of age and brain maturations
	Brattabø, Ingfrid Vaksdal	Detection of child maltreatment, the role of dental health personnel – A national cross-sectional study among public dental health personnel in Norway
	Fylkesnes, Marte Knag	Frykt, forhandlinger og deltakelse. Ungdommer og foreldre med etnisk minoritetsbakgrunn i møte med den norske barnevernstjenesten.
	Stiegler, Jan Reidar	Processing emotions in emotion-focused therapy. Exploring the impact of the two-chair dialogue intervention.
	Egelandsdal, Kjetil	Clickers and Formative Feedback at University Lectures. Exploring students and teachers' reception and use of feedback from clicker interventions.
	Torjussen, Lars Petter Storm	Foreningen av visdom og veltalenhet – utkast til en universitetsdidaktikk gjennom en kritikk og videreføring av Skjervheims pedagogiske filosofi på bakgrunn av Arendt og Foucault. *Eller hvorfor menneskelivet er mer som å spille fløyte enn å bygge et hus.*
	Selvik, Sabreen	A childhood at refuges. Children with multiple relocations at refuges for abused women.
2018 H	Leino, Tony Mathias	Structural game characteristics, game features, financial outcomes and gambling behaviour
	Raknes, Solfrid	Anxious Adolescents: Prevalence, Correlates, and Preventive Cogntive Behavioural Interventions
	Morken, Katharina Teresa Enehaug	Mentalization-based treatment of female patients with severe personality disorder and substance use disorder
	Braatveit, Kirsten Johanne	Intellectual disability among in-patients with substance use disorders
	Barua, Padmaja	Unequal Interdependencies: Exploring Power and Agency in Domestic Work Relations in Contemporary India
	Darkwah, Ernest	Caring for "parentless" children. An exploration of work-related experiences of caregivers in children's homes in Ghana.
	Valdersnes, Kjersti Bergheim	Safety Climate perceptions in High Reliability Organizations – the role of Psychological Capital

2019 V	Kongsgården, Petter	Vurderingspraksiser i teknologirike læringsmiljøer. En undersøkelse av læreres vurderingspraksiser i teknologirike læringsmiljøer og implikasjoner på elevenes medvirkning i egen læringsprosess.
	Vikene, Kjetil	Complexity in Rhythm and Parkinson's disease: Cognitive and Neuronal Correlates
	Heradstveit, Ove	Alcohol- and drug use among adolescents. School-related problems, childhood mental health problems, and psychiatric diagnoses.
	Riise, Eili Nygard	Concentrated exposure and response prevention for obsessive-compulsive disorder in adolescents: the Bergen 4-day treatment
	Vik, Alexandra	Imaging the Aging Brain: From Morphometry to Functional Connectivity
	Krossbakken, Elfrid	Personal and Contextual Factors Influencing Gaming Behaviour. Risk Factors and Prevention of Video Game Addiction.
	Solholm, Roar	Foreldrenes status og rolle i familie- og nærmiljøbaserte intervensjoner for barn med atferdsvansker
	Baldomir, Andrea Margarita	Children at Risk and Mothering Networks in Buenos Aires, Argentina: Analyses of Socialization and Law-Abiding Practices in Public Early Childhood Intervention.
	Samuelsson, Martin Per	Education for Deliberative Democracy. Theoretical assumptions and classroom practices.
	Visted, Endre	Emotion regulation difficulties. The role in onset, maintenance and recurrence of major depressive disorder.
2019 H	Nordmo, Morten	Sleep and naval performance. The impact of personality and leadership.
	Sveinsdottir, Vigdis	Supported Employment and preventing Early Disability (SEED)
	Dwyer, Gerard Eric	New approaches to the use of magnetic resonance spectroscopy for investigating the pathophysiology of auditory-verbal hallucinations
	Synnevåg, Ellen Strøm	Planning for Public Health. Balancing top-down and bottom-up approaches in Norwegian municipalities.
	Kvinge, Øystein Røsseland	Presentation in teacher education. A study of student teachers' transformation and representation of subject content using semiotic technology.
	Thorsen, Anders Lillevik	The emotional brain in obsessive-compulsive disorder
	Eldal, Kari	Sikkerheitsnettet som tek imot om eg fell – men som også kan fange meg. Korleis erfarer menneske med psykiske lidingar ei innlegging i psykisk helsevern? Eit samarbeidsbasert forskingsprosjekt mellom forskarar og brukarar.

	Svendsen, Julie Lillebostad	Self-compassion - Relationship with mindfulness, emotional stress symptoms and psychophysiological flexibility
2020 V	Albæk, Ane Ugland	Walking children through a minefield. Qualitative studies of professionals' experiences addressing abuse in child interviews.
	Ludvigsen, Kristine	Creating Spaces for Formative Feedback in Lectures. Understanding how use of educational technology can support formative assessment in lectures in higher education.
	Hansen, Hege	Tidlig intervensjon og recoveryprosesser ved førsteepisode psykose. En kvalitativ utforsking av ulike perspektiver.
	Nilsen, Sondre Aasen	After the Divorce: Academic Achievement, Mental Health, and Health Complaints in Adolescence. Heterogeneous associations by parental education, family structure, and siblings.
	Hovland, Runar Tengel	Kliniske tilbakemeldingssystemer i psykisk helsevern – implementering og praktisering
	Sæverot, Ane Malene	Bilde og pedagogikk. En empirisk undersøkelse av ungdoms fortellinger om bilder.
	Carlsen, Siv-Elin Leirvåg	Opioid maintenance treatment and social aspects of quality of life for first-time enrolled patients. A quantitative study.
	Haugen, Lill Susann Ynnesdal	Meeting places in Norwegian community mental health care: A participatory and community psychological inquiry
2020 H	Markova, Valeria	How do immigrants in Norway interpret, view, and prefer to cope with symptoms of depression? A mixed method study
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Graphic design: Communication Division, UiB / Print: Skipnes Kommunikasjon AS

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ISBN: 9788230862353 (print)
9788230853917 (PDF)