Coping strategies of mental health problems among refugee groups in Norway

Dixie Janice Brea Larios

Thesis for the degree of Philosophiae Doctor (PhD)
University of Bergen, Norway
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This thesis is presented through the Department of Psychosocial Science, Faculty of Psychology, University of Bergen.

My main supervisors have been Professor Gro Mjeldheim Sandal and Professor David Sam at the Department of Psychosocial Science, Faculty of Psychology, University of Bergen. My co-supervisor was Prof. Eugene Guribye at NORCE Kristiansand.

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Abreviations

Brief COPE	Coping Orientation to Problems Experienced Inventory (28 items)
CENC	Clinical encounters with refugees suffering from mental health problems
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5th edition
EM	Explanatory models
FGI	Focus Group Interview
HSCL-25	Hopkins Symptom Checklist (25 items)
ICD-10	International statistical classification of diseases and related health problems 10th edition
IPL	Immigration Policy Lab (12 items or 24 items)
NSD	Norwegian center for research data
PTSD	Post-traumatic stress disorder
REK	Regionale komiteer for medisink og helsefaglige forkskningsetikk
SAW	Society and Workplace Diversity Research Group
UNHCR	United Nations High Commissioner for Refugees
UoB	University of Bergen
WHO	World Health Organization

Abstract in English

Background: Migration is a stressful process that may affect the health of individuals, particularly when it involves fleeing from war, conflict, or persecution. Post-traumatic stress disorder and depression are mental health problems that often affect those experiencing flight and traumatic events in connection with fleeing. Knowledge of these matters is crucial, especially with asylum seekers and refugee groups when newly arrived in the receiving countries. Managing these stressors and acquiring help when needed will improve these population groups' future quality of life and well-being and facilitate integration in the local communities. The new waves of refugees fleeing to Norway remind us to acquire better knowledge about how people from other cultural backgrounds cope with mental health problems, seek help, and access necessary treatments. This PhD study aims to understand the knowledge of mental health problems from some refugee populations residing in Norway and identify their perceptions through explanatory models of mental health problems, such as depression and PTSD, and their ways of managing symptoms and seeking treatment.

Method: This PhD thesis aimed to assess the research questions through a mixed-method approach generated in three articles. The study started from a qualitative approach due to concerns that certain perspectives of mental health problems may differ because of cultural aspects and resettlement changes, which can result in ineffective treatments or misdiagnoses. Through focus group interviews (FGI) and vignettes portraying characters with symptoms of depression and post-traumatic stress disorder (based on the ICD-10 and DSM-5), this study aimed to identify individuals' knowledge and explanations for mental health problems among the refugee population in Norway. To acquire this, this PhD thesis selected the population groups from Afghanistan and Syria as the top countries that come as refugees to Norway.

Article 1 was a qualitative study using FGIs with Afghan participants living in Norway. Six FGIs were conducted using two vignettes that displayed a male and a female character with symptoms of depression and PTSD. The interviews were audio, and video recorded, transcribed verbatim, and managed with the program NVivo. The analysis identified themes that included causal and risk factors and preferred treatments for the vignette characters' situation.

Article 2 was a quantitative study that examined, through a cross-sectional study, the relationship between different aspects of integration and psychological distress among Afghans living in Norway. One-hundred and fourteen Afghans over the age of 18 responded to an online survey, answering questions on different scales, such as the Immigration Policy Lab index (IPL -12/24) and the Hopkins Symptoms Checklist (HSCL-25).

Article 3 was a quantitative study exploring the relationship between integration and coping strategies for depression among the Syrian population with a cross-sectional study. IPL12/24, HSCL-25 (13 items), and Brief COPE scales were assessed through an online survey.

Results: The findings for the qualitative study indicated that there are gender and generational differences in the management of depression and PTSD and in treatment preferences, but also in the experience of traumatic events while fleeing, especially for younger male participants. The results from the quantitative studies indicated that mental health problems such as depression contributed to the aspect of integration and ways of coping. The results also suggested that Afghan refugees' mental health is enhanced by belonging to a community, feeling connected and secure. Likewise, coping actively in an emotion-focused and avoidant manner hindered the psychological aspect of integration in the Afghan community, compared to the Syrian population, which used the problem-focused and active coping style.

Conclusion: As migration processes and clinical settings become more time-pressed, this study's findings may challenge the explanations within the refugee populations. By mapping individual perceptions of mental health problems among Afghans and other population groups such as Syrians, Somalians, and Ukrainians, we can improve the provision of mental health care and build trusting relationships that enhance the integration process for those suffering from mental health disorders. Understanding mental health in a cultural context can help provide better healthcare to those in need. The results of this study can contribute to the promotion of effective measures for mental health care services, openness to the cultural perspectives coming from the refugee communities by identifying their perceptions of mental health problems and how to deal with the symptoms, particularly in settings where integrating is of major importance.

Sammendrag (Abstract in Norwegian)

Bakgrunn: Migrasjon er en stressende prosess som kan påvirke helsen til enkeltpersoner, spesielt når den involverer flukt fra krig, konflikt eller forfølgelse. Posttraumatisk stresslidelse og depresjon er psykiske problemer som ofte rammer de som opplever flukt og traumatiske hendelser i forbindelse med flukt. Kunnskap om disse forholdene er avgjørende, spesielt med asylsøkere og flyktninggrupper når nyankomne i mottakerlandene. Å håndtere disse stressfaktorene og skaffe hjelp ved behov vil forbedre disse befolkningsgruppenes fremtidige livskvalitet og velvære og lette integreringen i lokalsamfunnene. Nye bølger av flyktninggrupper til Norge minner oss om å tilegne oss bedre kunnskap om hvordan mennesker med annen kulturell bakgrunn håndterer psykiske problemer, søker hjelp og får tilgang til nødvendig behandling. Dette doktorgradsstudiet tar sikte på å forstå kunnskapen om psykiske helseproblemer fra enkelte flyktning populasjoner bosatt i Norge og identifisere deres oppfatninger gjennom forklaringsmodeller for psykiske helseproblemer, som depresjon og PTSD, og deres måter å håndtere symptomer og søke behandling på.

Metode: Denne doktorgradsavhandlingen hadde som mål å vurdere forskningsspørsmålene gjennom en blandet metode og skapt i tre artikler. Studien startet fra en kvalitativ tilnærming på grunn av bekymring for at visse perspektiver på psykiske helseproblemer kan være forskjellige på grunn av kulturelle aspekter og gjenbosettingsendringer, noe som kan resultere i ineffektive behandlinger eller feildiagnoser. Gjennom fokusgruppeintervjuer (FGI) og ved å utvikle vignetter som skildrer karakterer med symptomer på depresjon og posttraumatisk stresslidelse basert på ICD-10 og DSM-5, hadde denne studien som mål å identifisere individers kunnskap og forklaringer på psykiske problemer blant de flyktning befolkningen i Norge. For å tilegne seg dette valgte denne oppgaven flyktning befolkningsgruppene fra Afghanistan og Syria som topp landene som kommer som flyktninger til Norge.

Artikkel 1 var en kvalitativ studie med bruk av FGI med afghanske deltakere bosatt i Norge. Seks fokusgruppeintervjuer ble utført med to vignetter som viste en mannlig og en kvinnelig karakter med symptomer på depresjon og PTSD. Intervjuene ble tatt opp med lyd og video, transkribert ordrett og administrert med programmet NVivo. Analysen identifiserte temaer som inkluderte årsaks- og risikofaktorer og foretrukne behandlinger for vignettfigurenes situasjon.

Artikkel 2 var en kvantitativ studie som undersøkte sammenhengen mellom ulike aspekter ved integrering og psykiske plager blant afghanske flyktninger i Norge gjennom en tverrsnitts studie. Ett hundre og fjorten afghanere over 18 år svarte på en nettbasert spørreundersøkelse, og svarte på spørsmål på forskjellige skalaer, slik som Immigration Policy Lab-indeksen (IPL -12/24) og Hopkins symptomsjekkliste (HSCL-25).

Artikkel 3 var også en kvantitativ studie som undersøkte forholdet mellom integrering og mestringsstrategier for depresjon blant den syriske befolkningen. Gjennom en nettbasert undersøkelse ble IPL12/24, HSCL-25 (13 elementer) og Brief COPE-skalaer vurdert.

Resultater: De kvalitative studiefunnene indikerte at det er kjønns- og generasjonsforskjeller i håndteringen av depresjon og PTSD og i behandlingspreferanser, men også i opplevelsen av traumatiske hendelser under flukt, spesielt for yngre mannlige deltakere. Resultatene fra de kvantitative studiene indikerte at psykiske problemer som depresjon bidrar til integreringsaspektet og mestringsmåter. Resultatene antydet også at afghanske flyktningers mentale helse forbedres ved å tilhøre et fellesskap, føle seg tilkoblet og trygg. På samme måte hindret mestring aktivt på en følelsesfokusert og unngående måte det psykologiske aspektet ved integrering i det afghanske samfunnet, sammenlignet med den syriske befolkningen, som brukte den problemfokuserte og aktive mestringsstilen.

Konklusjon: Ettersom migrasjonsprosesser og kliniske omgivelser blir mer tidspresset, kan denne studiens funn utfordre forklaringene i flyktning populasjonene. Ved å kartlegge

individuelle oppfatninger av psykiske helseproblemer blant afghanere og andre befolkningsgrupper som syrere, somaliere og ukrainere, kan vi forbedre tilbudet av psykisk helsehjelp og bygge tillitsfulle relasjoner som forbedrer integreringsprosessen for de som lider av psykiske lidelser. Å forstå psykisk helse i en kulturell kontekst kan bidra til å gi bedre helsetjenester til de som trenger det. Resultatene av denne studien kan bidra til å fremme effektive tiltak for psykisk helsevern, åpenhet for de kulturelle perspektivene som kommer fra flyktningmiljøene ved å identifisere deres oppfatninger av psykiske helseproblemer og hvordan man kan håndtere symptomene, spesielt i miljøer. hvor integrering er av stor betydning.

Overview of articles

List of publications

1. **Brea Larios, D**., Sandal, G.M., Guribye, E., Markova, V., Sam, DL. (2022): "Explanatory models of post-traumatic stress disorder (PTSD) and depression among Afghan refugees in Norway" BMC Psychology. Vol.10, Issue 1, pages1-13. ISSN-2050-7283. https://doi.org/10.1186/s40359-021-00709-0

2. **Brea Larios, D.**, Sam, D., Sandal, G.M. (2023): Psychological distress among Afghan refugees in Norway as a functional aspect of integration" *Front. Psychol.* 14:1143681. https://10.3389/fpsyg.2023.1143681

3. **Brea Larios, D.**, (2023): "Ways of coping with depression among Syrians residing in Norway" (sent to BMC Psychology journal).

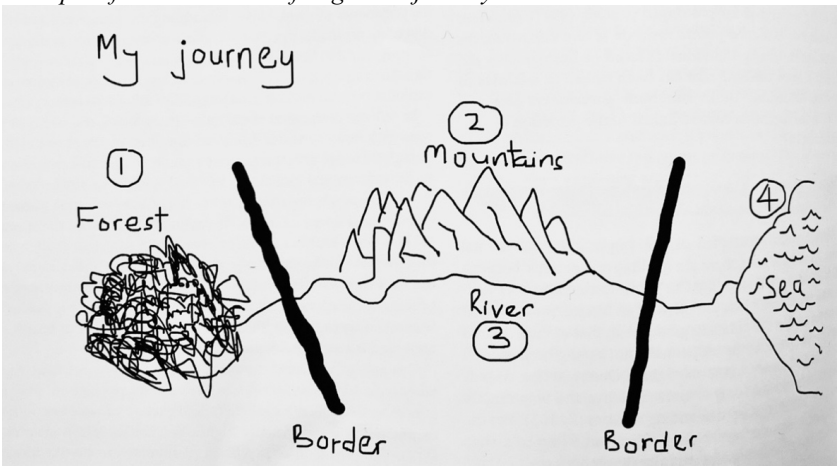
Contents

Preface: The journey

"Alina is a 36-year-old woman with bilateral severe visual impairment. Before the conflict on her country, she felt depressed in the context of her limited opportunities for education, work and finding a life partner. She was dependent on family members for support with activities of daily living and social activities. As the conflict worsened, male members of the family joined forces to defend their land. Many died in conflict and the women and children were forced to flee over many miles of harsh terrain till they got to a refugee camp in the neighbouring state" (Ayonrinde & Busuttil's case study in Bhugra, 2021, p. 224).

Like many migration stories, *Alina*'s story tells the problematic experiences and suffering in her migration journey. People like *Alina,* who are forcibly displaced from their homes and flee because of war and conflict, seek safety (Ayonrinde & Busuttil, 2021; Loescher, 2021). Most of these individuals carry their stories and losses, and the migration narrative gives us a glimpse and understanding of their experiences and journeys during flight. These journeys are across geographical spaces, borders, and different types of climates (see Figure 1) (Ayonrinde & Busuttil, 2021). This doctoral thesis wishes to acknowledge the migration narrative and meet the needs of the migrant groups in Norway by exploring how refugees understand and seek treatment for mental health problems.

Figure 1
Example of an illustration of migration journey.



Notes: Example of an illustration of the migration journey to explore experiences on physical migration (Ayonrinde & Busuttil in Bhugra, 2021, p. 224).

1. Introduction

Migration is a heterogeneous and stressful process before, during, and after the move, affecting not only a single person but also families and entire populations (Bhugra, 2004). In 2015, we experienced the most significant and fastest increase in the number of people displaced from their homes. Conflicts in Syria, Iraq, Afghanistan, Venezuela, and Ukraine, as well as persecutions in Southeast Asia and sub-Saharan Africa, have resulted in the highest number of displacements since the Second World War (UNHCR, 2022). These are not isolated incidents in the twenty-first century, but a global phenomenon that has led to massive displacements and flights (World Economic Forum, 2023; UNHCR, 2022). Most refugee groups, for example, are hosted by the neighboring countries from which these refugees originate. Nevertheless, significant movements to other destination countries are seen, especially with resettlement in high-income countries. In Norway, immigration has escalated in recent decades, and the number of refugees and asylum seekers has also increased, especially after the refugee crisis in 2015. In 2022, 819,356 migrants[1] were living in Norway (SSB, 2023). Of these, 29.9% had a refugee background. Only since 2017 have these numbers started to increase again due to the current situation in Ukraine (SSB, 2022).

Migration has become a significant public health challenge in several countries, especially regarding the topic of mental health. Migrants, including refugees, may be more vulnerable to mental health problems than the host population due to their current living situation, legal status, socio-economic factors, and previous separation from family members. In the case of a crisis or difficulties adapting to specific stressors after fleeing, refugees may suffer from the adverse effects of traumatic experiences resulting in a higher

[1] While the PhD thesis refers to the term refugees, the term migrants shall be used to encompass both refugees and asylum seekers as well as voluntary migrants moving from one country to another. For a more detailed explanation, see Chapter 4, section 4.2 of the dissertation.

risk for developing a mental health problem (Blackmore, Boyle, et al., 2020; Kliewer, 1992; Priebe et al., 2016).

Coping with specific stressors and managing specific life events are fundamental for the characteristics of an individual (Tweed & Conway, 2006), especially true for those forced to migrate. Managing certain situations will depend on the dynamic and the fluidity of a situation. Furthermore, specific barriers, cultural aspects, and perspectives of migration can influence how certain situations are handled (e.g., discrimination, stigmatization), preventing migrants from seeking help or coping with a situation. As a result, migrant groups may seek informal help or handle a problem differently. For example, cultural traditions or different understandings of certain health problems may influence how help seeking behaviors affect access to care and medical attention. Minor health problems can develop into significant ones due to the failure to seek health care or the lack of knowledge of the host country's health system. The shortage of specific approaches for diverse populations (e.g., absence of language services, community-based support staff, culturally relevant health promotion) may also affect migrants' access to health care (e.g., Handtke et al., 2019; Siddiq et al., 2022; Woodland et al., 2021).

Similarly, life changes related to social adjustments, socio-economic conditions, acculturation aspects and future expectations, can affect migrants' mental well-being and coping skills (Straiton et al., 2018; Østfold & Bjørkli, 2019). However, global developments have risen in recent years with international help and social media platforms contributing to the awareness of certain situations, particularly for migration health. The development of speaking other languages, for example, has helped bridge this gap and bring closure among populations by communicating and interacting with the world, particularly in times of pandemics. At the same time, healthcare providers face challenges in providing the best possible care to for example, patients from other countries of origin than the host country,

who often present with different symptoms than clinicians expect and do not receive a specific diagnosis (Straiton et al., 2018; Østfold & Bjørkli, 2019). Understanding the health perspectives of the migrant population and learning more about their backgrounds creates a safer environment for migrants, particularly refugees, in their process of migration.

2. Project and thesis structure

The primary mental health problems in the context of this study are post-traumatic stress disorder (PTSD) and depression. The definitions for these concepts correspond to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (2019) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (2013). This doctoral thesis also considers the prevalence of these mental health problems and previous studies among migrant groups, including refugees. The use of specific emotional terms and how individuals interpret and cope with certain circumstances may differ when trying to understand past trauma. However, these diagnoses may only reflect a medical perspective and do not necessarily consider cultural perspectives (e.g., Maercker & Perkonigg, 2013). For example, labels or attributions may help clarify cultural meanings (Murray, 2015). Cultural interpretation is therefore considered when understanding mental health problems in migrant groups in this study. Consequently, this PhD project aims to understand perceptions of mental health problems and identify ways to manage symptoms and treatment options in this population.

This doctoral thesis includes a qualitative and quantitative analysis of the study process and previous literature of some refugee populations and their relationship with mental health. Some research questions are designed to identify explanatory models and coping styles for mental health problems and to assess the relationship between psychological distress and integration into the host society. This PhD thesis intends to investigate how different refugee groups in Norway understand and cope with mental health problems. Therefore, the purpose of this thesis is to explore some migration perspectives and how they relate to the research questions. On the background of this research, this PhD thesis aims to answer the following research questions:

1. What are the explanatory models of post-traumatic stress disorder (PTSD) and depression held by refugees?
2. How do different cross-cultural coping inventories relate to more established measures of coping strategies for mental health problems among refugee groups in Norway?
3. How are the preferred coping strategies for depression associated with gender and identification with background culture?
4. How is the integration process related to mental health problems among these refugee groups?

To answer these research questions, I performed three studies using a mixed-method approach, as illustrated in Figure 2.

This PhD thesis investigated how different refugee groups in Norway understand and handle depression and post-traumatic stress disorder (PTSD), with particular focus on refugees living in Norway, especially the Afghan and Syrian population. Consequently, this thesis investigated the way in which people prefer to react to – or deal with depression, including help-seeking behaviors and preferred treatment, referred to as *coping strategies* by Lazarus and Folkman (1984).

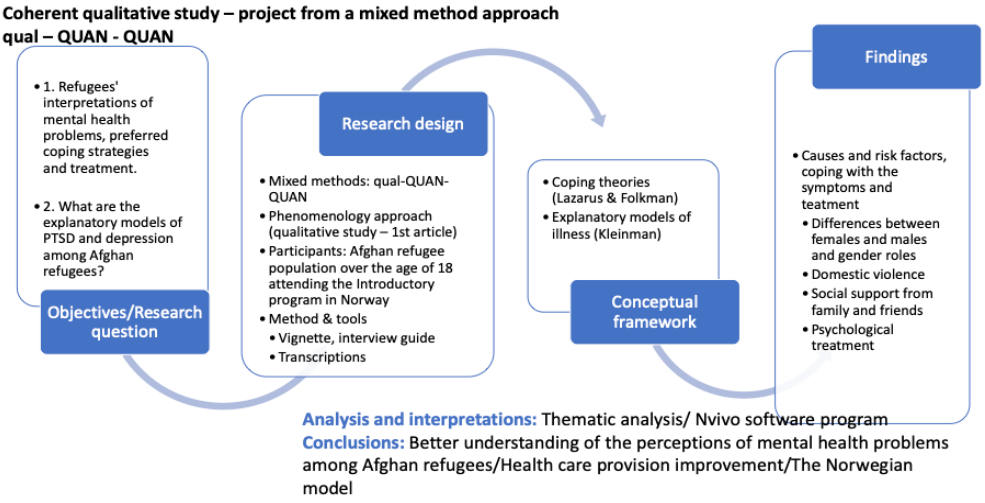
As a mixed-method project, this study carried both a qualitative and a quantitative method. The data were collected by focus group interviews and an online survey. The empirical setting covered and recruited participants from the mandatory *Introduction program*[2] in different municipalities in Norway for the qualitative study. The online survey

[2] Introduction program in Norway is a mandatory program for newly arrived foreign nationals between the ages 18 and 55 years. These foreign nationals have been granted either asylum (i.e., refugee status), or a residence permit on humanitarian grounds (through family reunion with the mentioned groups, on an independent basis due to abuse in marriage or cohabitation, or those who have acquired a work permit based on the Immigration Act section 8, 9, or 22). The goal of the program is to obtain basic qualifications in Norwegian language and the Norwegian social conditions to prepare for further work and education. https://www.regjeringen.no/en/topics/immigration-and-integration/asd/Verkemiddel-i-integreringsarbeidet/introduksjonsprogram/id2343472/ Accessed 02.12.2022.

was administered to the study populations (e.g., Afghans and Syrians residing in Norway), for the quantitative study of this PhD project. Respondents were recruited from invitations through different Norwegian organizations and institutions working with refugee groups, as well as social contexts and social media platforms where many from the study population participate.

Figure 2

Organizational framework of the mixed-method approach qual-QUAN-QUAN for the research project.



3. Review of the literature

A literature review was conducted for the theoretical framework to understand the research process and mind-mapping the various topics related to the project. The literature involved followed the thesis project's objectives to search the existing literature. Databases such as PubMed, Web of Science, and Google scholar, were used to gather the literature.

For the inclusion criteria, essential topics were comprised of identified keywords such as *refugees* OR *migrants*, *coping strategies* AND *help-seeking behaviors*, *explanatory models of mental illness* OR *idioms of distress* OR *perceptions of mental health problems*, among others. Previous literature on certain refugee groups cultural aspects were also included as essential to gather enough information for the addressed questions (e.g., *acculturation* OR *integration* AND *mental health problems* OR *PTSD* OR *depression* OR *anxiety*, as well as specific groups from the study populations (e.g., Afghans OR Syrians). The relevant literature was selected for the purpose of this study. The literature search was carried out from November 2018 through March 2020 with updated research articles through 2022. All information found for the background and theoretical framework was covered between 1960 and 2022. See Chapter 4 for more detailed information about the literature selected in the theoretical framework.

Previous research has reported a variety of mental health problems, with the prevalence of, for example, post-traumatic stress disorder (PTSD) and depressive and anxiety disorders indicating unadjusted prevalence and missing estimates of the prevalence of mental health problems, particularly among refugee groups and asylum seekers (e.g., Fazel et al., 2005; Peconga & Høgh Thøgersen, 2020; S. Slewa-Younan et al., 2017; Steel et al., 2009; Walther et al., 2020) Despite the increased rates of mental health problems among migrants and people with refugee background, a comprehensive review of the literature has also shown that coping with mental health problems (e.g., help-seeking behaviors, coping

strategies, primary care) remains low, due to risk factors including acculturative stress, cultural barriers, lack of understanding, and language deficits (e.g., Aldwin & Revenson, 1987; Byrow et al., 2020; d'Abreu et al., 2019; Gruner et al., 2020).

In the systematic review by Blackmore and colleagues (2020), several studies addressed the diagnosis of mental health problems, and the current estimates indicated in these studies might suggest that the prevalence of PTSD and depression may persist after migration. Other factors such as difficulty adjusting to a new country, social and cultural isolation, and limited opportunities, contributed to these problems. The review of the literature has helped develop this thesis and contributed to the backdrop for the theoretical framework and topic of this research.

4. Background and theoretical framework

To understand more thoroughly the content of this PhD thesis, some definitions regarding migration, refugees, and mental health have been considered in this doctoral dissertation.

4.1 Migration health

The concept of migration health refers to the "assessment and management of migration-related factors that may impact the physical, social, and mental well-being of migrants, as well as the public health of the host communities" (IOM, 2019, p. 139). Migration health, not only looks at the health status of migrants, it can also refer to how the migration process has affected the health of individuals, enhance inequities, quality, and improvement of health services (IOM, 2019). Although not all migrant groups have the same experiences during the migration process, the migration process could influence the health outcomes of some migrant groups, and visible differences between populations can lead to health disparities, such as in the prevalence of mental health.

A health outcome is defined as the "change in an individual, group, or population that is attributable to planned interventions and a series of actions" (WHO, 1998, p. 10). Health outcomes are often better in countries with advanced industrialization than in developing countries or countries where most migrants have emigrated (OECD, 2019a, 2019b). However, higher rates of mental health problems tend to occur in non-dominant groups, leading to changes in population health (IOM, 2020; Marmot & Wilkinson, 2005). Previous studies of migrant health have indicated that migration is a risk factor for mental health problems (Davies et al., 2009; Priebe et al., 2016). Pre- and post-migration experiences can contribute to this phenomenon (e.g., how migrants access health services or respond to specific prevention interventions), and strongly influencing health outcomes. Certain

examples of health outcomes among migrants have shown that they have either lower or higher rates of mental health problems and chronic diseases than the rest of the host populations (Jee & Or, 1999; OECD, 2019a; Straiton et al., 2017).

The Healthy Migrant Effect (Kumar & Diaz, 2019) for example, has also shown that migrants have better health than dominant groups, are younger than the general population, have lower mortality and higher life expectancy (NIPH, 2020; Wallace et al., 2022). This effect may also be related to the immigrant paradox (Coll & Marks, 2012), which looks at the assimilation patterns of the second generation of immigrants. Nevertheless, this healthy migrant effect may weaken as migrants extend their stay in the host country and encounter specific barriers that may affect their health (Ichou & Wallace, 2019). For instance, elderly refugees and migrants may be particularly vulnerable to poor health. The burden of disease may be attributed to specific mental health problems such as depression and post-traumatic stress disorder (PTSD) (Blackmore, Boyle, et al., 2020; Foo et al., 2018; Giacco et al., 2018). In addition, migrants in general, may be more likely to work in high-risk occupations, be exposed to dangerous accidents, and be more affected by weather conditions (Alaoui-Faris, 2022; Moyce & Schenker, 2018; Padilla & Miguel, 2009). When it comes to health, refugees have it worse than any other migrant groups (IMDi, 2021). Therefore, it would be interesting to investigate specific aspects that affect the well-being of migrant groups, particularly refugees in the host society.

What barriers can migrants encounter?

Physical accessibility can be challenging for certain migrant groups, concerning especially the spread of infectious diseases and violence-related injuries among refugee populations. For instance, overcrowded emergency rooms and poor health infrastructure in camps that could lead to less favorable health conditions compared to the services provided by health centers in the resettlement countries (Loescher, 2021). In recent times, the

circumstances affected by the pandemic have also created barriers for migrant groups. The mental health of these groups is also affected by conditions they have in the host countries or the trauma they experienced prior to migration. Access to health care often depends on government policies, availability of health care providers, and acquired legal status. Other issues arise following the increase in refugee influx with the lack of capacity and overburdened resources (e.g., underutilization of health services, difficulty navigating the system, and accessing primary care due to lack of eligibility) (Hauck & Brown, 2021; Hauff & Brunvatne, 2021; Sorenson, 2020). Moreover, financial barriers and other requirements could also be related to differences in health profiles, lack of awareness, and language communication.

Differing perceptions of how best to respond to health problems is another barrier that may discourage migrants from seeking medical care, opting instead for informal treatment. Often, there is a lack of approaches to dealing with diverse populations, even though the multiple contributions and community support. Consequently, forced migration related to war and conflict, for example, will still be associated with the characteristics and consequences that can affect mental health. Family ruptures and loss of social structure could also influence the emotional and affective component of migrants. In this case, refugee voices need to be heard so that institutions or health systems can better understand the perspectives and needs to provide effective interventions.

4.2 Understanding the concept of migrants

Various debates have revolved around the concept of migration when the terms migrants or refugees are used (Anthias, 2012). There are different ways to address these terms, although refugees and migrants are not always mutually exclusive or interchangeable (Anthias, 2012, p. 102; UNHCR, 2016b). At the international level, there is no legal or

universal definition of migrant (IOM, 2019; UNHCR, 2016b). *Migrant* is a catch-all term reflecting the general "lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons" (IOM, 2019, p. 132). Migration is often considered a voluntary process, and there are several categories for the term migrant (e.g., migrant workers, smuggled migrants, and international students). The term *immigrant* is also used from the perspective of the definition of long-term migrants (IOM, 2019; UN, 1998). Seeking asylum is a human right (UNHCR, 2016a), and sometimes interchanging the terms migrant and refugee for example, can lead to a loss of focus on legal protections for refugees. It is essential to make a distinction in terms of the different experiences. Refugees have been displaced due to war, persecution, or natural disasters. The historical background of the term refugee dates from the 1500s with the Huguenot wars in France and the consequences of absolutist power, religious conflicts, and persecution, which resulted in a massive emigration wave (Ther, 2021). Controls and measures regarding illegal emigration were also introduced as well as integration processes throughout Europe (Ther, 2021). Thus, the term *refugee* would refer to forcibly displaced persons and sometimes victims of human trafficking. Similarly, the term *asylum seeker* will refer to a person seeking international protection until they are recognized as refugees in the country to which they have resettled. Another term such as *forced migrant* could also refer to refugees and describes the movements of refugees, displaced persons, and, in some instances, victims of trafficking (IOM, 2019). All these terms encompass the concept of migrants. Consequently, the term *refugee* is well-based on the definition of the 1951 United Nations Convention, which states that a refugee is:

"...a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself 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." (IOM, 2019, p. 271).

Nevertheless, some of these terms can cause confusion and misinterpretation in public discourse or policy debates, having consequences in other migrant categories that could affect the lives and safety of for example, *refugees* (UNHCR, 2016b). Although these terms are used separately, there are different approaches to defining the term migrant: with an *inclusivist view*, in which the term migrant encompasses all categories, and a *residualist view*, which excludes those fleeing persecution and war (Carling, 2017; IOM, 2019).

4.3 The inclusivist and residualist view

According to the inclusivist view, the term migrant includes people who have moved away from their usual residence, regardless of their legal status or motives. *Inclusivists* use the term migrant to include various types of migrants: refugees, foreign workers, victims of trafficking, traveling spouses, international students, family reunification, and many other precise categories of people (Carling, 2017). In contrast, *residualists* believe that the term migrant refers to individuals who have left their place of residence for a reason other than fleeing persecution or war (Carling, 2017). This view provides for a diverse category and does not include the term refugee. Despite refugees' particular vulnerabilities and rights, inclusivists hope to lay the groundwork for analysis, policy, and debate that protects the rights of all migrants, including refugees who need protection under the 1951 Refugee Convention (Carling, 2017). Furthermore, the inclusivist perspective tries also to avoid stereotypes based on nationalities.

Implications for the study

Identifying a person as migrant consisted of all people on the move, including refugees, requiring some assistance and legal protection. The term refugee used in the present study does not affect this project's conceptual understanding of migration. However, understanding these terms was essential for the research process of this PhD thesis. The study population selected for the study gathered participants who have had or currently have refugee status or have been asylum seekers at some point. Some of these terms are included as categories to understand the term *migrant*, but not as an inclusion criterion for the participants in this study. For ethical reasons, participants' identity and status were not disclosed (for more thorough information regarding this aspect, see Materials and Methods section – 5.2.6 and 5.3.6). Nevertheless, the refugee status is often implied during the research processes, as participant recruitment and invitations to participate in a study were sent to different Norwegian institutions and organizations that often work with refugee groups and where potential participants from the countries of the study population come to Norway as refugees. Consequently, engagement with the *refugee* concept may not affect the transnational perspectives of migration (Anthias, 2012), meaning that future status changes could influence the object of reference as the study populations resettle in the host country, should the concept continue to be used (e.g., refugees acquiring citizenships). In this project and the generated articles, the term migrant is used broadly, emphasizing the inclusion of the term refugee, and the citizenship of the participants in the study.

4.3.2 Refugee populations

There are 32.5 million refugees worldwide, most of whom have been displaced due to war and conflict and continue seeking international protection (UNHCR, 2022). Since February 2022, over two million people have fled the country of Ukraine and refugee flows to date have already raised political questions (The Economist, 2022). In the resettlement

countries, the increasing numbers of refugees and asylum seekers (e.g., resettled refugees 56,584; returned refugees 429,234 in 2021) continue to pose challenges for effective health care and mental health professionals (UNHCR, 2022; UNHRC, 2020).

In 2021, in Norway, there were 46,042 persons with refugee status and 1,268 asylum seekers (60% men, 40% women) (UNHCR, 2022). The main countries sending refugees to Norway are the Syrian Arab Republic 16,180 (32%), Eritrea 11,543 (23%), Somalia 4,013 (8%), and Afghanistan 3,599 (7%) (SSB, 2020; UNHCR, 2022). Focusing primarily on refugee groups residing in Norway, this PhD thesis sought to obtain an overview of the population of Afghanistan and Syria, with regards to daily living patterns, understanding of mental health issues, help-seeking behaviors and coping with past trauma and mental health problems.

Refugee rights in Norway

Norway has made important contributions to international refugee protection with a well-established reception system, engaging in integration efforts and financial support, ensuring mainly that refugees are included in the Norwegian life upon arrival in Norway. This inclusion is seen in access to work, education, and social services to prevent extreme marginalization, disempowerment, or radicalization (NOAS, 2022; UNHCR, 2021). In addition, the right to healthcare for refugees or asylum seekers is ensured to the same patient treatment as the rest of the population (e.g., confidentiality, free interpreter, small fee payments, medical records access, and children's full entitlement to healthcare services) (The Norwegian Directorate of Health, 2022).

The cases of Syria and Afghanistan

Most refugees and asylum seekers come from a region with enormous humanitarian problems; many have experienced hostilities firsthand. In the recent years, Syrians and Afghans represent one of the largest refugee groups to arrive in Norway (UNHCR, 2022).

Trauma before and during flight has resulted in post-traumatic stress disorder, and other mental health problems for many Syrian and Afghan refugees (e.g., Alemi et al., 2014; Henkelmann et al., 2020; Nesterko et al., 2020; Priebe et al., 2016). Recent evidence and reported experiences by refugee groups suggested that exposure to traumatic events led to high risk for psychological distress (described as post-traumatic and depressive symptoms) (Alemi et al., 2014; Scholte et al., 2004; Tinghög et al., 2017).

Previous research in the United States showed that Afghan refugees faced language, education, and employment problems, presented cultural and family conflicts, and lack of community resources after relocation (Lipson, 1991; Lipson et al., 1995; Lipson & Omidian, 1997). Other recent studies have shown that Afghan refugees rarely use public health services and are more likely to seek help from family and social networks, particularly the younger generations (Anstiss & Ziaian, 2010). The population of Afghans living in Norway is around 10,500 (SSB, 2023), and Statistics Norway (2018) has indicated that Afghan refugees were among the minority groups reporting most loneliness. Previous reports have also indicated gender differences among Afghan women in Norway having better health than Afghan men (Larsen, 2017; Madar et al., 2020; Norwegian Institute of Public Health, 2017; Qureshi et al., 2022).

For the Syrian population residing in Norway, the numbers have changed specifically after 2015 (Tønnessen et al., 2020). This population's need for mental health services appeared to be significant regarding the quality of life and integration. For instance, 40% of Syrian respondents in the REFUGE study (2020) reported exposure to previous traumatic events (PTE), frightening situations, and experiences with torture before and after flight, with a prevalence of PTSD (34.7%). Even though the stressors encountered in the receiving countries, strong willingness to adapt and participate in the destination culture was also shown (El Khoury, 2019; Roblain et al., 2017).

4.4 Different perspectives of migration

During the migration process, certain stages can affect some of the migrant populations (Bhugra, 2004). These stages can occur over multiple periods, and future health outcomes could be affected by for example, the risk of acquiring a mental health problem (e.g., depression) for these migrant groups. Thus, adaptation plays an important role in the migration process, from changes and cultural factors (e.g., stress and burdens, language, life events, social support, and expectations) (Bhugra, 2004). Nevertheless, mental health and migration could be examined from the different perspectives of migration theories. Because there are multiple perspectives to approach migration, this section interweaves mental health with other perspectives by exploring mainly the concepts of acculturation, integration, and coping (Berry, 2019; Lazarus & Folkman, 1984). To present a broader meaning of the migrant process, other perspectives are also considered, such as gender roles, intersectionality (Carbado et al., 2013), vulnerability (Birkmann, 2006), and positionality (Andreassen & Myong, 2017; Carling et al., 2014; Dahinden et al., 2021).

4.4.1 The vulnerability approach

Vulnerability is an overused term in the context of refugee groups. The use of the vulnerability term is often debated in the media and in policymaking when referring to refugee groups, which can result in stereotypes, stigma and loss of social identity to those beneficiaries of protection (Goffman, 1963; Mendola & Pera, 2022). Fatalities, injuries, homelessness, and loss of income are human, social, and physical losses often caused by war and conflict (Birkmann, 2006), adding biases to how the vulnerability is labeled. Because of the different perspectives and uses in the migration discourse, this term has multiple definitions and conceptual frameworks. *Vulnerability* is understood as multidimensional, dynamic, scale-dependent, and site-specific (Birkmann, 2006). This term can change over

time as conditions are determined by physical, social, economic, and environmental factors or the processes that determine the susceptibility of a person, community, assets, or systems to the effects of hazards through direct or indirect losses (Gabel et al., 2022).

Vulnerability is considered in this project in terms of how individuals are seen when they are at risk of acquiring a mental health problem as a result of their past and current experiences (Birkmann, 2006). A vulnerability assessment may be based on the likelihood that refugee groups will develop a mental health problem, which could relate to challenges of adjustment and integration in the host country (e.g., low socioeconomic status, social isolation, and a sense of helplessness) (Dalgard et al., 2006). The high prevalence of adult mental health problems (Bhugra, 2004; Scholte et al., 2004), the loss of social status and family relationships, changes in cultural values, are some of the stressors to blame for the risk of vulnerability influencing illness recognition and response (Alemi et al., 2014; Alemi et al., 2016; Birkmann, 2006; Kleinman, 2004). Therefore, understanding cultural patterns may ensure awareness of the migration perspectives and further ensure, for example, appropriate treatment for refugee populations (Alemi et al., 2017; Angel & Thoits, 1987).

4.4.2 Acculturation

The term acculturation is often used in the context of migration and refers to a transitional process (Berry, 2021; MacLachlan et al., 2007). This process involves the discernment of "... beliefs, customs, values, and knowledge of another culture through direct contact with it, usually after migration from one place to another" (Colman, 2015, p. 5). However, during acculturation, a person encounters two cultures, which leads not only to cultural experiences but also to changes in other domains (e.g., social and psychological) (Berry in Bhugra, 2021). These changes, which occur primarily when resettling in the host country, would include migration policies and social services, new places of residence

(temporary housing or refugee camps), and changes in nutrition or disease resistance, among others (Berry in Bhugra, 2021).

In Berry's (2021) model of acculturation, different types of acculturation strategies are identified, which distinguish "… orientations towards one's own group and those toward other groups" (p. 311) (e.g., cultural aspects from the home country and the host country). Berry's (2021) acculturation model includes four strategies: *Integration* (interest in maintaining both the original culture and from the larger society), *Assimilation* (when individuals do not wish to maintain their cultural identity and seek daily interaction with the larger society), *Separation* (avoid interaction with others and hold onto the original culture), and *Marginalization* (neither interest in own's culture nor the host society) (Berry in Bhugra, 2021, p. 312). Early in the migration process, and sometimes without knowing it, migrants adopt, work toward, and use (often for cultural loss enforcement or discrimination) one of these possible strategies during resettlement. These strategies may also have implications for the social and health aspects through the different experiences migrant groups encounter after the resettlement in the host country. The acculturation model from Berry (2021) has also been considered in terms of preferences for whether successful integration has been achieved and how some integrate in the host society and others do not.

Social and cultural aspects such as social discrimination, language, or religion could also be involved. Language for example, is an essential behavioral indicator of acculturation (Bhui & Bhugra, 2007; Meinhof & Galasiński, 2005), such as learning the language of the host-country. Mental health literacy (i.e., migrants expressing knowledge and/or beliefs about specific health topics) can also be considered an acculturation indicator, in terms of getting acquainted with host-country social and health system (Jorm, 2015). However, other indicators such as changes in diet, could be seen as superficial changes among individuals. Furthermore, changes in cultural identity, values, and personality may be more problematic,

resulting in acculturative stress for some migrant groups (Berry in Bhugra, 2021).

Acculturative stress

Acculturation can also refer to adapting and coping with new situations (Shen & Takeuchi, 2001), and the migration process can be viewed as a stressor. Thus, these stressors during post-migration could pose some health risks that may lead to acculturative stress. Riedel and colleagues (2011) spoke of acculturative stress in migrant groups due to the difficulties in the cultural contact while adapting to a new country. Profound changes (e.g., in identity, values, and personality) can be manifested in uncertainty, anxiety, and depression, leading to acculturative stress. Refugees may also experience these changes as they adjust to their new surroundings, even after the effects of forced migration. However, certain cultural aspects in the process (e.g., values and norms) and in the environment (e.g., different climate in the resettling country than in the country of origin) may play an essential role in adaptation by promoting development and growth (Marsella & Kaplan, 2002). This contact with the host country can also function as a change that can influence behavior in a community (e.g., customs, rituals, foods). Consequently, successful in managing these changes can lead to high psychological well-being and positive outcomes. Acculturative stress might refer to unresolved issues due to difficulties in cross-cultural contact that are not easily overcome when adapting to a new society (Riedel et al., 2011). The acculturation model has outlined these factors that may influence people's adjustments to a new cultural context. As refugees experience the profound changes in their lives, the acculturation model helps them to adjust and cope, while understanding the factors that contribute to their acculturative stress.

Adaptation of refugees

Adaptation takes many forms in a sociocultural and psychological context, including assimilation or integration (Berry in Bhugra, 2021) and in terms of diversity and equity

(Berry, 2016). Thus, adaptation is an outcome (which may or may not be positive) referring to the changes that occur in a person in response to the experience of acculturation (Berry, 2021, p. 313). Masgoret & Ward (2006) proposed and validated the concept of adaptation with a social and psychological distinction. These distinctions refer to an individual's psychological well-being (e.g., feeling well determined by personal variables, life-changing events, and social support), while the sociocultural distinctions refer to the ability to adapt to new cross-cultural environments (e.g., doing well determined by cultural knowledge, contacts, and positive intergroup attitudes). Therefore, not having a sense of belonging (i.e., loss of self-identity) could lead to shame and stigma (Anthias, 2012; Goffman, 1963; Pierret, 2003), especially when people have a mental health problem. Mental health services may be stigmatized based on values that may influence help-seeking behaviors in the future. People struggling with a mental health problem may experience adaptation differently.

4.4.3 Integration vs. assimilation

A fundamental approach considered in this PhD thesis is the concept of integration. *Integration* is contested, operationalized, and valued differently across countries (e.g., Alba & Foner, 2014; Berry, 2021; Donato & Ferris, 2020; Doucerain, 2019; Favell, 2019). In the discourse of several European countries, the term integration is often used instead of the term assimilation, while for example, in the United States, assimilation is frequently used when referring to second generations (Alba & Foner, 2015; Alba et al., 2012). As part of the four different acculturation strategies from Berry (2003), integration is a debated concept embedded in the theories and perspectives of migration. Considering the experiences of different migrant groups (e.g., refugees), integration allows for behavioral changes and how these changes shape the individuals (Berry, 2003, p. 27). Berry's conceptual understanding of the integration strategy is also considered from a theoretical standpoint grounded in the adaptation process and cultural maintenance. Not all migrants are

the same when it comes to integration. This study wished to understand integration from theory to practice.

Some migrants, including refugees, may have had similar traumatic experiences (at different points in time), and certain migrant groups may have ethnic similarities to natives, barely visible educational and occupational status, but also religious differences and lower human capital, among other aspects that can pose challenges to the integration process. These aspects may also indicate differences in migrant groups with different status (e.g., refugee or asylum seeker) or other health status compared to the host population (Ekeberg & Abebe, 2021).

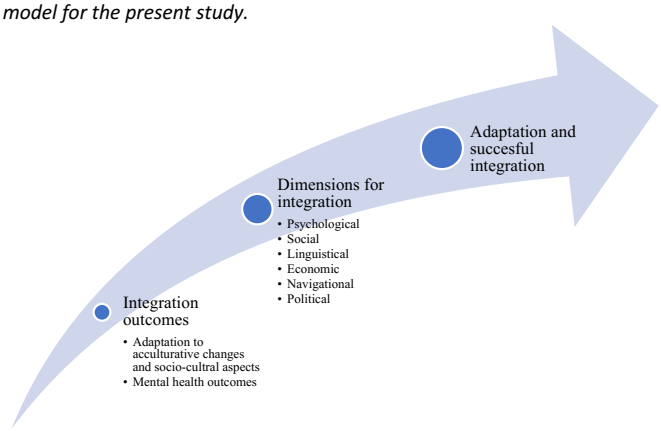
Following Harder and colleagues (Harder et al., 2018b), acquiring integration may also indicate a *successful integration* in the host society, which is determined by "the extent to which migrants have the knowledge and capacity to build a successful, fulfilling life in the host society" (p. 10083). Integration can therefore be measured in multiple dimensions (i.e., psychological, social, linguistic, political, economic, and navigational). For example, the ability to speak the host language, navigate the system, socialize, or find a job, to name a few. These dimensions explain how people successfully integrate into the host society from different aspects. Harder and colleagues (2018b) measured practical outcomes from these dimensions for an individual to achieve a certain level of success when integrating (see Methods and materials section for more information about the integration scale). The concept of successful integration by Harder and colleagues (2018b) is crucial for the theoretical background of this study.

The integration strategy from Berry (2003) is an alternative to acculturation in the host society, an aspect from Harder and colleagues'(2018a; 2018b) that can be measured in multiple dimensions to understand how successful integration is achieved (see Figure 3 for an Overview of the integration model). The following model wishes to illustrate integration

based on the multiple dimensions of integration from Harder and colleagues, encompassing Berry's theoretical aspect of the integration strategy from the model of acculturation. With this model, integration is a process embedded in the perspectives of migration indicating the adaptation with acculturative aspects and changes (e.g., changes in mental health outcomes) that help achieve successful integration in multiple dimensions.

Figure 3.

Integration model for the present study.



Notes: The illustration of the integration model encompasses aspects of the process of adaptation and integration based on the dimensions of successful integration by Harder and colleagues' (2018b) and the theoretical standpoints by Berry's (2021) integration strategy used in this study.

Integration in the Norwegian society

Measuring succesful integration in the Norwegian society often involves access to knowledge and facts with indicators that would help policymakers and professionals in the different areas of the society and the general public. For instance, the Directorate of Integration and Diversity (IMDi) (https://www.imdi.no/) provides an overview of the overall state of integration in Norway. In 2022, IMDi reported indicators of aspects from the Norwegian society such as education, employment, and finances, everyday life encounters and freedom rights, among others, as key to successful integration for migrants, including refugees, living in Norway. Furthermore, the Norwegian Ministries (https://www.regjeringen.no; https://www.imdi.no) have provided information to the public about migration and integration (e.g., migrants in work and education, as well as their living conditions and participation in the Norwegian society) (Migration and integration 2021 report in https://www.regjeringen.no). These reports illustrate the differences and similarities between migrant groups and the rest of the population indicating aspects of integration and quality of life compared to the Norwegian population.

4.4.4 Other indirect perspectives of migration

Gender

It is assumed that mentally healthier people are more likely to decide to migrate and to successfully manage the migration process than any other group (Thara & Raman in Bhugra, 2021). However, in forced migration and fleeing, this may not necessarily be the case. The asylum process can also affect people's mental health, particularly that of women (Gerritsen et al., 2006; Laban et al., 2004; Shameran Slewa-Younan et al., 2017). Negative experiences had a stronger impact on gender inequalities than other aspects of migration (e.g., lack of social support). Asylum seekers and refugee women have been diagnosed with depression

and PTSD more frequently than men, suggesting gender differences in mental health problems among these migrant groups (e.g., Ekblad & Hollander, 2011; Hollander et al., 2011; Humphris & Bradby, 2017). Compared to male refugees, female refugees from low-income countries were at a higher risk for mental health problems when moving to a high-income country (Hollander, 2013). Studies have also shown that refugee women are more likely to purchase psychotropic drugs than non-refugee women (Hollander in Thara & Raman, 2021). Another study (Blight et al., 2006) had also shown that having a job improved men's health, in contrast to women who had access to the labor market activities (e.g., employed or actively seeking employment) and lived in urban areas. Regarding gender gaps, refugee women from Afghanistan, for example, had lower workforce participation in their home country than in the host country (seen in data from EU countries and Scandinavia) (Liebig & Tronstad, 2018). This gender gap could indicate different social challenges in the acculturation process (Ramirez et al., 2018), benefiting the integration of women in terms of labor market activity in the host country.

Social and behavioral aspects can also be seen in the traditional and cultural backgrounds of the study population. For example, Afghanistan, as a collective and patriarchal society, women's role may differ from the men's (e.g., marrying at a very young age, no access to educational participation) (Entezar, 2007). Different paradigms could be incorporated in different dimensions to support the gender perspectives of migration in this thesis. For instance, social paradigms that exclude women in the society, such as seeing men as the breadwinners or decision-makers (Anthias, 2012). Agency could also be related for example, to the inner action and developing motivation, for both women and men, after resettling in the new country (Anthias, 2012; Deci & Ryan, 1991).

Intersectionality and positionality

Other migration perspectives reflected in this PhD thesis were the concepts of intersectionality and positionality. *Intersectionality* is rooted in inequality and unequal power relations and, as a sociological theory, describes how a person may face multiple types of intersecting discrimination (e.g., in terms of gender, age, ethnicity, physical activity/ability, class, or other characteristics that make them worse off than their peers) (Andreassen & Myong, 2017). The concept of intersectionality refers to various aspects of identity and social systems interacting with one another and relating to inequality, such as racism, classism, or sexism (APA, 2020, par. 401). People belong to a variety of social groups, and structural inequalities can lead to marginalized identities (e.g., immigrant status, religion, ethnicity, socioeconomic status, among other variables) (APA, 2020). *Intersectionality* refers to how social aspects such as ethnicity, religion, class, and sexuality interact to affect people's lives and circumstances (Carbado et al., 2013; Crenshaw, 1990; Crenshaw, 2017). For example, viewing migrants and refugee groups as homogenous, rather than providing specific supports to meet their needs, based, for example, on age and disabilities, among other factors (Tribe & Jalonen, 2021, p. 284). Being affected, for example, by discrimination can be contextualized by the experiences encountered during the migration process and hinder communication with others (e.g., not receiving the necessary information or barriers associated with certain mental health problems). Refugee groups for example, should be seen as a heterogeneous group with the purpose of providing the necessary support (Patel et al., 2018).

On the other hand, *positionality* in migration research focuses on the characteristics of the researchers' meanings and practical aspects of the research process (e.g., in data collection and analysis), particularly in qualitative studies (Carling et al., 2014). Furthermore, when considering the issue of positionality from the perspective of migration

theories, some of this study's considerations were represented in gender roles. For instance, the position the study population holds and the role in the new society, female representation, or the researchers' point of view. See personal reflexivity regarding positionality in Materials and methods Chapter.

4.5 The conceptual understanding of mental health problems

According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (2019), *mental health problems* is a general term that refers to mental illness or mental disorders. The latest version of the ICD-10 (2019) defines depressive disorders as mild, moderate, or severe episodes of depression associated with decreased interest, pleasure, energy, and activity. A cultural conceptualization of the condition describes how people understand, experience, and communicate their symptoms or problems (American Psychiatric Association, 2013; WHO, 2019). This conceptualization includes cultural syndromes, idioms of distress, and explanatory models, and understanding a person's cultural reference group may help assess the severity and meaning of certain distressing experiences. For example, when assessing help-seeking patterns by using traditional alternatives or other complementary sources of care (American Psychiatric Association, 2013). Causal knowledge and beliefs about depressive and traumatic episodes have been associated with treatment preferences and treatments without cultural sensitivity (Hagmayer & Engelmann, 2014; Mobashery et al., 2020). For instance, mental health problems that are viewed from a Western perspective (e.g., following a deductive approach, dividing health from disease). In contrast to an Eastern perspective (e.g., following an inductive approach, health as a balanced state and disease as unbalanced) (Krendl & Pescosolido, 2020; Tsuei, 1978; Unschuld, 2009). Thus, the sociocultural aspects and clinical characteristics used in the host society may play an essential role when identifying

mental health problems, in addition to the high stigma toward individuals with mental illness from Eastern and Western countries (Cheng, 2015; Cheon & Chiao, 2012; Mirza et al., 2019). Some of these characteristics are also referred as cultural, influencing future treatment decisions (Angel & Thoits, 1987; Kleinman, 2004). Therefore, understanding the meaning of illness from other cultural perspectives could ensure appropriate treatment for different groups in the population, such as refugees (e.g., Alemi et al., 2017; Angel & Thoits, 1987). For refugee groups who have experienced grief, trauma, or negative situations, *depression* and *post-traumatic stress disorder* are the mental health problems that formed the backdrop for this project.

4.5.1 Assessing PTSD and depression

This PhD thesis has used the definitions of post-traumatic stress disorder (PTSD) and depression from the ICD-10 (WHO, 2019) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013), respectively, as mental health problems, and are defined as follows:

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder (PTSD) was first defined in 1980 (APA, 1980), referring to individuals who have been exposed to traumatic events and exhibit a particular pattern of psychological phenomena. A traumatic event is different from other types of stress in life, and therefore, people respond to situations in which they are seriously threatened with, such as death or injury, fear, horror, and helplessness (Reyes et al., 2008). This traumatic experience can lead to intrusive and recurrent symptoms, persistent avoidance, and negative mood alterations (American Psychiatric Association, 2013, p. 271). Depending on the nature of the traumatic event, the severity of PTSD may vary across cultural groups in terms of the impact of the disorder, the significance of the traumatic event, and other cultural

factors such as acculturative stress, religious persecution, and cultural variations of symptoms (e.g., idioms of distress).

Depression

The concept of *Depression* is referred to as clinical depression and major depressive disorder. Depending on the severity of the depressive episode, depression is specified by different codes (e.g., mild, moderate, or severe) (DSM-V) (American Psychiatric Association, 2013). The diagnostic criteria include five or more depressive moods (e.g., feeling sad, empty, hopeless) or loss of interest and pleasure symptoms within a two-week period (American Psychiatric Association, 2013, p. 160). Other disorders that often accompany depressive disorders can also include substance-related disorders, panic disorders, and obsessive-compulsive disorders (American Psychiatric Association, 2013). Awareness in most countries suggests that cases of depression may go unrecognized, especially with somatic symptoms in primary care.

4.5.2 Mental health of migrant populations

The proportion of migrants with high levels of mental health problems is on average higher than in the general population, and post-migration factors and perceived discrimination may significantly affect the mental health of these groups (Straiton et al., 2019). The risk of developing a mental health problem may be related to for example, acculturative stress, poor socio-economic conditions, lack of social support, or negative experiences (e.g., past trauma and negative life events) (e.g., Abebe et al., 2014; Bekteshi & Kang, 2020; Carroll et al., 2020). For certain migrant groups, barriers are more likely to exist (e.g., lack of access, time, and information, and difficulties understanding and navigating the healthcare system (Mobashery et al., 2020).

Research has shown a link between migration and mental illness, with high prevalence of mental health problems in adults such as depression and post-traumatic stress disorder

(PTSD) (Bhugra, 2004; Mobashery et al., 2020; Scholte et al., 2004). The Norwegian Institute of Public Health (2017) found that refugees from war-affected areas reported more mental health problems than the general population. Furthermore, 64% of refugee patients that were exposed to previous trauma had both PTSD and a major depressive disorder; and 80% of those with PTSD had three or more different diagnoses (Teodorescu et al., 2012). Prevalent factors, such as unemployment, education, and weak social networks, were also related to increasing comorbidity among refugees (Im et al., 2020; Momartin et al., 2004; Teodorescu et al., 2012). Stressors in the migration process that might be associated with depression often include loss of family and loss of cultural values due to displacement, playing also a significant role (Alemi et al., 2014; Qais Alemi et al., 2016; Kleinman, 2004). In this case, refugee groups are often affected by the stressors and therefore considered an at-risk group for mental health problems (Coelho et al., 1980; Kienzler & Sapkota, 2020; Kurt et al., 2021).

Health beliefs

This study is premised on conceptualizing that scientific knowledge is culturally "situated" (Haraway, 1988; Reiter, 2017). Interpretation of culturally situated knowledge must always consider the society in which it is produced (Caretta, 2015; Haraway, 1988, 2020). Culture and language can significantly affect how a patient interprets "depression" or "mental illness" (Blackmore, Gray, et al., 2020; Leff, 1977). Therefore, prior beliefs that traumatic experiences negatively impact health have been shown to influence health ratings, symptom severity, and health outcomes (Dunmore et al., 2001; Frazier et al., 2001). The concept of mental health problems might be recognized by understanding past trauma, with the value of cultural interpretation through for example, emotional terminologies and meanings of suffering. For instance, some beliefs in the role of religious or cultural

influences could inform further treatment (e.g., by social support, taking precautions, or with religious ties some refugee groups rely on) (Alemi et al., 2014; Bemak et al., 2003).

Discrepancies in understanding cultural beliefs about mental health may hinder the recognition of mental health problems in patients from other cultures, leading to misdiagnosis and treatment errors. Therefore, knowledge and perceptions of mental health problems are embedded in people's worldviews (De Jong & Hinton, 2018), which can be viewed with the help of explanatory models.

Mental health literacy and idioms of distress

Cultural idioms of distress are expressions of distress that do not necessarily involve specific symptoms or syndromes but represent collective and shared ways of experiencing and speaking about personal or social concerns (American Psychiatric Association, 2013, p. 758). For example, when people talk about "depression" in everyday life, may be referring to very different forms of suffering without assigning them to a specific group of symptoms, syndromes, or disorders. Forms of expression are related to cultural values, norms, and health concerns, and can vary across cultures (Hinton & Lewis-Fernández, 2010; Kleinman, 1980; Nichter, 1981). Nichter (1981) defined *idioms of distress* as different ways to express distress. Cultural explanations or perceived causes are often followed by labels, attributions, or features of an explanatory model that indicate the culturally accepted meaning or etiology of symptoms, illnesses, or conditions (American Psychiatric Association, 2013, p. 758). Therefore, idioms of distress must also be considered in a social context and not just as a psychological process (Alemi et al., 2017; De Jong & Van Ommeren, 2005; Nichter, 1981). Idioms of distress and perceptions of mental health problems may be influenced by the challenges faced by some refugee groups, for example. A population group may have linguistic connotations of a pathogenic nature to understand the impact of certain trauma experiences (Wilson & Drožđek, 2007).

In the case of Afghanistan for example, stories and metaphors are culturally appropriate to communicate about a situation. One of the two main languages of Afghanistan is Dari. Health in Dari means *whole* (Shorish-Shamley in Bemak et al., 2003). Bemak and colleagues (2003) noted that the traditional view of good health is based on the interrelationship between purity and impurity. Differences in idioms of distress may also be evident in how people within their own culture express their suffering (Hinton & Lewis-Fernández, 2010). For instance, there are several idioms of describing distress among Afghans, such as *jigar khun*, "bloody liver," which occurs after a very painful event in a person's life or after chronic stress, or *fishar* with "very low energy or motivation" (De Jong & Hinton, 2018; Hinton et al., 2015; Miller et al., 2006). In addition, some idioms among Afghans describe *waswasi*, such as “thinking a lot”, “constant worry”, *whami*, “unreasonable anxiety and frightening dreams”, and *peyran*, “being possessed by ghosts”, among others, with a variety of somatic complaints. These idioms may be related to PTSD symptoms and depression (De Jong & Hinton, 2018; Miller et al., 2006; Ventevogel, 2016). Given the lack of literature and studies on mental health literacy (Jorm, 2000; Slewa-Younan et al., 2014) among certain refugee groups, understanding the knowledge and perceptions about mental health problems is essential. Previous studies have shown that mental health services, when adapted to ethnic minorities, have a positive impact (Bhui et al., 2015; Bhui & Bhugra, 2002).

4.5.3 Explanatory models

To acquire an understanding of cultural patterns, idioms of distress, and mental health problems, this doctoral project focuses on the concept of explanatory models. An explanatory model for any illness is often influenced by education, cultural values, past experiences, and age, among other factors (Weiss in Bhugra & Bhui, 2018). Several instruments used to assess an explanatory model often follow a structure of cultural and

health aspects, for example, with the beliefs individuals hold about suffering and misfortune (Dinos et al., 2018, p. 106). The concept of an explanatory model was developed as a clinical application of an anthropological concept that includes information about lay beliefs about illness, illness narratives, perceived causes, and treatment (Good, 1986; Kleinman, 1980).

The main concept of explanatory models for this study comes from Kleinman (1980), which is defined as "notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (p. 5). Theoretically, this project draws on including ideas about how people understand illness and view their medical history, the cause of illness, and further treatment (Kleinman, 1980; Littlewood & Lipsedge, 1997). In this study, an explanatory model demonstrates the importance of asking about patients' explanations for symptoms and suffering of mental health problems.

An explanatory model can also explore ethnic differences, for example, from different stress patterns, causes or even stigma associated with illness (Dinos et al., 2018; Weiss & Somma, 2007; Weiss, 2018). Explanatory models used in a psychosocial context wish to follow a structure of cultural meanings bridging the gap between theory and empiricism (Dinos et al., 2018). This way, an *emic* approach could assess the phenomenon from within the cultural contexts through variations of perceptions and interpretations of suffering (Cheon & Chiao, 2012; Dinos et al., 2018; Patel, 1995; Pereira et al., 2007), resulting in conceptualizing mental health problems differently and patients seeking different treatments (Spoont et al., 2005) (See Chapter 5, section 5.2). Therefore, patterns of distress and perceived causes, illness-specific issues, help-seeking behaviors, and general health beliefs can be used to understand how patients perceive mental health problems from medical, psychological, and cultural perspectives in explanatory models (Weiss, 1997). However, common confrontations in a cross-cultural context are evident, for example, in the

relationship between the patient and the health care system. Table 1 provides an overview of common confrontations that patients and healthcare providers may encounter.

Table 1

Overview of the intercultural communication among health care providers and the patient

Health care provider	**Patient**
Noticing differences: *"Oh my god, I've never had a patient from this culture!"*	Noticing differences: *"It's the first time I am referred to a psychotherapist!"*
Sees patient as stereotype: *"Oh, I see now, I have been taught that this is a common behavior in people from this culture!"*	Fears of being judged: *"My God, I hope he's not judging me by the culture I am from."*
Shows anxiety and frustration: *"I'm aware that I'm not handling this situation correctly and it's worrying."*	Shows anxiety and frustration: *"What a pity that I'm obliged to follow a treatment that I don't believe in."*

Notes: This overview illustrates some examples when confronting differences and similarities of cultural representations of mental health problems and different phases of intercultural communication. From Bennegadi's (2021) therapeutic framework in *Mental illness and migrants in Europe* (pp. 80-83).

One of the proposed solutions is cultural mediation, a practiced intervention that helps avoid these confrontations and bridge the knowledge between explanatory models (Bennegadi, 2021, p. 83). Understanding these aspects can maximize mutual understanding. In Norway, some studies have been conducted to better understand this from the GP's perspective (e.g., Czapka & Sagbakken, 2020; Harris, 2022; Mbanya et al., 2019) and teach refugee groups about cultural and social aspects of Norwegian society (e.g., Introduction program) (IMDi2019). Therefore, the importance of cross-cultural communication could be in the explanatory models of mental health problems, which could contribute to further improvement of mental health care.

Further considerations

A therapeutic framework could be derived from the explanatory models of mental health problems that underpin initiatives to improve mental health care for migrants and refugees. For example, a cultural consultation service (CCS) established by Kirmayer (2003), wished to bridge the cultural gap between health care providers and migrant groups.

Through this method, patients can better understand the treatment process, receive health services tailored to their needs, and benefit from better overall experiences and treatment outcomes (Bennegadi, 2021). Often, cultural differences can complicate patient care, whether in diagnostic assessment, treatment planning and adherence, or most importantly, the doctor-patient relationship (Bennegadi, 2021). CCS tries to assess patients' narratives and experiences in a cultural context using interpreters and cultural mediators through the clinical assessment. In addition, this method can help bridge the cultural gap between patient and clinician, leading to improved communication and better health outcomes through cross-cultural communication and cultural competency training (Bennegadi, 2021). Furthermore, this relationship could also be related to mediating stressors and symptoms in other ways.

The World Health Organization (WHO) (2016) has developed Problem Management Plus (PM+) as a low-intensity psychological intervention for refugee groups. When adapting Problem Management Plus (PM+) to a local context, symptoms and functioning can be assessed at baseline, six months, and one year later when this program is implemented (Coleman et al., 2021; WHO, 2016). This communication service program is newly introduced in Norway (e.g., by official organizations dealing with refugee health, such as the Center for Migration Health in Bergen)[3] to conduct a cultural adaptation of this program to the target population (e.g., refugee groups) before implementation. This adaptation will identify the characteristics of the local population based on previous literature, focus group discussions with individuals familiar with the culture of this group and their current situation (e.g., health workers and refugee professionals) (Perera et al., 2020). Understanding cross-cultural communication is essential to providing effective mental health care (Bennegadi, 2021; Bhawuk et al., 2006; Kirmayer et al., 2003).

[3] Center for Migration health (SEMI) is a municipal health service for asylum seekers, family reunification of refugees, and newly arrived refugees. https://www.bergen.kommune.no/omkommunen/avdelinger/senter-for-migrasjonshelse. Accessed 18th of January 2023.

4.6 How to manage mental health problems

"When you are refugees, the whole world cares for you – but I don't want it. I want my tiny apartment. I want my job that I don't like. I want to see my boss. I want to spend two hours every day on the metro. I want to be tired. I want to do homework with my children…All the things I hate – that's what I want."
Inna Blahoravina, a refugee who fled Kyiv with her young daughters. The New Yorker.

4.6.1 Coping as a theory

Coping is a central concept in psychological stress theory (Krohne, 2002). Lazarus and Folkman (1984) most influential model of psychological distress defined coping as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of a person" (p. 141). The coping process consists of various elements that a person may use to manage a stressful situation. How people prefer to respond to or deal with mental health problems, such as seeking help or finding their own ways of treatment, are referred to as coping strategies (Lazarus & Folkman, 1984). This coping perspective focuses on how one deals with psychological distress by using skills and strategies to manage a difficult situation. Individuals broadly distinguish between problem-focused coping (i.e., attempting to change the person's negative emotions) and emotion-focused coping (i.e., internally reducing a negative emotional state) (Lazarus & Folkman, 1984). For instance, confronting or avoiding seeking support and making changes after stressful situations.

Although various coping elements have been considered, Lazarus & Folkman's (1984) definition of coping has served as the theoretical framework for this project. As part of other coping theories (Krohne, 2002; Kuo, 2011; Skinner et al., 2003), other measure scales such as the Ways of Coping Questionnaire (WCQ) (Folkman et al., 1986), the Cross-Cultural Coping Inventory (CCCI) (Tobin et al., 1989), and the COPE scales (Carver, 1997; Carver et al., 1989) among others, have been evaluated to help develop parts of the survey used in this PhD thesis (see Chapter 5, section 5.3.2 and 5.3.3).

Sometimes not all coping scales can be useful for the different aspects of society; for example, scales in different languages with standardized questions directed to different population groups (e.g., refugee groups). Different events such as the migration process and cultural aspects of some population groups may bring out different responses; therefore, reflecting on perceptions and interpretations of certain groups should be considered. This way, some standardized coping scales may measure coping by showing different preferred strategies from the different groups within a society. For instance, one could relate coping to psychological distress and the integration process in a host society.

Regardless of previous mental health status, coping can also affect the well-being of individuals, when specific demands exceed a person's resources affecting their mental health (Folkman et al., 1986; Lazarus, 1966). For instance, people with poor mental health may use different and less effective strategies than those with better mental health (Aldwin & Revenson, 1987). However, specific coping patterns and behaviors may often be encouraged, rewarded, and considered appropriate in some cultural settings but not in others (Yeh et al. in Wong & Wong, 2006). In the case of refugee groups suffering from mental health problems, some of these resources may be affected by previous traumatic events, violent scenarios, and the social challenges encountered in the resettlement country. Therefore, adaptation and acculturation aspects might also be essential for coping (Ward in Kuo, 2014).

4.6.2 Implications of measuring coping instruments

Many of the existing coping scales are often oriented toward problem- and emotion-focused coping behaviors (e.g., Carver, 1997; Dias et al., 2012; Eisenberg et al., 2012; Folkman & Lazarus, 1988; Poulus et al., 2020; Tobin et al., 1989) rather than culturally specific coping practices, sources, or attitudes (Yeh et al. in Wong & Wong, 2006). For instance, some orientations may differ from previous coping models and measures, such as

collective coping strategies or in analyzing the effectiveness of coping behaviors in terms of underlying specific cultural beliefs, values, and orientations (B. C. Kuo, 2013; Yeh et al., 2006). Nevertheless, some coping strategies may follow a collectivistic approach addressing behaviors from a cultural orientation of collectivism (Hofstede, 2011; B. C. H. Kuo, 2013; Schwarz, 2006). Previous studies in Norway have indicated this aspect by seeking social support and other preferred treatments within migrant and refugee groups (Brea Larios et al., 2022; Erdal et al., 2011; Markova & Sandal, 2016; Aarethun et al., 2021). Some health outcomes can, however, be adversely affected by the preferred coping strategies.

5. Materials and methods

The starting point for the mixed-methods approach in this study is the concept of explanatory models for mental health problems and symptom management among refugees in Norway. Detection and treatment of illness can be effective when the cultural context of the illness experience is understood (American Psychiatric Association, 2013). Based on previous research on different migrant groups (e.g., refugee groups at risk of developing mental health problems, difficulties in integrating into the host society, and/or lower utilization of health services, among others), focus group interviews were chosen for the qualitative part of the study with the focus to identify the explanatory models for PTSD and depression among Afghan refugees living in Norway.

In response to concerns that perceptions of mental health problems in countries affected by conflict zones may hinder effective treatments for some refugee populations, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (2013) was revised. As a result, the DSM-5 incorporated the cultural concept of burden to distinguish cultural factors contributing to mental illness, including cultural explanations and idioms of distress. Nevertheless, people's explanations for illness and preferred treatments are still difficult to discern. Therefore, a qualitative method was the backdrop for this study.

Furthermore, two vignettes were developed and used in the focus group interviews, one vignette displaying a character with symptoms of PTSD based on the International Classification of Diseases and Related Health Problems (ICD-10) (WHO, 2019), and another vignette displaying symptoms of depression (DSM-5) (APA, 2013). Participants discussed possible causal factors and solutions to the situation of the vignette characters. Findings revealed participants' perspectives of migration and coping strategies that addressed the social causes of mental health problems and risk factors that might affect refugees in these situations.

As part of the mixed-methods approach, this project also used a quantitative study to discern certain aspects of refugees' integration and coping strategies with mental health problems in the host society. With an online survey based on standardized questionnaires from different scales in the quantitative component, the relationship between psychological distress (i.e., anxiety and depression) (HSCL-25) (Derogatis et al., 1974) and integration (Harder et al., 2018b), was explored, as well as looking into refugees' ways of coping (Carver, 1997) with mental health problems in Norway.

The combination of the qualitative and quantitative research components attempts to give meaning and sequence to the mixed methods approach that will strengthen the contribution to this study (Schoonenboom & Johnson, 2017) (see more detailed information in sections 5.2 and 5.3).

5.1 Research study design

This PhD thesis follows a qualitative driven nested mixed methods design (Hesse-Biber & Johnson, 2015) consisting of mixing qualitative and quantitative methods carried out as separate studies within the same research project. In both the qualitative and quantitative phases, this study explores how theories and assumptions can be used to discover and support the main research questions. The main component of this project is the topic of migration and mental health problems among refugee groups in Norway, specifically PTSD and depression, with the attempt to answer the research questions.

The project encompasses a theoretical framework that includes an umbrella term for theories related to explanatory models of illness narratives, acculturation, and coping strategies for mental health problems. The qualitative part of the study will attempt to shed light on the participants' subjective experiences. This way, the social reality of the assumptions is based on subjective meanings that will contribute to the formation of the

knowledge component (Hesse-Biber & Johnson, 2015). The quantitative study will attempt to increase our knowledge of the study population based on the research questions and the results of the statistical data.

5.1.1 Mixed-methods study design

The mixed-methods approach in this study is characterized by an initial phase of qualitative data collection and analysis, followed by further quantitative data collection and analysis (Fetters et al., 2013), resulting in three articles. Article one covered the qualitative portion of the study, while articles two and three covered the quantitative component (see articles in the dissertation appendix). All three articles were analyzed separately using a study design framework (Fetters et al., 2013). The idea of a mixed-method study design was to explain, explore, and interpret a phenomenon to develop and test a new instrument addressing questions and theoretical perspectives at different levels (Fetters et al., 2013).

This mixed-method study design is driven sequentially (i.e., qual - QUAN – QUAN) *"... by having one study follow and build on the next"* (Hesse-Biber & Johnson, 2015, p. 10), attempting to explore a phenomenon that enhances both the qualitative and quantitative data of the study (see Figure 2). This approach aims to explore and support the research questions based on the theories and instruments used in this study's qualitative and quantitative phases (see Figure 4 for an overview of the mixed-method approach). A qualitative driven approach focusing on identifying explanatory models of mental health problems (Kleinman, 1980) and a quantitative component to explore and examine the aspects of integration with psychological distress and coping strategies (Carver et al., 1989; Derogatis et al., 1974; Harder et al., 2018b; Tobin et al., 1989). The data for both components were assembled in different phases (focus groups interviews and standardized questionnaires); therefore, this mixed-methods study is an *exploratory sequential study design* (e.g., deductive, sequential, exploratory, multiphase study) with an initial phase of qualitative data collection and

analysis followed by another phase of quantitative data collection (to develop an instrument) and analysis (Fetters et al., 2013; Schoonenboom & Johnson, 2017).

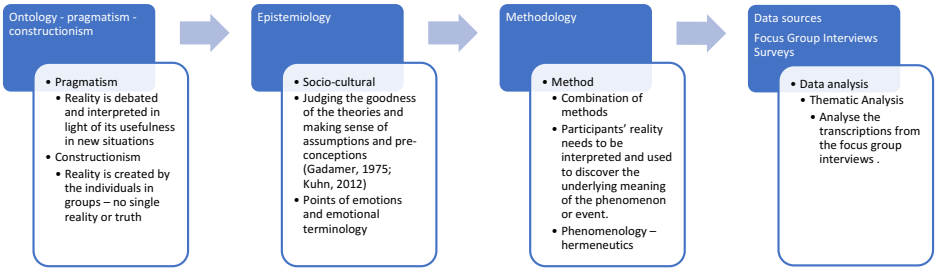
5.1.2 Ontology and epistemology

The hermeneutic phenomenology of this study follows the process of our own interpretations of the world and the daily representations of truth that we see through our values making sense of our own experiences (Ho et al., 2017; Van Manen, 2014). By describing and interpreting the lived experiences and perspectives of the population studied, the phenomenological process can be used to understand the social reality and phenomena. The results of this study may have significant implications for the epistemology and ontology of psychology, as qualitative and quantitative approaches view social reality differently, whether they are multifaceted (in terms of subjectivity) or concrete (finding certainty in the objective) (Hesse-Biber & Johnson, 2015). In the field of psychology, coping mechanisms and mental health treatments in Norway may emphasize the importance of people's subjective experiences and seek to understand the constructions individuals have of reality. The critical ontology underscores the concern to identify explanatory models for mental health problems (e.g., depression and PTSD) among some refugee groups in Norway and consider the cultural assumptions, health literacy (or lack thereof), and cultural knowledge of the different group populations and their needs (Braun & Clarke, 2022). This study's ontological and epistemological assumptions focused on the subjective form, the social process and factors that may influence the phenomenon investigated (understanding the phenomena from the perspective of the study population) (Braun & Clarke, 2006; Yilmaz, 2013). With the help of thematic analysis, main themes of knowledge and interpretations of depression and PTSD from the study participants can be identified. This method may have difficulties in establishing an epistemological focus, still, theories based on exploratory models (Kleinman, 1980) were adaptable and flexible in developing more

knowledge and making assumptions consistent with the research questions and the methodological approach (Smith, 2015). See Figure 4 for an overview of the ontology and epistemology process of this study.

Figure 4

Ontology and epistemology process of the mixed-method approach of the study.



5.2 Qualitative research: Study 1

The qualitative component of this project follows a hermeneutic phenomenological approach that explores various theories and concepts regarding knowledge and perceptions of mental health problems (e.g., depression and PTSD) in our study population. To interpret our phenomenon, thematic analysis (2006) was the chosen strategy.

The theoretical framework of this study suggested that individuals often understand and handle mental health problems with a former knowledge of the subject in terms of their health beliefs and cultural aspects. The phenomenological approach focuses on different concepts and theories regarding the perceptions and knowledge of mental health problems from the perspectives of the study population (see section 3). Theoretically, this study is based on Kleinman's (1980) concept of explanatory models, which focuses on a layman's views of illness within illness narratives, perceived causes, and treatment. The qualitative

approach can test ideas and assumptions, such as the explanatory model identified that was generated from the ongoing data collection. The qualitative study in the PhD project investigated the Afghan population residing in Norway.

5.2.1 Sampling and procedure

The eligibility criteria for the qualitative data collection of this study consisted of Afghan adults residing in Norway over the age of 18 attending the Norwegian Introduction program.

Instruments and participants of the qualitative study

The recruitment of the participants was done with the help of Norwegian municipalities. Invitations and information about the research project were sent out to recruit participants that were attending the national Introduction program in Norway. Afghan adults attending the program from the educational centers in two regions in Norway (e.g., *Vestland* and *Agder*) were invited to participate.

Focus groups were used with semi-structured interviews, an interview guide, and two vignettes as instruments in the research design for the qualitative part of this study. These instruments were chosen for the participants to defend and discuss their perspectives of the study phenomena in a safe setting, which helped gather data with higher ecological validity (Cyr, 2019; Willig & Rogers, 2017). These instruments also helped the study explore issues that were potentially difficult to discuss; thus, with a vignette, participants could engage in a discussion involving the sensitive topic from a non-personal to a less threatening perspective.

Participants were given semi-structured open-ended questions from an interview guide asking them to discuss the situation of the vignette characters. The participants could relate to the vignette character with someone they knew – such as a friend or a family member. Other questions related to gender differences, mental health views, and other social

factors, both in Norway and in Afghanistan, were contemplated. The interview guide was modified based on questions previously developed by Kleinman (Kleinman, 1980; 1973) and Lloyd and colleagues (1998) to elicit explanatory models (see interview guide in Appendix 2).

A total of six focus groups (FGIs) were conducted with two to six participants, separated by gender (i.e., males and females). A single individual interview also occurred due to the absence of the remaining participants in one FGI. Data from the individual interview was removed from the study analysis and only used as a single perspective and background for the focus group interviews.

Focus group interviews

As a qualitative data collection method, a focus group is a *"research technique that collects data through group interaction on a topic determined by the researcher"* (Morgan, 1996, p. 130). When using focus groups instead of individual interviews, participants engage in a discussion moderated by the researcher and asking questions to keep the discussion flowing among the group participants (Smith, 2015). Focus groups are a more natural communication process to understand how participants individually process their perceptions and contexts from other experiences (Willig in Cooper et al., 2009). Using groups as a data collection tool helped the study reveal what participants think and why they think about the researched phenomenon. According to Willig (2008), a key challenge was to find data collection methods that would *"encourage participants to express themselves as freely and openly as possible"* (p. 12). The study followed an *emic* approach that started from the participants' cultural context to understand meaning and connection with other cultural elements (Patel, 1995), with participants defending their perceptions in a safe environment that helped collect data with transparency (Cyr, 2019; Willig, 2008; Yilmaz, 2013). Cultural interpretations (e.g., layman's views of mental health problems, perceived causes, and

treatment) were considered, consistent with the emotional terminology used in explanatory models for depression and PTSD. Nevertheless, some preparation was made beforehand, as a sensitive topic is discussed among participants who do not know each other. Follow-up questions were asked for the participants to respond and discuss their perceptions and approach to the situation. This part of the study attempted to shed light on the participants' subjective experiences during the focus group discussions.

Vignettes

This study's vignettes (see Appendix 4) were used to stimulate discussion among participants during the focus group interviews. In focus group interviews, a vignette creates an appropriate environment for sharing ideas about sensitive topics. In addition, vignettes can serve as a discussion starter for individuals from different backgrounds if the topic is considered personal or sensitive (Barter & Renold, 1999). The vignettes used in this study included a character situation in which an attempt was made to portray the personal issues and experiences of a hypothetical person suffering from a mental health problem. The vignette sought to distance itself from the sensitive topic so that participants could engage in the discussion without feeling personally exposed or triggered.

Each vignette described a story with a realistic example of a person exhibiting symptoms of PTSD and depression according to ICD-10 (2019) and DSM-5 (2013). The vignette with depression symptoms was refined and developed based on a vignette used in previous studies with migrants (Erdal et al., 2011; Markova & Sandal, 2016). The PTSD symptoms vignette was also refined based on a vignette used in another previous study (Yaser et al., 2016). The vignettes used in the focus groups for this study described an Afghan person named either Mossa (male) or Zarina (female) to facilitate the identification of the study participants (the gender of the vignette character matched that of the participants) (see vignette in Appendix 4). Two FGIs were based on a PTSD vignette

character and four FGIs were based on a depression vignette character. The individual interview was based on the PTSD vignette character.

The use of a vignette in this study explored topics that might have been difficult for participants to discuss and allowed participants to address a sensitive topic from an impersonal and less threatening perspective. After reading the vignettes and followed by an interview guide, participants answered questions about the situation of the vignette character. Participants were not encouraged to report their behavior but to indicate what they would advise the vignette character to do. However, the vignettes allowed participants to portray their perceptions and meanings concerning the vignette character's situation, taking into consideration gender, traditional, and cultural aspects of the study population (Gray et al., 2015). Furthermore, participants helped identify solutions, such as different strategies and appropriate treatment for the vignette characters.

5.2.2 Thematic analysis

Participants' perceptions were the focus of this qualitative research study. The study used a qualitative, descriptive-interpretive design incorporating a theoretical framework and flexible analysis to guide the explanatory models. The thematic analysis in this study tried to make sense of the information from the data collected and get an overview of the main themes from the focus group interviews.

Data were analyzed using the thematic analysis method by Braun & Clarke (2006; 2022) to identify and interpret the data collected in a flexible manner by coding responses into themes and categories. Followed by a deductive and constructivist approach and operated within a critical relativist framework with the purpose of capturing truth. The thematic analysis allowed exploring the participants’ social perspectives and subjective meanings surrounding the vignette characters' situations and the realities expressed in the

dataset (Braun & Clarke, 2006; Braun et al., 2019; Saldana, 2009; Smith, 2015). An analysis is always influenced by the researcher's theoretical assumptions, disciplinary knowledge, and training. The thematic analysis identifies patterns and themes in a data set to gain insight. To better understand the data, themes are coded and developed to analyze the existing theoretical concepts.

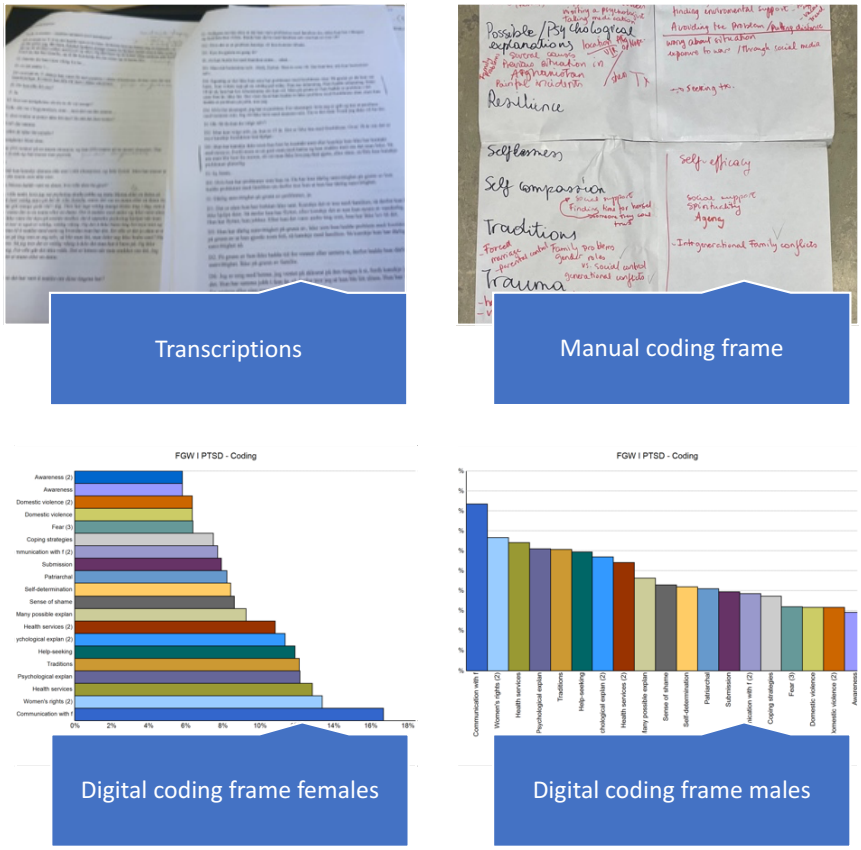
Thematic analysis is “an accessible and robust method for developing, analyzing, and interpreting patterns across a qualitative dataset, which involves a systematic process of data coding to develop themes” (Braun & Clarke, 2022, p. 4). This qualitative study used this approach to identify people's experiences and knowledge from qualitative data collected (Braun & Clarke, 2022). The analysis process in this study started with all interviews being transcribed verbatim from the audio and video recordings by the doctoral candidate and revised with a research assistant. The coded data were reviewed and discussed with the research collaborators to determine the fit of the potential themes. Transcripts of the focus group interviews were analyzed, and themes were identified, marking categories from Norwegian to English. All transcriptions were modeled separately by the researchers involved. The data were coded and managed manually and with the software program NVivo12 (2018), organizing the data into main categories as a coding frame (Attride-Stirling, 2001; Braun & Clarke, 2006).

The thematic analysis focused on different aspects of the Afghan participants' knowledge and perceptions of mental health problems (e.g., PTSD and depression) making sense of the shared meanings and experiences. The deductive approach allowed the process to code and develop themes based on the theoretical concepts. The coding rounds focused on the interview content including possible explanations and refinements of the themes. Preliminary codes were assigned to the data to describe the content. The coding rounds yielded underlying themes that led to global themes (Attride-Stirling, 2001), establishing

coherence among multiple codes. The coding frame was elaborated, revised, and modified, adapting (new) themes and subthemes, and the data were read several times. Patterns in the different interviews were searched for, and these aspects spoke to possible conceptualizations and created different categories. See Figure 5 for an overview of the coding frame process both manually and digitally.

Figure 5.

Overview of the coding frame process



Notes: The coding frame was conducted manually and digitally with the software program NVivo (NVivo, 2018).

5.2.3 Quality of the qualitative approach

For this qualitative study, the validity of the explanatory model followed an *emic* approach collecting data from the perspective of individuals rather than an etic view which often focuses on the local observations from the researcher (Dein in Littlewood, 2007; Weiss & Somma, 2007). Aspects that can give meaning to values, norms, and emotional circumstances are also *emic*, meaning they are applied in specific cultural contexts. For example, what is considered to be a strong emotion in one cultural tradition may be considered to be a mild emotion in another cultural tradition.

The *emic* approach may require detailed knowledge of certain cultural aspects. For example, the cultural language of illness and health terminologies, explanatory models, beliefs, and healing practices to ensure a cultural competence. In contrast, an *etic* approach would describe causal explanations (Tantam & Sayar in Bhugra & Bhui, 2018). This study focused on an *emic* approach through the variations of the participants' perceptions and interpretations of suffering and mental health problems from the vignette characters.

Credibility and *dependability* have been used in qualitative research instead of validity and reliability, which are more accord in quantitative studies (Smith, 2015; Yilmaz, 2013). Before the interviews began, a trusting relationship was established regarding the participants' willingness to share information and engage in the discussions. Considerations are also taken in terms of the subjectivity of the expected answers. The interview guide, in which the procedure and questions were described, validated all the changes made during the study—checking data accuracy as a follow-up with some study members, translators, pilot-testers, and the research team (Yilmaz, 2013).

Confirmability is also an aspect considered in the qualitative process. Observations were made, and notes were taken during the interviews, including quotes from the thematic analysis to prevent bias in the data (Yilmaz, 2013). Because of the confidentiality agreement,

any description of sociodemographic data was anonymized. Concerning *transferability*, this study could be conducted with other populations based on purposive sampling. A reflexive journal reported the epistemological and personal reflexivity of the thematic analysis (see section 5.2.5).

5.2.4 Implications of the qualitative study

The vignettes used in this study were applied and developed for this study (Erdal et al., 2011; Gray et al., 2015; Markova & Sandal, 2016) and based on the theoretical framework for PTSD and depression. The vignettes were also adapted for the intended focus groups so the participants could discuss the sensitive topics without being triggered. Both vignettes attempted to allow the participants to interpret the mental health problems, the social circumstances, and express their meanings of the vignette characters' situation, considering, for example, cultural aspects (Gray et al., 2015). When exploring the cultural aspects from an emic approach, gender roles were considered. For instance, the focus groups were gender-separated, following certain norms (e.g., Afghan traditions). Potential differences in the explanatory models were detected across the findings.

Invitations to participate were sent to the introductory programs in the municipalities. Variations in the time of arrival to Norway were identified during the focus group discussions. However, these responses were removed and presented as short (no less than six months) to an extended period (over two years residing in Norway) to protect the participants' anonymity. Furthermore, participants were not screened for this study. In the analysis process, the interviews were transcribed in the Norwegian language, taken from the Dari and Pashto translations, and the quotations from the themes were translated into English for article writing and publication.

5.2.5 Observations and reflexivity

Epistemological reflexivity

In thematic analysis, theoretical frameworks are used in conjunction with questions that draw on the experiences and perceptions of individuals. The reality of the participants in this study was mediated by their sociocultural interpretations of mental health problems in critical contexts with an ontological orientation. The analysis also allowed for exploring power dynamics and intersectional identities and wondering about the cultural dimensions that shape the conversations around mental health. Several methodological and ethical challenges arose during the study. For example, one of the main ethical considerations of the study was the need to create a safe space for the participants to openly talk about experiences with mental health problems while also protecting their identity. Because three languages were used during the interviews, much could be overlooked or overheard. Therefore, language and communication during the interviews and translations were critical and considered, not only for the selected method but also for other types of analysis (e.g., discourse analysis), due to language barriers that could affect the interviews. However, the discourse was only fundamental to how people use language to perform, persuade, and approach a position of power. As participants discussed the vignette character with each other, their opinions and perspectives became clear. While the discourse itself was not considered a method, the way participants used their language structure was considered a source in the study. This aspect highlighted the importance of discourse in how language is used to gain and maintain power dynamics, demonstrate positions, and shape collective understanding.

Studying certain topics of migration could lead to assumptions and categorizations (Dahinden et al., 2021). For example, the researcher's cultural experiences may lead to not being considered a "Norwegian researcher" if they were also migrants. Likewise, a female

researcher may also bring insight into the value of gender roles. As a result of this reflection, participants' impressions of gender roles could also be accepted or rejected. In a setting where the focus group interviews are conducted and separated by gender, culturally based traditions (from both sides) may lead to different reactions to, for example, gender (e.g., men not accepting the role of the women in the group).

Furthermore, blindness to gender and ethnic background is part of a qualitative interview (Silverman, 2016). Particular challenges can arise during post-interview reflections based on previous assumptions influencing the process in terms of the literature, observations, and the information participants in a study were willing to provide. These assumptions might influence the relationship between the researcher and the participants. However, the participants were very open to participating and communicating their thoughts in the discussions.

Personal reflexivity

Given that this study focused on refugee groups and mental health, specific knowledge from previous studies and the participants' home country played an important role during the research process in understanding how participants may perceive mental health problems. As a researcher, one strives to learn about a study population's cultural characteristics and circumstances, especially if they are not related to one's own. As a migrant, one seeks to distance oneself from the subjectivity of the topic and knowledge about migration to gain more clarity about the participants' perspectives regarding similar experiences encountered in the migration and integration process. As a female researcher, one tries to balance the research process and gender roles (in terms of the traditional and cultural aspects of the study population).

As a doctoral candidate, working on a qualitative project leads to an ongoing process of reflection. My perspective is not only singular but evolving in terms of acquiring various

perspectives from the research topic and the study population, being tolerant of uncertainties, and setting aside assumptions that might influence the research in the analysis process. This research training has allowed me to enhance my philosophical position of wonder and exploration, learning more from the theoretical perspectives and the experience acquired in the collection and data analysis.

5.2.6 Ethical considerations

The data collection and procedure were approved by the Norwegian Regional Ethical Committee (REC) (Project number 273645). The necessary permissions were obtained for this PhD project and the recruitment of participants for the focus group interviews. Participants were informed about the project, and potentially sensitive information about the participants was not allowed to be discussed during the focus group interviews. Before the focus group interviews began, participants were presented with Norwegian consent forms to sign. Participants were informed of the purpose of the study, the protection of confidentiality, how the data would be handled, and the future publication of findings from those responsible in the educational centers and the researchers in the project. Participants could leave the focus groups if they no longer wished to participate. All written information about the study was translated from Norwegian into the participants' language (Dari and Pashto being the official languages of Afghanistan). All participants in the focus group interviews signed the informed consent form. The interviews were conducted in Norwegian and in spaces owned by the communities (e.g., public libraries and school grounds). Interpreters were provided information about the project for the focus group interviews. In one interview, one of the interpreters wanted to participate in the interviews. As a precaution, a consent form was also signed by this interpreter. The interviews were audio and video recorded. Transcription was verbatim, and all personal information provided during the interviews was anonymized. The data was handled with care and confidentiality

using the SAFE[4] program, which secures sensitive data provided by the University of Bergen. The collected data was deleted after the analysis was conducted and in accordance with the ethical approval committee.

5.3 Quantitative research: Studies 2 and 3

The quantitative component of this PhD thesis addresses collecting information from samples and statistical data analysis. The research questions for the quantitative approach aimed at preferred coping strategies for mental health problems among different refugee groups living in Norway associated with integrating in the Norwegian society. For this, a survey with standardized questionnaires was developed and used, including different scales to answer the research questions. The questions compiled various standardized instruments to answer the research question focusing on different scales of cross-cultural and mental health aspects that reflect the characteristics of the study population.

5.3.1 The cross-sectional study

Based on the theoretical perspectives relevant to the project's study background, the quantitative research design aims to examine how the study population perceives and copes with specific mental health problems. In a cross-sectional design, information is recorded, and observed data is collected at one point in time to describe the research questions (Cummings, 2018). This method helps examine and compare the variables across the study populations that might be similar in specific characteristics. Among these characteristics considered in the study are sociodemographic characteristics (e.g., age, gender, and education). The cross-sectional study design also wishes to assess attitudes and patterns about the study population of this project (Kesmodel, 2018). The research interest in this

[4] SAFE program provided by the University of Bergen https://it.uib.no/ithjelp/images/b/b2/SAFE_E_-_For_decision_makers.pdf

project lies in whether the coping strategies for mental health problems within the selected study population are more effective or differ from the coping model used in this study. As a result of the study design, many variables can be analyzed simultaneously, allowing us to identify patterns, correlations, and prevalence of certain mental health problems such as depression and post-traumatic stress disorder (Cummings, 2018). Other empirical tests or intervention strategies may benefit from these types of studies. Data collection from the cross-sectional study will be used with survey questionnaires.

5.3.2 Sampling and procedure

The quantitative part of this study started with developing a questionnaire for the main project: Clinical encounters with refugees suffering from mental health problems (CENC)[5] consisting of integrated scales focused on *coping strategies* and *help-seeking behaviors* as the primary focus of the research project. For a fair distribution, the survey included these two main variables and the related scales, considering certain characteristics of the study populations, language, and gender. With the research team's collaboration, both the *help-seeking* and *coping* variables were embedded in a questionnaire to be used further and separately for data collection and in a comparative approach for the three refugee groups previously selected in the main project: Afghanistan, Somalia, and Syria. Considering that there is often low response in survey research for migrant populations, sampling was reflected on the challenges encountered when selecting a study population (e.g., refugee groups) and reaching potential respondents (Tourangeau, 2014).

[5] This PhD study is a subproject of the main project: Clinical encounters with refugees suffering from mental health problems (CENC) in the Society and Workplace Diversity research Group (SAW) at the University of Bergen https://www.uib.no/en/rg/saw/114420/clinical-encounters-refugees-suffering-mental-health-problems. Assessed April 12, 2023.

The development of the main questionnaire consisted of an invitation, consent to participate, information on how each participant was recruited, and socio-demographic questions. Furthermore, different scales with standardized questionnaires were particularly selected for the *coping* and *help-seeking* scales, including a reformed vignette (the same vignette used in the qualitative study) displaying a person with symptoms of depression from ICD-10 (WHO, 2019). The depression vignette used in the main questionnaire matched the gender of the participants and cultural background of the study population (e.g., Mossa (male) and Zarina (female) from the Afghan group, and Karam (male) and Ghazala (female) for the Syrian group). See vignettes in Appendix 4.

For the mental health component, other scales were reformed and included in the main questionnaire, such as the Short-form Health Survey (SF-12v2) (Ware Jr et al., 1996) for self-reported health, Sense of Coherence (SOC-13) (Antonovsky, 1993) for resilience, the Hopkins symptom checklist (HSCL-25) (Derogatis et al., 1974) for psychological distress, and the Immigrant Policy Lab index (IPL-12/24) (Harder et al., 2018b) scales for the integration aspect. See Table 2 for an overview of the scales used in the main survey for the *coping* and *help-seeking* variables. This PhD project comprised only the *coping* scales developed for the main questionnaire, including the survey process, participant recruitment, and analysis.

The development of the *coping* questionnaire was based on certain items for coping behaviors, such as the WCQ scales from Folkman & Lazarus (1988), Brief COPE (Carver et al., 1989), and the Utrecht Coping List (Schreurs et al., 1993), among others.

Table 2

Overview of the scales used for the CENC project.

Coping scales	Help-seeking scales
Socio-demographic variables (6 items) [a] Short Form of Health Survey (SF-12v2/SF-36) (1 item) [a] Depression vignette (7 items) [a] Hopkins symptom Checklist (HSCL-25) (10 items for anxiety, 15 items for depression) [a]	
• Cross-cultural coping inventory (CCS-I) (37 items) [b] • Brief COPE (28 items) [b] • Sense of Coherence (13 items) [b]	• General Help-seeking Questionnaire (GHSQ) (42 items) [c] • Client Satisfaction Questionnaire (CSQ-3) (3 items) [c] • Experience with health services (4 items) [c]

Note. [a]Reflects the common items selected for both the Coping and Help-seeking variables. [b] Reflects the scale and items selected for the coping variable. [c] Reflects the scale and items selected for the help-seeking variable. The table comprises the coping scales used for this PhD study.

After further consideration, the final *coping* questionnaire comprised the Brief COPE scale (Carver, 1997) and a reformed coping questionnaire based on the Cross-cultural Coping Strategies Inventory—Short Form (CCD-CI) (Tobin, 1995; Tobin et al., 1989). The latter previously used and reformed in the study of Markova and Sandal (2016) with items related to help-seeking behaviors and social support. To address some of the *coping* questions, the depression vignette used for the qualitative study was integrated into the scales used for the Coping Strategies Inventory, (see Appendix 4). Consequently, to assess psychological distress (depression and anxiety), the questionnaire included the scale of the Hopkins symptoms checklist (HSCL-25) (Derogatis et al., 1974). The Immigration policy lab index (IPL 12/24) (Harder et al., 2018b) was also included to address aspects of successful integration.

Instruments

The online survey was created with the SurveyXact software program (www.surveyxact.com) by the doctoral candidate and two members of the research group along with some collaboration from the SurveyXact technical team at the University of

Bergen. The formation of the survey was randomized by gender and by the main variables of coping strategies and help-seeking behaviors so that fifty percent of the participants would answer one of the two embedded questionnaires after consenting to participate and answering the randomized questions and return to continue responding to the main questionnaire with the other scales (e.g., IPL 12/24, HSCL-25). Most of the scales used for the main survey came from standardized questionnaires in English and Norwegian languages. The survey was sent to translation companies (e.g., Semantix and Noricom)[6] and translated into the languages of the study populations selected (i.e., Norwegian, Dari, Pashto, Arabic, and Somalian). After rigorous revisions, the survey was completed and unchangeable in the summer of 2019. The survey was also posted online on the Society and Workplace Diversity Research Group's (SAW) webpage (https://www.uib.no/en/rg/saw) at the University of Bergen.

The Hopkins symptoms checklist (HSCL-25)

To measure psychological distress (i.e., depression and anxiety) the survey included the Hopkins symptoms checklist (HSCL-25) consisting of 10 items about anxiety and 13 items about depression, and two somatic symptoms (Derogatis et al., 1974). This checklist was used as a research instrument, not as a diagnostic tool, and did not screen participants' mental health nor distinguish between mental health conditions among refugee populations in Norway. The Hopkins symptoms checklist has been previously used in migration studies involving refugee and asylum seekers populations (Jakobsen et al., 2011; Strand et al., 2003; Ventevogel et al., 2007; Vindbjerg et al., 2021). Other scales were considered for the main questionnaire to assess psychological distress such as the Hospital anxiety and depression (HADS) (Zigmond & Snaith, 1983) and Kessler Psychological Distress (Kessler & Mroczek,

[6] Semantix https://www.semantix.com and Noricom https://www.noricom.no/en/hjem are linguistic service providers agencies located in Norway.

1994). However, HSCL-25 was selected for the final questionnaire to assess psychological distress. The study relied on item-total score in evaluating the individual responses, based on the full 25 items instead of subscales when considering psychological distress (depression and anxiety). This process has been done in previous study analyses (Lee et al., 2008; Lhewa et al., 2007; Tinghög & Carstensen, 2010). However, parts of this study also focused on the depression aspect, with only 13 items of the HCSL-25 used as subscale.

The Immigration Policy Lab (IPL-12/24)

In the attempt to explore integration, the study included the Immigration Policy Lab index scale (IPL-12/24) by Harder and colleagues (2018b). This index assesses integration in a multidimensional way, with psychological, economic, social, navigational, linguistic, and political aspects. These six aspects of integration attempt to focus on the awareness of general proprieties, interpersonal factors, and ability to handle basic requirements, among others, in the host-country. The IPL-12/124 has been validated in international studies (Harder et al., 2018a; Harder et al., 2018b) and used in international research (e.g., Alaimo et al., 2022; Emeriau et al., 2022; Harris et al., 2021; Kunwar, 2020). The survey developed for this project excluded the political aspect as irrelevant to the purpose of this study.

Brief COPE

This PhD study used the Brief COPE scale created by Carver (1989) to assess coping strategies. According to Carver (1997), coping strategies are measured with the Coping Orientation to Problems Experienced inventory (COPE) using the abbreviated version of the original 60-question inventory – Brief COPE. Brief COPE (1997) measures ways individuals use to cope with a stressful life event in 28 items, structured in 14 strategy types (each consisting of two items per type). The Brief COPE questionnaire has been translated into several languages (e.g., Kapsou et al., 2010; Kim & Seidlitz, 2002; Knoll et al., 2005; Muller & Spitz, 2003) and validated in different populations and countries (Carver, 1997; García et

al., 2018; Hamdan-Mansour et al., 2013). Based on Carver's (1997) scoring measure, the coping strategies type can be classified into three categories: 1) problem-focused coping, characterized by facets of *active coping, use of informational support, planning, and positive reframing* designed to deal with stressful situations, 2) emotion-focused coping would involve facets of *venting, use of emotional support, humor, acceptance, self-blame, and religion* to regulate emotions associated with a stressful situation, and 3) avoidant coping characterized by *self-distraction, denial, substance use, and behavioral disengagement* to indicate physical or cognitive efforts to disengage from the stressor (see survey questions in Appendix 7). Moreover, these strategies can also be related to the coping theories proposed by Lazarus & Folkman (1986) for emotion and problem-focused coping strategies and further reformed by Dias (2012) and Poulus (2020). Additionally, the use of these strategies can also vary depending on the individual, their environment, or the situation in which they are faced with.

Participants of the quantitative study

The data collected for this PhD project included responses from Afghan and Syrian participants over the age of 18 living in Norway. With the help of the research team, the participants for this quantitative study were recruited through e-mail invitation letters sent to various Norwegian organizations, institutions, and local associations working with refugees in Norway, particularly from the three study populations previously selected in the main project CENC (e.g., Afghanistan, Somalia, and Syria). Collaborators from the Introduction program in various Norwegian municipalities contributed mainly for the recruitment of the participants. Survey responses were to be collected both online and in paper-format. The survey was distributed both in paper format and digitally with the help of electronic devices (e.g., iPad). Flyers were distributed with the link to the online survey with a QR code for mobile phone and iPad use. Recruitment was also conducted in person in four of the main

cities in Norway (Oslo, Trondheim, Tromsø, and Bergen), where participants gathered and answered the questionnaire (both paper-format and digitally).

Data were collected between the fall of 2019 and spring of 2021. Data collection for the Syrian group was completed in spring 2020 (before the COVID-19 pandemic began). Data from the Afghan group were collected in two waves (before and after the pandemic). The first wave was collected with low responses prior to March 2020. The recruitment of Afghan participants proved difficult to recruit during the fall of 2019. The main challenge was reaching potential participants, a problem that was exacerbated with the pandemic situation in Norway. Due to the low response rate for both groups, randomization of variables in the survey had resulted in a skewed distribution of responses.

A total of N=271 participants from Afghanistan and N=264 from Syria consented to participate in this study. After randomization N=146 (53%) of Afghan participants and N= 199 (75%) of Syrian participants responded to the main questionnaire (with 50% of the respondents going to each of the embedded scales for coping and help-seeking variables).

The first wave to recruit participants was halted in March 2020 due to the pandemic, with the attempt of starting a new wave in the fall of 2020. Some considerations for pausing relied on the responses from the participants may be affected by the current situation. Given the difficulty in recruiting more participants from Afghanistan and the lack of sufficient numerical data, new suggestions for data collection were considered, such as revising the G-power calculation and examining how appropriate, consistent, and reliable it would be to work with minimal data (Hoyle, 1999). To increase participation, e-mail invitations with the link to the online survey were again sent to various Norwegian organizations, and social media platforms were considered to facilitate participation for online users (e.g., Facebook groups). With the help of research assistants, a renewed attempt was made to physically recruit in a couple of Norwegian municipalities with no participation from the Afghan

population (both online and paper-format). Furthermore, due to new national pandemic regulations, the recruitment was paused. A second wave began during the winter and spring of 2021 with a new implementation strategy to recruit more participants using Facebook ads (https://www.facebook.com/business/ads). The response resulted in doubling the number of participants recruited before the survey closed in April 2021.

To recruit the participants through Facebook ads, the research team followed Facebook standards (https://www.facebook.com/business/ads/ad-objectives) to categorize these ads for potential participants. Different interests were filtered with the attempt to connect the Afghan users online with categories such as *nationality, living in Norway, ages between 18-66, all genders*, targeting interests related to the Afghan population (e.g., language, music, sports, TV, news, media networks, among others). The filtering gave a potential number to acquire the expected goal number of participants for the study. The responses from the Afghan group only came from the online survey.

Selection and G-Power calculation

The proposed G-power calculation resulted in N=130 participants per group from the main project proposal (previously N=200). Since the quantitative studies of this PhD project used some of the scales from the main questionnaire, and the sample size was relatively small, a power sensitivity calculation was done with G*Power 3.1 to indicate the effect of the data collected from the study population in each of the scales used in the two survey studies (Faul et al., 2009). For study 2, a sensitivity power analysis (G*Power 3.1.9.6) was calculated for multiple regression with 8 predictors to detect a small effect for the selected scales (t-tests for linear multiple regression). The sample (N=114) was sensitive to the effects of above Cohen's d=0.07 with 80% power (alpha=0.05, two tailed) (Bartlett, 2022; Faul et al., 2009). For study 3, a sensitivity power analysis was conducted to detect a minimum effect based on the sample size (G*Power 3.1.9.6). The sample (N=96) was

sensitive to the effects above Cohen's d=0.3 with 80% power (alpha .05, two tailed) (Bartlett, 2022; Faul et al., 2009).

5.3.3 Statistical analysis

The statistical analysis was managed with the statistical program SPSS (2020). Certain inquiries during the analysis process were done with the help of other statistical programs, such as Jamovi (Bartlett, 2022) and JASP Team (2023), for further understanding of the process.

5.3.4 Ethical considerations

Following the confidentiality agreement and anonymity approach, the questionnaire did not include questions regarding the status or identity of the participants as well as their contact information. As a quality measure, the survey was back-translated with research assistants and other translators from Afghanistan and Syria, and pilot-tested with volunteers from the study populations. This method helped the research team reflect and work on differences in adapting cross-cultural concepts and spot errors in poorly drafted wording, especially when working with different languages. Other guidelines for survey research preparation among refugee populations should also be considered regarding participant recruitment from hard-to-reach populations.

5.3.5 Implications for the quantitative study

This study also contemplated minimizing differences between the sample and the study population (Fowler, 2009). For example, if the study population exhibited levels of variability (e.g., age group, levels of education, accessibility), a probability selection was considered for the overall estimate or oversampling (Fowler, 2009). This approach may reduce potential bias in future results by ensuring that the sample is representative of the

study population. Additionally, these considerations might allow for a more accurate estimation of the study population's characteristics by accounting for any differences in the population. However, these deviations might show from the actual characteristics of the study population (from the recruitment of the respondents to the responses given), which could differ from the targeted population in terms of education, language use, identity, etc. For instance, the targeted population in Norway would likely have a refugee status at the time of participation. However, when considering participants in a study population, general aspects of that population should be included (e.g., a representative sample for that specific study population living in Norway - including those with refugee status), which may have an effect when recruiting participants of such study populations, creating for example, data collection difficulties. Even if similar characteristics are part of the purpose of the study, some of these challenges can occur when there is a difference between the sample and the population in the survey process (Fowler, 2009).

5.3.6 Further considerations

After consenting to survey participation, respondents could start participating in the online survey. The scales from both main variables (coping and help-seeking) were randomized and the randomization started after answering the question about gender. The embedded survey was split in two for each of the two variables of the main project. This randomization could have led to missing some respondents along the way before finishing the survey which could say something about the number of respondents participating in the survey. However, some of the missing data points from different scales were due to the randomization of the study and study design. The results from SurveyXact can report the total number of participants from both the help-seeking and the coping scales.

5.4 Observations about the PhD thesis project

Among the studied population, no mental health problems were screened or diagnosed. For this study, we considered refugee groups whose populations have migrated to Norway as refugees (because of conflict and war) as the potential participants. The purpose of this study was to understand how certain refugee groups in Norway perceive depression and post-traumatic stress disorder (PTSD) and how they prefer to deal with them. Developing mental health services for this group on a more empirical basis is also an objective of this study. Our research also provides insight into the potential needs of these refugee groups in terms of mental health services and interventions, so that patients can be better supported in dealing with depression and PTSD. Additionally, the study gathered the participants from Norwegian institutions, considered reference groups, such as members of municipalities and national organizations that work with refugees and clinical psychologists and specialists with backgrounds from the study populations. This approach was done in order to receive feedback from those closest to the study population and gain a broader perspective on the academic process. This ensured that the study was able to draw on a range of expert knowledge and insights, to provide an in-depth and comprehensive understanding of the experience of refugees in Norway.

6. Results

6.1.1 Summary article 1 (Focus group interviews)

As a result of the refugee crisis in 2015 and the flight among conflicted countries, many asylum seekers and refugee groups fled their countries of origin. We may be facing a new wave of Afghan refugees due to the current situation in Afghanistan (after August, 2021), which necessitates more knowledge about how to deal with their mental health issues. To effectively provide health care to refugee groups in Norwegian society, acquire background knowledge, and understand different cultural perspectives on mental health, this study aimed to learn how to identify explanatory models (EM) of depression and post-traumatic stress disorder (PTSD) among Afghans living in Norway.

Our qualitative study in article 1, consisted of six gender-separated, semi-structured focus group interviews with 27 Afghan participants. The participants were recruited through the introduction program in different municipalities in Norway. The participants signed a consent invitation prior to participating. The vignettes used as instruments described a male and female fictional character with symptoms of depression or PTSD in line with DSM-5 (American Psychiatric Association, 2013) and ICD-10 (WHO, 2019) latest version criteria. Participants answered the interview guide was used, and after reading the vignettes, participants responded openly to the questions creating a discussion within the groups. The interviews were gender-separated, audio and video recorded, and transcribed verbatim afterward. The analysis was done manually and managed with the program NVivo (2018), finding themes to identify the explanatory models. The research team involved in the study revised the analysis and the findings showed that the explanatory models of depression and post-traumatic stress disorder varied with gender, age, generation, and migration narratives. With the results of the study, it was observed that males and females had different perspectives on depression and post-traumatic stress disorder, which were also impacted by

their age, generation, and migration experiences. The participants suggested different potential causes, which risk factors may affect a person suffering from a mental health problem, and ways of managing symptoms of depression and PTSD depending on the context (e.g., in Norway vs. Afghanistan). In describing the different causes of the mental health problems in the vignettes (depression/PTSD), the female participants tended to emphasize domestic problems and gender issues while males focused more on acculturation challenges. Marriage and starting a family were among the possible solutions to manage the vignette character situations. The younger males discussed mostly traumatic experiences before and during flight as possible causes and finding social support among their peers.

This study concluded that in practice, condensing a single set of explanatory models within a group may not only be analytically challenging in a time-pressed clinical setting, especially after arrival, but it could also be misleading. Therefore, it is important to consider the various factors involved in decision-making and be aware of any potential biases when interpreting a patient's clinical presentation. The perspectives of mental health problems and how to manage symptoms of PTSD and depression may vary in cultural, gender-based, and generational aspects. Each patient's unique story and cultural background can influence the way they perceive and cope with mental health problems. It is important to understand these issues in order to provide more effective and holistic care. Additionally, recognizing generational differences such as the effects of technology on mental health can help clinicians tailor treatment plans and create more meaningful connections with patients. As a way to understand and provide better health care for refugee patients, we propose asking empathic questions and mapping individual refugee patients' perceptions of the causes and treatments, notably relating to mental health problems, as a starting point for building trust in the Norwegian community and inviting patients to share and put into practice their expertise and narratives about their own lives.

6.1.2 Summary articles 2 and 3 (Survey study)

As refugees undergo adversities before, during, and after their flight, they become susceptible to certain mental health problems. As such, these mental health issues can have a long-lasting and profound impact on the entire refugee experience affecting the integration process in the host society. Several factors indicate successful integration among refugee groups, including feelings of connectedness, language acquisition, navigating the system, and acquiring basic needs. Unfortunately, the mental health problems that refugees experience can act as a barrier to integration. For example, lack of connectedness and language acquisition can be directly tied to the depression, anxiety, and PTSD that refugees often experience. Furthermore, the lack of access to basic needs can also exacerbate existing mental health issues, making it even more difficult for refugees to successfully integrate into the host society.

In article 2, a cross-sectional study examined the relationship between different integration aspects and psychological distress among Afghan refugees in Norway. Hundred and fourteen (42%) Afghans answered questions from the Immigration Policy Lab index (IPL-12/24) (Harder et al., 2018b) and the Hopkins symptoms checklist (HSCL-25) (Derogatis et al., 1974). Hierarchical multiple regression analysis showed that the psychological and navigational aspects of integration predicted psychological distress. Having a sense of belonging, being part of a community, and feeling secure were some of the main psychological aspects of integration that benefit Afghan refugees' well-being and mental health. This suggests that feeling accepted and included in a community is critical for the psychological well-being of refugees, as it helps reduce the distress of adjusting to a new environment. The same goes to the ways refugee groups cope with certain mental health problems while integrating in the host society. Fleeing often involves adapting to unfamiliar environments and new cultural situations, increasing the emphasis on coping strategies and

quality of life during resettlement for these populations. Whether it is war and conflict, migration, or its detrimental effects on mental health, understanding how refugees manage difficult situations is crucial, especially when they suffer a mental health problem while integrating into the host society. In some cases, refugees may have experienced traumatic events that make it hard for them to adjust to new surroundings. This can lead to feelings of isolation and alienation, which can have a negative effect on their mental health. Developing such coping strategies is also crucial for the successful integration of individuals into new communities.

In article 3, the study explored how the Syrian population cope with depression and how this could affect the integration process. This study used a cross-sectional study design with an online survey to explore the relationship between integration aspects and coping strategies for depression from the Syrian population living in Norway. A total of N=96 Syrian participants (40%) responded to the questions from the scale used in this study. The results have indicated that certain levels of integration were associated with better mental health outcomes, suggesting a strong relationship between the ability to cope with flight challenges, a new environment, and successful integration. Planning, active coping, positive reframing, and instrumental support were associated with psychological and social dimensions of integration and were more likely to appear after arrival. By engaging in problem-focused behaviors, Syrians can create a sense of control and mastery over their environment, which can help with better adjustments and feel more connected to Norway. The integration of refugees into their new society can be further complicated by their need to find new sources of support and guidance. These results from both the Afghan and Syrian communities in Norway highlight the importance of providing support and resources to refugees to help them cope with their new realities. Coping strategies are important for refugees to manage any situation that may arise from the transition process and provide them with the tools

necessary to build new relationships in their new communities. Identifying and understanding different ways of coping can help refugees adjust to their new environment and successfully integrate into their new communities. The ways of coping with certain situations may be affected by cultural aspects or influenced by new surroundings. Therefore, providing support and resources to help refugees cope with flight challenges can positively impact their quality of life. Feeling secure and connected to the local community may enhance the choices of coping strategies that will benefit the well-being of the refugees.

7. Discussion

The overall purpose of this PhD thesis was to identify the explanatory models of PTSD and depression among refugee groups in Norway and the cross-cultural inventories that relate to these mental health problems related to integration aspects in Norwegian society.

Specific research questions were developed and explored across three research articles to achieve the study's overall goal. The purpose of these questions was to understand better how certain variables, such as specific mental health problems and the management of depressive symptoms, were related to the overall study goal. Conclusions and future recommendations were formulated based on the research study's results. The research questions in each article were tailored to examine the relationship between variables and phenomena. The significant findings will be discussed under three headings. The objectives of the research study and its results will be explained next. A second section is dedicated to the strengths and limitations of the thesis. Lastly, the third section will include the study findings' implications for future practices and implementations.

7.1 Explanatory models of post-traumatic stress disorder (PTSD) and depression held by refugees and preferred coping strategies for depression

Understanding the perceptions of mental health problems and the perspectives of migration in this mixed-methods project may help facilitate finding and providing appropriate treatments and better health care services to some refugee populations in Norway. As a result of the dynamic terminologies in the explanatory models of depression and PTSD, cultural aspects were considered essential when identifying the experiences and

perspectives of individuals (for instance, the Afghan population living in Norway), which carried different interpretations and explanations.

The explanatory models of PTSD and depression identified in the qualitative study emphasized differences in mental health care, for example, how distress is expressed and dealt with. In addition, the explanatory models have highlighted how the contrasts from a Western model could be embedded in the Norwegian healthcare system's standard guidelines for diagnosis and treatment. Some contrasts may suggest that mental health care in Norway should be tailored to meet the patients' cultural and social needs. However, the focus would involve shifting from a Western-centric approach to a more holistic one, considering the sociocultural contexts that may impact mental health. This new approach would include understanding how distress is experienced and expressed in different cultural aspects, norms, and expectations that shape how people seek help and access treatment, creating diverse forms of health treatment (e.g., implementing different strategies for consultation services and treatment assessments) (Bennegadi, 2021; Unschuld, 2009). Many refugee groups have come from communities where mental health services may not exist or have been unavailable. From a refugee group perspective, dealing with a mental health problem that may involve cultural norms or taboos, such as preferred treatments related to causal factors (e.g., local healers or religious rituals), the relationships to language and reliance on medical treatment are to be considered further after some of the findings in the current study. These aspects can also pose a challenge for refugee communities, as they are already dealing with the stressors of displacement and may not have access to the same resources and services as their host communities. Language barriers and cultural differences can make it difficult to adequately access and understand the available mental health services. Therefore, the present study might be interpreted as a pure deficit model, stating that migrants, including refugees, might differ from dominant groups in host societies due to the so-called cultural deficits that

could impair mental health and integration; and lack of psychosocial support, for instance, that could affect refugees' mental health. Although situations and challenges vary widely, condensing a single set of explanatory models within a group could be misleading. Consequently, asking empathic questions and mapping individual refugee patients' perceptions regarding causes and treatment could be a useful starting point for building trust, especially post-migration in resettlement countries. Even though this is not always the case, Norway has already started with assessments to provide better service to those in need. However, these considerations can be further done by engaging patients in conversations and listening to their stories to understand their lived experiences and context. This process allows practitioners to develop a holistic and culturally appropriate mental health plan that best meets the patient's needs.

The explanatory models may sometimes be too static to convey the fluid status of perceptions among patients. There are risks that tentative and uncertain perceptions explored by individuals may become reified and made definitive in the shape of a coherent explanatory model. The findings in the current study suggest that no accurate and generalized explanatory model will represent, for example, all Afghan perceptions (about causes and treatment) and that individual perceptions will likely change over time. Kleinman's (1988) method of asking open-ended questions could help promote clinical self-reflexivity and improve clinical communication. However, the findings of the explanatory models suggested otherwise (e.g., social support from family and friends and reaching out to the Norwegian community), indicating some similarities to the Norwegian model. Yet, the participants had reservations about the professionals' ability to understand the refugees' situations. These findings can also encompass with previous studies among refugee groups and the explanatory models of mental health problems (Alemi & Stempel, 2018; Alemi et al., 2017; Markova & Sandal, 2016; Stempel et al., 2017; Aarethun et al., 2021). When

professionals ask empathic questions and roughly map patients' perceptions, they may be better able to build trusting relationships with refugee patients and invite them to share and practice their expertise. Furthermore, post-migration factors might have been affected when exploring integration aspects. Gathering the data from the perspectives of the individuals has added actual value to this study (Weiss in Bhugra & Bhui, 2018; Yilmaz, 2013).

7.2 The relationship between psychological distress and integration in Norwegian society among refugee groups

New living conditions and the environment could influence changes in known behavior patterns in a study population (e.g., changes in physical activity, diet, working conditions, new language) in the host population (Berry, 2021). Other health consequences of migration such as depression and coping with certain situations in the host country, could also develop (e.g., finding basic needs, navigating the system, and seeking help through the health care system). A sense of belonging in the resettlement country may lead to better mental health outcomes, which is essential for future social and economic integration, as suggested in the current study's results. When newcomers feel they belong and are secure in the new society, this facilitates integration, especially for refugee groups. Developing health services adapted to the needs of refugees is crucial for their quality of life, especially upon arrival in the new country and in the follow-up of the integration process, which may be anchored in the Norwegian model. Improving refugees' mental health can have economic benefits that help reduce social costs and improve integration capacity, which can have positive psychological effects. There is a great need for mental health services for migrants, especially refugee groups, regarding the individual's quality of life and integration into the host society.

On the other hand, the results suggest that the level of integration may indicate some effect variations associated with mental distress in the study population. Unemployment, as a factor that could affect integration, can also affect mental health. Furthermore, the more educated, the better the integration, especially in language learning, as the results suggested for the Syrian population in the present study. Those integrated into the host society may know where to find a doctor and contact others but without the attempt to navigate the system. A more active way of finding basic needs and contacting the community indicated how integration was related to coping with depression. Therefore, assessing the degree of integration and psychological distress may indicate the impact of migration on specific refugee groups.

During the study design, gender was also considered as a perspective of migration and in the context of social groups. Some of the findings from this study suggested that some of the psychological needs have been met, with women more likely to seek help from family and health services than men. At the same time, men repressed the idea that a psychological problem might even exist, as suggested in the results of this study. Furthermore, women's sense of autonomy and competence may be related to their choices in various situations (Reeve, 2018). For example, women empowering themselves after leaving violent situations or identify future development opportunities for themselves and their families in the host country. However, no differences were indicated concerning integration, with no significant contribution. Cultural values, education, and age were among the social factors influencing explanatory models for any mental health problem (Weiss in Bhugra & Bhui, 2018). The psychological aspect of integration, such as a sense of belonging and not being isolated from the host society, may strengthen the integration process and the ability to navigate the system and act with core integration areas such as education, employment, social connections, and health care access (e.g., Ager & Strang, 2008; Thapa et al., 2007; Walther, 2021), a certain

level of integration with the psychological dimension of integration can be considered, to a certain degree, as a sign of successful integration.

7.3 Management of depression among refugee groups while integrating in Norway

How a mental health problem is perceived and approached by individuals could influence the coping behaviors and treatment choices. The way individuals manage a situation can be associated with cultural variations and adaptation to the host society, carrying the risk of trauma with certain coping attitudes that may lead to less psychological well-being. Coping can therefore be seen as the culturally mediated process affecting certain attitudes and orientations (Leff, 1977). However, choosing specific coping perspectives can facilitate adapting to challenging situations and managing specific mental health problems such as depression and PTSD. This perspective is often considered as a collective phenomenon (e.g., among migrant groups), and may depend on the particular situations, the choices made of coping styles, and the responses from different population groups (e.g., Aldwin & Revenson, 1987; Lazarus, 1984; Lazarus, 2000; Spaulding et al., 2010). The results of the current study indicating problem-focused coping rather than emotion-focused coping suggest that certain refugee groups may manage external demands and mental health problems during the integration process in an active way (Lazarus & Folkman, Carver, 1997; 1984). When it comes to contacting others and seeking help, differences in mental health care utilization may have several explanations, including cultural norms and taboos related to mental health problems, language difficulties, and low trust in the treatment apparatus (Sandvik et al., 2012). These disparities can underscore the importance of ensuring that appropriate mental health care for migrants, including refugees, is based on understanding how different groups cope with such health problems and how they would prefer to cope.

Inconsistencies in the results of the present study related to coping and vicarious experiences (e.g., lack of social support) with integration may indicate a lower predictor of self-efficacy (Bandura, 1997; Reeve, 2018). Nevertheless, this might raise questions about whether coping styles for depression are less effective when based on previous coping experiences (e.g., past experiences or beliefs) (Ahh & Bong in Renninger & Hidi, 2019). The results indicate that the Syrian population copes in a more problem-focused manner by being active in, for example, contacting others in the community. Some of these coping experiences could be measured through the lens of other groups, peers, and family members, as well as how coping might help with various aspects of integration in a host society (i.e., changing coping styles after integration). Nonetheless, when examining identity and how migrants are constructed, the associations of belonging may be problematic in the context of maintaining different social identities. These population groups may need to constantly negotiate between cultural aspects and find a balance between different aspects of their own identities while integrating (Anthias, 2012; Dahinden et al., 2021). As a result, migrants, including refugees, may be forced to redefine their identities constantly. This process of redefining identity can have a profound psychological impact on migrants, as they must adapt to their new environment while striving to maintain their own sense of self. However, categorizing a population group, such as using the term refugees incorrectly, could indicate some of these aspects. Further research and other theoretical approaches could address coping with certain stressful situations may be influenced by the new surroundings. Therefore, the concept of integration is related to the different perspectives of migration that are possible in the host country as well as the laws governing its migration system. In order to understand the complexity of migration dynamics, to include migrant groups in host societies, and to engage the public in the process, integration is essential, especially when coping with a mental health problem.

7.4 Strengths and limitations

The process and findings acquired in this project has given some insight to the importance of people's narratives and the identification of the explanatory models of certain mental health problems. In the same way, understating how certain refugee groups, such as Afghans and Syrians, can perceive and manage mental health problems help with their integration process. The results of the current study can contribute to the Norwegian society by gaining a broader understanding of the differences and similarities of different migrant groups, particularly refugees when resettling in Norway. This small contribution may guide the health care system for better planning and treatment provision through their services and the development of certain policies that may contribute to a better integration among refugee and migrant groups.

This PhD thesis tried to collect data from the refugee groups selected. However, recruiting participants in a study from a hard-to-reach population is a challenge in survey research (e.g., trying to locate the participants at a national level and sending invitations to different organizations working with refugees). The pandemic situation in Norway also contributed to this challenge leading to different waves of data collection, gathering small data among these groups. Even though new implementation strategies for recruiting participants (e.g., use of social media platforms and paper format of the online survey), the small samples from both study populations, especially from the Afghan participants, contributed efficiently to the data and answered the research questions of this project. Sufficient insights could be granted by analyzing small data, by for example individual level descriptions. Other methods, such as qualitative interviews could be used in a small data approach. However, further research might be needed to measure other specific aspects of coping with mental health problems, and methodological approaches (e.g., sampling and implementation strategies) for hard-to-reach populations.

7.4.1 The vignettes

Using vignettes and narratives to understand population perspectives is crucial to qualitative and mixed-method studies. By using vignettes, people can explore certain actions in context and discuss topics from other perspectives that may clarify their judgments regarding those topics. Vignettes and narratives give readers a better understanding of how people think, feel, and make decisions. This helps to illustrate how different perspectives can influence decisions and how people interact with each other. Additionally, vignettes and narratives can provide insight into how people make sense of their experiences and how they might change their behavior based on those experiences (Barter & Renold, 1999; Erfanian et al., 2020; Gray et al., 2015). Focus groups reproduce the social contexts that allow researchers to develop vignettes. Vignettes can provide a more vivid and personal viewpoint rather than just presenting facts and figures and direct questions regarding a sensitive topic such as a mental health problem (Cyr, 2019; Erfanian et al., 2020). Stories allow readers to gain a deeper understanding of certain issues and gain insight into how different people approach the same situation. Therefore, the use of vignettes and focus groups creates a safe environment where people can express their thoughts and feelings without fear or judgment. This helps to create a realistic representation of the context from the vignette and helps to understand how people make decisions and interact with each other. As researchers, we can gain insight into complicated contextual concepts and sensitive topics less threateningly through, for example, focus groups (Barter & Renold, 1999; Cyr, 2019). Therefore, using vignettes in focus groups can be a powerful tool for researchers looking to understand how people make sense of their experiences and how they may change their behavior.

7.4.2 The cross-sectional study

Often, research questions address changes based on the validity of scales (Bono & McNamara, 2011). In cross-sectional studies, researchers wish to assess knowledge and

attitudes and identify patterns (Cummings, 2018; Kesmodel, 2018) some questions may be incompatible with questions regarding causality or change, and more robust tests may be helpful to measure a variable or manipulate variables linked to others. For example, the integration scale used in this study had been previously validated in migrant groups. Still, due to small data, this wasn't the case for all variables (e.g., which aspects of integration predicted psychological distress or how circumstantial situations may affect the responses in that particular time (e.g., the pandemic). Data collection may have affected some of the responses during the first wave and after the pandemic breach. Strong causal attributions cannot be raised with cross-sectional data, regardless of analytical tools. Thus, further research might be needed to identify the full potential of the scale, such as to explore how different aspects of integration may be associated with psychological distress and how contextual factors may influence the responses given. However, even with small samples and limited data from hard-to reach populations, acquiring small data can also indicate efficiency in survey research with the advantage for the current and future research projects regarding collecting data among these population groups (Tourangeau et al., 2014). Future predictors and implementations could affect interpretation bias. However, caution is warranted when interpreting data from small samples (Hekler et al., 2019). Finding consistent patterns in small groups is important for qualitative and quantitative studies (e.g., cross-sectional studies).

A helpful approach could be a longitudinal study, that can test changes by reexamining samples and individuals over time (Cummings, 2018). This way, the development of integration in Norwegian society may change over time and suggest whether there is a predictor or not of psychological distress. Longitudinal studies are needed to understand better the causal relationships, in this case, between psychological distress and integration, and coping with certain mental health problems while integrating in the host

society. Furthermore, qualitative research can explore the contextual factors that influence the responses given on the scale, such as the participants' cultural backgrounds, beliefs and attitudes, and home environment, reinforcing the mixed-method approach of this project. However, this study may benefit from the cross-sectional study, despite data collection challenges from a hard-to-reach population. The study was easier to conduct with a cost-effective data collection where all variables were monitored at one point in time than it would have been with a longitudinal study, and with no concerns about attribution had to be considered. The results of this study may help determine if the development of certain aspects of integration in Norwegian society is a reliable predictor of psychological distress. Using a cross-sectional study, the project obtained a snapshot of the study populations that looked for patterns and attitudes, allowing the researchers to analyze the current situation more precisely, giving an accurate understanding of the relationship between integration, coping, and mental health problems.

Since cross-sectional data may have difficulty establishing causal attributions or changes, different data structures can be used to make inferences about change. To test the questions of interest, the research design must match the research questions. This study attempted to do so as part of the research design process and has been reflected upon following the study results. However, further considerations involving changes or causal associations or recognizing questions regarding a psychological process may be included by developing and using other study designs.

8. Implications and conclusions

The different perceptions of mental health problems found in this study may reflect when revising certain assumptions and policies of integration. Some of the results might be related to the different perspectives of migration (e.g., intersectionality), making access to help more difficult. Not to mention the burden that mental health stigma could bring, such as social disapproval and labeling when considering cultural aspects (Ahmedani, 2011; Byrne, 2000; Goffman, 1963). Therefore, improving the mental health of the refugee population in Norway through treatments based on particular aspects of the refugee populations can be a goal for a more effective Norwegian health care system. Furthermore, the lack or abundance of power during the integration process (i.e., staying at home, not obtaining a job nor education) could be among the changes and challenges to overcome (Anthias, 2012; Dahinden et al., 2021).

Regarding the recruiting of participants in this project, some aspects can be considered from the overall process. Even though new strategies were integrated in the process, such as using social media platforms, to increase participation and survey response among the study population, there were still some differences between the study groups. Methodological and ethical considerations should be taken more carefully to identify possible biases in refugee research. Some of the assumptions may indicate that some of the participants did not wish to continue responding the survey even after consenting to participate; considering for example that survey was probably too long, finding difficulties in understanding the questions, lacking reading skills due to low education level, or probably some of the questions did not apply to those who had recently come to Norway. However, the study indicated that most of the participants had medium to high levels of education.

Furthermore, the low participation among Afghan women could also be due to less use of social media compared to the male participants and more involvement in other activities such as family obligations. Maybe the Facebook ads categories did not reach enough interest online for the women participants. The amount of time in Norway post-resettlement for the participants in the study was excluded from the survey, and the age of arrival in Norway was the only variable acquired that showed most of the participants had lived in Norway more than 5 to 10 years. The question could not consider the time in host country in the analysis of the study (with the limitations in the number of predictors used) and could not give much information regarding setting and time. This question tried to exclude any identification and protection of the participant. Cross-sectional studies conducted at specific times, such as during the integration process, could also yield different results; particularly during pandemics, which could portray a misleading picture of integration. From a methodological perspective, cross-sectional results may bias some conclusions that could be better drawn from longitudinal studies. However, this perspective could also be misleading because different individuals go through different stages of acculturation. It is unclear whether the observed patterns represent individual differences in acculturation strategies (i.e., integration) or timing (some may be further along in the process, and others may be at the beginning of the process). The lack of enough responses not being representative for the study populations makes it difficult to work further with the collected data. However, some descriptive studies could be considered for further research, and the implementation of strategies for sampling such as the use of social media platforms (e.g., Facebook ads) can help future recruitment of participant in hard-to-reach populations. The challenges and limitations when collecting data among refugee groups could be considered for future survey research (e.g., scoring, and low responses).

The coping mechanisms could be seen as a direct result of the length of the refugee crisis and migration process. The amount of time refugees had to adjust to their new environment could be a critical factor in determining how successful these coping strategies have been. The findings also highlight the importance of the research process into the perceptions of mental health problems among different refugee groups, ensuring and helping healthcare professionals better identify, diagnose, and treat mental health conditions by understanding the nuances and the cultural context of each individual mental health experience.

9. Appendix

List of Appendix

Appendix 1	Invitation to participate in the study.
Appendix 2	Interview guide (in the Norwegian language) based on previous pilot interviews with different groups before survey recruitment and participation (developed and revised during the months of January - February 2019).
Appendix 3	Consent form for participants in the focus groups interviews in paper 1 (Norwegian language).
Appendix 4	Vignettes for PTSD and depression symptoms for the focus group interviews used in (article 1) and for the online survey (used in article 3) (in English and Norwegian languages).
Appendix 5	Consent forms to participate in the online survey (in Norwegian). Pashto and Dari for article 2 and Arabic for article 3.
Appendix 6	Flyer, invitation letter, and consent form to participate in the online survey distributed to the participants for articles 2 and 3.
Appendix 7	Online survey used for articles 2 and 3 (Coping questionnaire male version)
Appendix 8	Articles 1, 2, and 3

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Appendix 1 Invitation to participate in the study

Bergen (dato)

Deltakelse i undersøkelse

Universitetet i Bergen gjennomfører en undersøkelse om hvordan helsetjenestene i Norge kan bli bedre tilpasset flyktningers behov. Til dette ønsker vi kontakt med flyktninger.

Vi vil derfor spørre deg om du vil du være med på denne undersøkelsen.

Det er helt frivillig a delta på dette. Den som takker ja til å bli med, vil delta i en gruppesamtale sammen med 4-7 andre personer fra Afghanistan. Samtalen er 1 gang og varer i ca. 1,5 time. De andre deltakerne vil også være av samme kjønn som deg.

Mange flyktninger synes at det er vanskelig å komme til et nytt land, og mange har hatt vonde opplevelser før og under flukten. Et mål med prosjektet er å få mer kunnskap om hvordan helsetjenester i Norge kan tilpasses de behovene som flyktninger har.

I samtalen vil du ikke få spørsmål om dine egne opplevelser eller helsen din. Det vil bli presentert en historie som gruppen vil diskutere. Det er bestilt tolk til samtalen.

Sted:

Tid:

Vennligst svar (ja eller nei) innen den (dato) ved a ringe eller sende sms til din kontaktperson (Navn og telefonnummer).

Vi håper du har anledning til å delta!

Hvis du har noen flere spørsmål kan du også kontakte meg.

Med vennlig hilsen,

Dixie Brea
Doktorgradsstipendiat
Institutt for samfunnspsykologi
Det psykologiske fakultet
Universitetet i Bergen

Professor Gro Sandal
Institutt for samfunnspsykologi
Det psykologiske fakultet
Universitetet i Bergen

Intervjuguide

Åpning/informasjon

- Introduksjon av prosjektet, forskningsgruppen. Hvem er vi, hvorfor er vi her og hva er formålet med prosjektet. Dette er det de vet fra før:

Hvem vi er (fra UiB), og at det er et fokusgruppeintervju. Vi er ute etter å lære mer om hvordan mennesker fra Afghanistan tenker at det norske helsevesenet bedre kan møte behovene til syriske flyktninger. Det er frivillig å delta. Man sier akkurat så mye som man selv er komfortabel med, og intervjuene foregår i kjønnsdelte grupper. Varer i ca. 90min. Vi er ikke ute etter å spørre private spørsmål om hver deltaker, eller personlige spørsmål knyttet til deltakernes egen helse.

- Klargjør rollene til alle i forskningsgruppen, inkludert tolken (taushetsplikt).
- Forklar hvordan intervjuet er strukturert. 1) vignett, 2) deltakerne skal svare ut fra en posisjon som om de var *karakteren sin* venn og vil aldri bli bedt om å si noe om seg selv.
- Les igjennom samtykkeerklæring i felleskap på pashto og på norsk, og forklar rettighetene til deltakerne. Åpning for spørsmål. Frammøtte som er villige til å delta bes om å signere villighetserklæring. Tolk må også nevne sin taushetsplikt.
- Forklar og undersøk om det er å ok å bruke video, og hvordan datamaterialet vil oppbevares og håndteres i etterkant av intervjuet.

Ta en kort pause på et par minutter hvor de som ønsker å hente mer kaffe, mat, osv. kan gjøre det, og dersom noen ikke ønsker å delta, kan de forlate rommet nå.

- Deltakere oppfordres til å behandle informasjon som blir gitt av andre deltakere i intervjuene konfidensielt. Tolk må også nevne sin taushetsplikt.
- Understreke at de svarer så mye som de selv er komfortable med, og det er fult lov å la være å svare.

Åpningsspørsmål

- Kan dere kort presentere dere selv? Gjerne alder og botid i Norge, utdanningsnivå og familiesituasjon/nettverk i Norge.

Presentasjon av vignett-oppgaven/assosiasjonsoppgaven

- Før opplesing av vignetten, presiser igjen hvilen posisjon informantene skal ha når de hører den og svarer på spørsmålene i etterkant: «Tenk deg at du er en god venn av Mossa/Zarina.»

Vignette (tok bort vignette)

Oppfølgingsspørsmål til vignette

1. Mener du at noe er i veien med Mossa/Zarina? I så fall, hva?
2. Hva kan være forklaringen på at Mossa/Zarina har det på denne måten?
3. Du er Mossa/Zarina sin venn, hva ville du råde Mossa/Zarina til å gjøre? Hvilke råd vil du gi han/henne?
    a. Har han/hun en sykdom? I så fall, hva/hvilken?
4. Mossa/Zarina er fra din etniske gruppe, hvor tror du han ville søke hjelp?

5. Tror du Mossa/Zarina var fra din etniske gruppe kan få hjelp fra det offentlige helsevesenet? Hvis ja, hvordan? Hvis nei, hvorfor ikke?
6. Hva kan en lege gjøre/hva kan en psykolog gjøre?
7. Hvordan mener du at det norske helsevesenet best mulig kan hjelpe folk som Mossa/Zarina?
8. Er det noe hjelp som du ikke finner i Norge som du mener Mossa/Zarina burde fått?

Hvis tid

9. Tror du det vil være forskjeller på hvordan mennesker fra Afghanistan tenker og hva nordmenn ville ha anbefalt Mossa/Zarina å gjøre i denne situasjonen? I så fall, hvordan?
10. Tror du det er forskjeller mellom etniske grupper i forhold til hvordan Mossa/Zarina sine problemer blir forstått og hva han/hun blir anbefalt å gjøre? Hvis ja, hvordan?
11. Om det hadde vært en kvinne/mann (motsatt av presentert case) som hadde tilsvarende problemer, hvordan ville dere tenkt da?

Avslutningsspørsmål

12. Er det noe mer dere ønsker å legge til, som dere tenker på og ikke har fått sagt?
13. Hvordan synes dere gikk? Var det ok?
14. *I etterkant av intervjuene vil vi informere om at det foreligger et tilbud for flyktninger med posttraumatiske symptomer ved Introduksjonssenteret for flyktninger og hvor de kan få oppfølging ved behov.*

Kommentarer

Ta med fokus på:

- Relasjoner med familie, foreldre, ektefelle
- Tradisjoner (religiøse eller kulturelle)
- Religiøse ledere (overnaturlige: Nazar (evil eye) og Jinns)
- Rituale bønn og bruk av amuletter
- Bruk av helsetjenester
- Bruk av alternative midler

Praktisk å huske

- **ha med kamera og opptaker**
- **Ha dem sittende i en halvsirkel, og sitte på samme nivå som dem.**
- **Kjøpe inn mat (pizza eller brus), frukt, te, kaffe, eller kjeks**

Appendix 3 Consent form to participate in the FGIs (in Norwegian, Pashto and Dari languages)

INVITASJON TIL Å DELTA I UNDERSØKELSE OM PSYKISK HELSE

FORESPØRSEL OM Å DELTA I UNDERSØKELSE

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 55 58 31 86, epostadresse: vilde aarethun@uib.no
eller Dixie Brea, telefonnummer: 55589150, epostadresse: dixie.brea@uib.no.

Med vennlig hilsen
Gro Mjeldheim Sandal
Professor, prosjektleder

JEG ER VILLIG TIL Å DELTA I UNDERSØKELSEN

در روانی روغتیا په تحقیق کې د ونډه اخیستلو بلنه

در روانی روغتیا په تحقیق کې د ونډه اخیستلو بلنه

ډیر خلک در ژوند په لړ کې، خپله ، یا د هغه د کورنۍ غړي او یا ملګری یې یو ځل او یا څو ځلې د رواني ستونځو سره مخامخ کیږي . ددې تحقیق موخه د هغه کسانو څخه د ډیرو معلوماتو لاس ته راوړل دي چې د بل کلتور دي او دا چې د هغوی په اند څرنګه کیدای شي چې ددې ستونځې سره په ښه توګه مبارزه وشي او په هغه باندې تسلط حاصل شي . د پروژې یو اوږد مهاله موخه داده چې مونږ ددې ستونځې په هکله ډیره پوهه لاس ته راوړو تر څو وکولای شو چې د ناروی روغتیایی خدمتونه بهتره شي او د هغه کسانو چې د نورو هیوادنو څخه را ځي روغتیایی اړتیاوی رفع شي .

د پروژې محتویات څه شي دي؟

دا تحقیق د برګن [Bergen] د پوهنتون د ارواه پوهنې د پوهنځي د کلتوری تنوع د تحقیقاتی ګروپ او د ناروی د تحقیقاتی د شورا په مالي مرسته سرته رسیږي . ددې تحقیقاتی ګروپ په هکله تاسو کولای شي چې زمونږ انترنټي پاڼه کې (https://www.uib.no/fg/saw) ډیر معلومات لاس ته راوړی .

د ګډون کوونکي په صفت له تاسو او 7 - 4 نورو کسانو سره په یوه ګروپ کې یوه مرکه کیږي چې دغه کسان به تاسو د هیواد څخه وي . ګډون کوونکي په ګروپ کې به د یو جنس څخه وي (یعنی ټول ګروپ به یا نارینه او یا ښځینه وي) . مرکه کوونکي به له تاسو څخه په ناوړیژی ژبه پوښتنه کوي لیکن هلته به د تاسو د اصلي ژبې ژباړونکي حاضر وی . تاسو کولای شي چې په خپل ژبه هم ځواب ووایي .

ګډون کوونکي غواړي چې په لومړي سر کې د هر تن په هکله لنډ معلومات واوري . ددې څخه وروسته تاسو او نورو ګډون کوونکو ته پوښتنې درکول کیږي چې یاد تن څه ډول کولای شي چې د خپل روانی ستونځی حل کړي . له تاسو څخه به د شخصی ژوند او صحت په هکله پوښتنه ونشي . مرکه به ۹۰ دقیقی وي او فلمبرداري کیږي . د مرکې څخه وروسته محققین ټول معلومات (ټکي په ټکي) لیکي او دهغې څخه وروسته ویډیو به ړنګه (پاکه) شي . مرکه یوازی د تحقیق کوونکی په واسطه چې ویډوګانو ته لاسرسي لري ترسره کیږي . ویډیو ګاني تر هغه وخته چې پاکي شي په محفوظه سیف کي ساتل کیږي .

په مرکه کې ونډه اخیستل داوطلبانه (په خپله خوښه) ده هر وخت چې تاسو غوښتي وي، پرته له دې چې د چا پوښتنې ته څه ځواب ووایی، کولای شي چې ځان له مرکې څخه حذف کړی . تاسو هم کولای شي چې یوی پوښتنې ته د ځواب ورکولو څخه ډډه وکړي، او یا دا چې د پوښتنې د شرح ورکولو څخه ډډه وکړي . که چیرته تاسو غواړي چې ونډه واخلي له تاسو څخه هیله کیږي چې رضایت لیک (اجازه نامه) چې په بله پاڼه کې ده امضاء کړي .

هغه معلوماتو سره چې تاسو یې مونږ ته راکوي څه کیږي؟

تر هغه وخته پورې چې د تاسو هویت په معلوماتو کې تثبیت کیدلای شی تاسو لاندینی حقوق لري :

- هغه شخصي معلومات چې د تاسو په راجستر شوي دی د لیدلو حق ،
- د تاسو د شخصي معلوماتو د صحیح کولو حق ،
- د تاسو د شخصي معلوماتو د پاک کولو حق ،
- د تاسو د شخصي معلوماتو د سپارلو حق (د معلوماتو د ورکولو وړتوب) ،
- د تاسو د شخصی معلوماتو د برسی په هکله د شخصی محرماتو د محافظت افسر او یا د معلوماتو د تفتیش اداري ته د شکایت د لیږلو حق .

کله چې د ویډیوګانو معلومات ولیکل شول د هغه څخه نومونه حذف کیږي او ټول معلومات په داسی توګه بې نومه کیږي چې ګډون کوونکی ونه پیژندل شي . که چیرې تاسو غوښتي وي ځان د تحقیق او مرکې څخه حذف کړي تاسو کولای شي د هغه معلوماتو د پاکولو غوښتنه وکړي چې تاسو د ونډه اخیستلو په اوږده مونږ ته راکړي او لیکل شوي دي . دا غوښتنه تر هغه وخته کولای شي چې ویډیو ګانی نه وي پاکي شوي . د ویډیوګانو د پاکیدلو څخه وروسته د معلوماتو د ګډون کوونکو د پیژندنې چې کوم معلومات یې ورکړي به ناممکنه وي . ثبت شوي ویډیویی فلمونه به د 2019 ام کال د اکتوبر تر میاشتې پاک شي .

در روانی روغتیا په تحقیق کي د ونډه اخیستلو بلنه

د معلوماتو د پایلې (نتیجه) د وړاندی کولو په وخت کي به د ګډون کوونکو پیژنده ونه شي . د تحقیق پایله یا نتیجه به په تدریس، علمی لیکنو کي به هم په ملی او هم بین المللی سطح وکارول یا وړاندي شي .

پروژه د روان کال د 01.06.2021 نیټې پورې دوام وکړي . کله چې پروژه پای ته ورسیده تاسو کولای شي چې د پایلې خلاصه راپور د تحقیقاتی ګروپ په انترنتي صحفه کي ومومئ .

تاییدی او تصویب کول

د طبی او صحي د تحقیقاتو محلي کمیټي [REK] دغه پروژه برسي او (2013/2181-4, 2016/32-5, 2018/1794 -5) د مخه تاییدی یې ورکړي ده . د ناروی د معلوماتو د تحقیق مرکز سهامي شرکت ته، د برګن د پوهنتون له خواه د ورکړل شوي دنده په اساس دا په ډاګه شوی چې په دي پروژه کي د شخصي معلوماتو برسی د دشخصي محرماتو د قانون سره سمون خوري .

در روانی روغتیا په تحقیق کي د ونډه اخیستلو بلنه

د اړیکو معلومات

مونږ هلیه مند یو چې تاسو دغه تحقیق کي په داوطلبانه توګه ونډه واخلي . که چیرته تاسو پوښتنه لري او یا غواړی چې د خپل د حقونو څخه برخه مند شي تاسو کولای شي چې لاندنیو کسانوسره اړیکه ټینګه کړي :

- د دوکتورا محصله دیکسی بریا [Dixie Brea] ، د تیلیفون شمیره : 555 89 159 ، الکترونیکي آدرس:dixie.brea@uib.no.
- د برګن پوهنتون کي د شخصی محرماتو د محافظت افسر : یانکه هلین ویم *[Janecke Helen Veim]* ، الکترونیکی آدرس : janecke.veim@uib.no ، د تیلیفون شمیره : 55 58 20 29/930 30 721

په درناوي

ګرو میلد هیم ساندال [Gro Mjeldheim Sandal]

پروفیسور / د پروژې آمر

ځای او نیټه لاسلیک (د پروژې آمر)

" زه په دغه پروژه کي په خپله خوښه ونډه اخلم او اجازه ورکوم چې زما شخصی معلوماتو څخه په هغه ډول چې دلته بیان شوي دي کار واخیستل شي"

ځای او نیټه د ګډون کوونکي لاسلیک

د ګډون کوونکي نوم په واضح توګه ولیکل شي

دعوت به شرکت در تحقیقات بر روی صحت و سلامتی روان

دعوت به شرکت در تحقیقات بر روی صحت و سلامتی روان

بسیاری از افراد یک یا چند بار در طول زندگی خود، یا نزد خودشان یا خانواده و یا نزد دوستانشان، مشکلات روانی را تجربه می‌کنند. هدف از این مطالعه به دست آوردن دانش بیشتر است در مورد اینکه چگونه مردم از فرهنگ‌های مختلف بر این باورند که میتوان بر این نوع مشکلات به بهترین نوع ممکن غلبه کرد. یکی از اهداف پروژه این است که با ارائه درک بهتر، چگونه میتوان خدمات صحه و سلامتی روحی و روانی در کشور ناروی را بهتر کرد و آن را با احتیاجات و نیازهای افرادی که به این کشور مهاجرت میکنند، تطبیق داد.

این پروژه شامل چیست؟

این تحقیقات/نظرسنجی توسط گروه پژوهشی تنوع فرهنگی در جامعه و کار در دانشکده روانشناسی دانشگاه برگن برگزار میشود، و توسط شورای تحقیقاتی ناروی تامین مالی میشود. شما میتوانید در مورد گروه تحقیقات در وب سایت ما معلومات بیشتری کسب کنید (https://www.uib.no/fg/saw).

بعنوان یک شرکت‌کننده از شما درخواست میشود که همراه با ٤ تا ٧ نفر دیگر که آنها هم از کشور شما مهاجرت کرده‌اند در یک گفتگوی جمعی شرکت کنید. افراد شرکت‌کننده دیگر نیز از همجنس شما خواهند بود. شخصی که با شما گفتگو میکند سؤالاتش را با زبان نروژی میپرسد، ولی یک ترجمان حضور خواهد داشت که سؤالات را به زبان شما ترجمه خواهد کرد. همچنین شما میتوانید جوابهای خود را با زبان خودتان بیان کنید.

شرکت‌کنندگان در این گفتگو ابتدا داستانی را در مورد یک شخص گوش خواهند کرد. بعد از آن از شما و بقیه شرکت‌کنندگان پرسان خواهد شد که این شخص چگونه میتواند به بهترین نحو ممکن مشکلاتش را چاره‌سر کند. از شما درخواست نخواهد شد تا در مورد صحه و سلامتی یا زندگی خصوصی خودتان معلومات ارائه دهید. این گفتگو تقریبا ۹۰ دقیقه طول خواهد کشید و ضبط ویدئو خواهد شد. بعد از این گفتگوها محققین متن معلومات این ویدئوها را رونویسی خواهند کرد، و بعد از آن فیلم‌های ویدئو پاک و حذف خواهند شد. فقط محققین این گفتگوها را انجام خواهند داد که به نوار ویدیویی آنها هم دسترسی خواهند داشت. تا زمانی که این نوار ویدیویی‌ها حذف خواهند شد در یک کمد مطمئن و قفل‌دار از آنها نگهداری خواهد شد.

مشارکت در این گفتگوها کاملا آزادانه و داوطلبانه میباشد و شما میتوانید هر زمان که بخواهید بدون آنکه توضیحی بدهید آن را بازپس بگیرید. همچنین شما میتوانید در گفتگوها به بعضی از سؤالات که از شما پرسان خواهد شد پاسخ ندهید یا با جزئیات جواب ندهید. در صورتی که میخواهید مشارکت داشته باشید، از شما درخواست میشود که رضایت نامه را در صفحه بعدی امضاء کنید.

برای این معلوماتی که شما ارائه میدهید چه اتفاقی خواهد افتاد؟

تا زمانی که شما را میتوان از طریق معلوماتهای ارائه شده شناسایی کرد، حق دارید:

- دسترسی به معلومات شخصی که در مورد شما جمع آوری شده است
- اصلاح معلومات شخصی در مورد شما
- حذف اطلاعات شخصی در مورد شما،
- دریافت یک کپی از اطلاعات شخصی شما (انتقال معلومات)
- ارسال شکایت به اداره حفاظت از داده یا سازمان حفاظت از معلومات شخصی در مورد بررسی معلومات شخصی خود

دعوت به شرکت در تحقیقات بر روی صحت و سلامتی روان

وقتی که نوارهای ویدیویی رونویسی شدند، تمامی معلومات بصورت محرمانه باقی خواهد ماند و بعدا نمی‌توان آنها را به شما یا سایر شرکت‌کنندگان دیگر ربط داد. اگر نظرتان این بود که خود را از این نظرسنجی کنار بکشید، میتوانید تقاضا کنید که این معلوماتی را که شما ارائه داده‌اید از روی رونویسی‌ها هم حذف شود. شما میتوانید اینکار تا زمانی که نوارهای ویدیویی حذف میشوند انجام دهید. چون بعد از آن امکان ندارد که شخص را شناسایی کرد یا معلوماتی را که ایشان داده است بتوان حذف کرد. نوار ویدیوها تا تاریخ اکتبر ۲۰۱۹ حذف خواهند شد.

هنگام ارائه نتایج حاصل از این نظرسنجی، نتایج آن را نمی توان به افراد پیوند داد. این نتایج در سخنرانی‌ها و مقالات علمی در سطح ملی و بین المللی ارائه خواهد شد.

این پروژه تا تاریخ ۲۰۲۱,٦,۱ طول خواهد کشید. پس از اتمام این پروژه، میتوانید خلاصه ای از نتایج آن را در وب سایت گروه تحقیقاتی پیدا کنید.

تأییدیه

کمیته منطقه‌ای پزشکی (REK) و اخلاق تحقیقاتی مرتبط با سلامتی، این پروژه را مورد ارزیابی قرار داده است، و تأییدیه قبلی آن را داده است (٤-٢٠١٣/٢١٨١، ٥-٢٠١٦/٣٢، ٥-٢٠١٨/١٧٩٤). به نمایندگی از طرف دانشگاه برگن، مرکز تحقیقات بر روی معلومات نروژی به این نتیجه رسیده است که بررسی معلومات شخصی در این پروژه با سیاست حفظ حریم خصوصی مطابقت دارد.

ما بر اساس رضایت شما معلومات مربوط به شما را بررسی میکنیم.

معلومات تماس/ارتباط

ما امیدواریم که شما مایل به شرکت در این نظرسنجی باشید.

اگر سوالی دارید، یا میخواهید از حقوق خود استفاده کنید، میتوانید از طریق زیر تماس بگیرید:

- دانشجوی درجه دکترا Dixie Brea، تلفن نمبر: ٥٥٥٨٩١٥٠، ایمیل: dixie.brea@uib.no
- مسئول حفاظت از معلومات در دانشگاه برگن: *Janecke Helen Veim*، ایمیل: janecke.veim@uib.no،
  تلفن نمبر: ۹۳۰ ۳۰ ۷۲۱ / ٥٥ ٥٨ ٢٠ ٢٩

با درود و احتـــرام

Gro Mjeldheim Sandal

پروفسور/رئیس پروژه

محل و تاریخ　　امضـــاء (رئیس پروژه)

"من موافقت می کنم که در این پروژه شرکت داشته باشم و معلومات شخصی من همانطور که شرح داده شده است مورد استفاده قرار بگیرد"

محل و تاریخ　　امضـــاء شرکت کننده

نام شرکت کننده با حروف کلان

Vignette Depression (engelsk/norsk)

Mossa/Zarina is a 27-year-old waiter in a restaurant in Bergen. He/she was born in Oslo to parents who were restaurant owners but has made Bergen his/her home for 5 years. In the last few weeks, he has been experiencing feelings of sadness every day. Mossa/Zarina's sadness has been continuous, and he cannot attribute it to any specific event or to the season. It is hard for him/her to go to work every day; he/she used to enjoy the company of his/her co-workers and working at the restaurant, but now he/she cannot find any pleasure in this. In fact, Mossa/Zarina has little interest in most activities that he once enjoyed. He/she is not married and lives alone, near his brother/her sister. Usually, they enjoy going out together and with friends. But now he/she does not enjoy this anymore. Mossa/Zarina feels very guilty about feeling so sad and feels that he has let down his brother/her sister and friends. He/she has tried to change his/her work habits and start new hobbies to become motivated again, but he/she cannot concentrate on these tasks. Even his brother/her sister has now commented that Mossa/Zarina gets distracted too easily and cannot make decisions. Since these problems began, Mossa/Zarina has been sleeping poorly every night; he/she has trouble falling asleep and often wakes up during the night. A few nights ago, as he/she lay awake, trying to fall asleep, Mossa/Zarina began to cry because he/she felt so helpless.

Mossa/Zarina 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. Mossa/Zarinas tristhet har vært uavbrutt og han/hun kan ikke finne noen forklaring på de ut ifra ting som har skjedd eller årstiden. Det er vanskelig for ham/henne 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 Mossa/Zarina lite interessert i de fleste aktivitetene som han/hun pleide å like tidligere. Mossa/Zarina 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. Mossa/Zarina har veldig dårlig samvittighet fordi han/hun er så trist og han/hun føler at han/hun har sviktet 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 Mossa/Zarina 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.

Appendix 4 Vignette for Post-traumatic stress disorder (PTSD) used in the FGIs

Vignette PTSD (English) - Mossa

Mossa is a 27-year old waiter in a restaurant in Bergen. He was born in Afghanistan, but had to flee his home country. He lives together with his wife and children. When Mossa first came to Norway, he felt relieved and thought about the future. He made plans for himself and his family. However, soon he is troubled by frequent nightmares about experiences that he had before and during the flight, he has problems falling asleep, and he wakes up many times every night. He often experiences flashbacks of frightening memories, and avoids conversations, situations, for example TV-programs, that can remind him of difficult experiences. He avoids places that awakes memories from the past that he tries to forget. He often feels tense and have pain in his body without any reason. He is easily startled when hearing loud sounds such as a car backfiring or fireworks. Lately both his wife and colleagues in the restaurant have commented that he seems restless and irritable. He feels numb and indifferent to people around him, and even have difficulties with having positive emotions when he is together with his children. He has tried to become more engaged in his family and work, but he finds it very hard. This makes him feel guilty and worthless. It is important for him to take care of his children. When asked about how he feels about the future, Mossa replies that he feels hopeless and does not believe he will live a long life.

Vignette PTSD - Zarina

Zarina is a 27-year old waiter in a restaurant in Bergen. She was born in Afghanistan, but had to flee her home country. She lives together with her husband and children. When Zarina first came to Norway, she felt relieved and thought about the future. She made plans for herself and her family. However, soon she is troubled by frequent nightmares about experiences that she had before and during the flight, she has problems falling asleep, and she wakes up many times every night. She often experiences flashbacks of frightening memories, and avoids conversations, situations, for example TV-programs, that can remind her of difficult experiences. She avoids places that awakes memories from the past that she tries to forget. She often feels tense and have pain in her body without any reason. She is easily startled when hearing loud sounds such as a car backfiring or fireworks. Lately both her husband and colleagues in the restaurant have commented that she seems restless and irritable. She feels numb and indifferent to people around her, and even have difficulties with having positive emotions when she is together with her children. She has tried to become more engaged in her family and work, but she finds it very hard. This makes her feel guilty and worthless. It is important for her to take care of her children. When asked about how she feels about the future, Zarina replies that she feels hopeless and does not believe she will live a long life.

Appendix 5 Consent form to particpate in the online survey (in Pashto, Dari and Arabic)

دعوه للمشاركة في بحث عن الصحة النفسية

كثير من الناس يمرون بمشاكل نفسية مرة أو عدة مرات على مدار حياتهم ، سواء مع أنفسهم أو مع الأسرة أو الأصدقاء .
الهدف من هذه الدراسة هو الحصول على معلومات عن أراء الناس من مختلف الثقافات حول طريقة التعامل مع صعوبات الحياة والسيطرة عليها بأفضل طريقة ممكنة .ويهدف المشروع أيضا إلى تكوين فهم أفضل حول كيفية تقديم خدمات الصحة النفسية في النرويج كي تكون مناسبة لاحتياجات الأشخاص القادمين من بلدان أخرى

ماذا يتضمن المشروع؟

يتم إجراء البحث من قبل مجموعة البحث في التنوع الثقافي في المجتمع والحياة العملية
(Forskningsgruppen for kulturelt mangfold i samfunn og arbeidsliv)
ويتم تمويلها من قبل مجلس البحوث النرويجي (Norges Forskningsråd) وذلك في كلية علم النفس في جامعة بارجين (Bergen)
يمكنك قراءة المزيد عن مجموعة البحث على موقعنا: (https://www.uib.no/fg/saw)
بصفتك مشاركًا في الاستبيان ، سيُطلب منك أولاً قراءة فقرة قصيرة عن أحد الأشخاص .بعد ذلك ، سيكون لديك بعض الأسئلة حول رأيك الخاص بكيفية تعامل هذا الشخص مع مشكلاته على نحو أفضل .سوف يُطلب منك أيضًا الإجابة عن بعض الأسئلة عن نفسك وعن تجاربك في استخدام الخدمات الصحية المختلفة.
المشاركة في هذا المشروع تطوعية .وإذا كنت ترغب في المشاركة ، فاضغط على "أرغب في المشاركة في في أسفل الصفحة وحينها سوف تنتقل إلى الاستبيان .يمكنك في أي وقت ودون إبداء أي أسباب سحب موافقتك وإنهاء إجابتك قبل أن تنتهي من الاستبيان

ما الذي يحدث للمعلومات التي تُدلي بها؟

نظرًا أنّنا نجمع المعلومات بطريقة لا تجعل من الممكن التعرّف عليك وعلى إجاباتك تحديداً، لذلك لا يمكن حذفها بعد الردّ عليها .سوف يتم التعامل مع المعلومات التي تدلي بها بسرية تامة، ولن يُطلب منك أن تقدم أي اسم أو تاريخ ميلاد أو غيرها من المعلومات التي قد ترتبط بك مباشرة.
سيتم عرض النتائج في المحاضرات والمقالات العلمية على المستويين الوطني والدولي .سوف يستمر المشروع حتى 01/06/ 2021 .بعد إنهاء المشروع ستجد ملخصًا للنتائج على الموقع الالكتروني لمجموعة البحث.

الموافقة

نقوم بالتعامل مع المعلومات التي تخصك بناءً على موافقتك.
وهذه المهمة تتم تحت رعاية جامعة بارجين ،وبموافقة المركز النرويجي للبحوث والبيانات والذي قرر ان التعامل مع البيانات الشخصية في هذا المشروع سيكون طبقا للائحة سياسة الخصوصية .وقد نظرت اللجنة الإقليمية للطب وأخلاقيات البحوث الصحية (REK) : معرف الوثيقة .1794/ 2018-1 في المشروع وقدمت موافقة مسبقة برقم: 1078887
تم استلام الوثيقة بتاريخ 25.09.2018.

معلومات الاتصال:

نأمل أن تكون راغبا في المشاركة في الاستبيان .إذا كان لديك أي أسئلة ، يرجى الاتصال بطالب الدكتوراه فيلدا أوريتون Vilde Aarethun، عنوان البريد الإلكتروني: vilde.aarethun@uib.no ،الهاتف55583186
أو طالب الدكتوراه ديكسي بريا Dixie Brea ، عنوان البريد الإلكتروني: dixie.brea@uib.no ،هاتف: 55583216

يجب أن يكون عمرك ١٨ عاماً للمشاركة في هذا الإستبيان .بالضغط على الزر، أنا أقر أني مستعد للمشاركة في هذا الإستبيان، وأنك تؤكد أيضاً أنك قد بلغت سن ١٨ عاماً

مع تحيات
جرو ميالهيم ساندال

د روانی / عصبی روغتیا په هکله یه څیړنه کی د ګډون بلن لیک

ډیر انسانان د خپل د ژوند په ترڅ کی یو یا څو ځلی له روانی روغتیا یی ستونزو سره مخامخ کیږی ، یا په خپله او یا د کورنی غړی یی او یا ملګری یی . له دی مطالعی څخه موخه دا ده چی په دی هکله نوره پوهه ترلاسه شی چی خلک په نورو مختلفو فرهنګونو کی څه فکر لری چی دی ډول ستونزو سره باید څنګه چلند وشی تر څو تر قابو لاندی راشی . ددی پروژی څخه یو بل هدف دا ده چی وشو کولای دا پوهه لا ډیره کړو چی څنګه کولای شو په ناروی کی روانی روغتیایی خدمتونه د هغو خلکو لپاره چی له نورو ملکو څخه دی د هغو دی اړتیاوو په اساس عیار / برابر کړو .

په دی پروژه کی څه شی شامل دی ؟

دا څیړنه د ټولنی او په کاری ژوند کی د فرهنګی تنوع لپاره د څیړونکو د یوی ډلی له خوا ، چی د برګن په پوهنتون کی له روان پیژندنی پوهنځی سره تراو لری ، تر سره کیږی ، او مصارف یی د ناروی د محققینو د شورا له خوا ورکول کیږی . تاسی کولی شی د مونږ د څیړونکو د ډلی په هکله د ډیرو معلوماتو لپاره زمونږ په بریښنایی پاڼو کی ولولی (https://www.uib.no/fg/saw).

په دی څیړنه کی د یوه ګډونکونکی په صفت له تاسی څخه به غوښتنه وشی چی د یو کس په اړوند یو لنډ متن ولولی . وروسته به له تاسی څخه ځینی پوښتنی وشی چی دی تاسی په فکر به دغه کس څنګه کولای شی د خپل ستونزی په یو ښه توګه حل کړی . له تاسی څخه به هم پوښتنه وشی چی ځینو پوښتنو ته د تاسی په هکله ځواب ورکړی ، او دی تاسی د تجربو په هکله له صحی خدمتونو نه له ګټی اخیستلو څخه .

د تاسو ګډون په پروژه کی د ستاسو په خوښه ده . که چیری تاسی غواړی چی ګډون وکړی ، نو د « هو زه غواړم چی په څیړنه کی برخه واخل » ته چی د پاڼی په لندنی برخه کی شتون لری فشار ورکړی ، بیا به تاسی د پوښتنو فورمی ته ور منتقل شی . تاسی کولی شی بی له دی چی دلیل یی ووایی د خپل رضایت لیک بیرته واخلی او سوالونو ته ځواب ورکول مخکی له دی چی ختم شی ختم کړی .

له هغو معلومات سره چی تاسی یی ورکوی څه کیږی ؟

مونږ نه شو کولای هغه معلومات را ټول کړو کوم چی د هغه پواسطه وشو کولای تا او یا د تاسی په واسطه ورکړل شوی ځوابونه په نښه کړو ، نو له دی امله نه شو کولای وروسته له دی چی تاسی پوښتنو ته ځوابونه وویل هغه له منځه یوسو . په ټولو هغه معلوماتو باندی چی تاسی یی ورکوی په ډیره محرمه توګه کار کیږی ، او تاسی به د خپل نوم ، د زیږیدلو نمبر او یا داسی نور معلومات چی په مستقیمه توګه له تاسی سره تړلی وی ، نه ورکوی . د څیړنو نتیجی به په لکچرونو او ساینسی مقالو کی په ملی او بین المللی سطحه کی وړاندی کیږی . دا پروژه به تر ۲۰۲۱,۰۶,۰۱ پوری دوام وکړی . وروسته له دی چی پروژه ختمه شی تاسی کولای شی د هغه د نتیجو خلاصه د څیړونکو د ډلی په بریښنایی پاڼه کی وګوری .

منظوری

مونږ به پر معلوماتو باندی د تاسی د رضایت لیک پر بنسټ کار وکړو .

NSD (د ناروی د تحقیقاتی معلوماتو مرکز) چی د برګن د پوهنتون له خوا ورته دنده ورکړل شوی وه دا یی و څیړل چی آیا په شخصی معلوماتو باندی کار کول په دی پروژه کی د شخصی معلوماتو د قوانینو سره په مطابقت کی دی او که نه . د روغتیا لپاره د سیمه ییزې کمیټي (REK) او د روغتیا اړونده اخلاقی څیړنو دا پروژه وڅیړله او تایید یی کړه . ۲۰۱۸/۱۷۹۴-۱ . د سند د پیژندنی نمبر : ۱۰۷۸۸۸۷ ، سند په ۲۵,۰۹,۲۰۱۸ کی راورسیده .

د اړیکی نیولو لپاره معلومات

مونږ هیله مند یو چی تاسی وغواړی چی په دی څیړنه کی برخه واخلی . که چیری تاسی کومه پوښتنه لری د دوکترا له محصل ویلده اورتون (Vilde Aarethun) سره په دی شمیره کی (۵۵۵۸۳۱۸۶) او په دی بریښنایی لیک (vilde.aarethun@uib.no) کی اړیکه ونیسی . او یا د دوکترا له محصل دیکسی بریا (Dixie Brea) سره په دی شمیره کی (۵۵۸۹۱۵۰) او په دی بریښنایی لیک (dixie.brea@uib.no) کی اړیکه ونیسی .

په درناوی

ګرو میلد هیم ساندال (Gro Mjeldheim Sandal)

پروفیسر ، د پروژی مشر

دعوت به شرکت در تحقیقات بر روی صحت و سلامتی روان

بسیاری از افراد یک یا چند بار در طول زندگی خود، یا نزد خودشان یا خانواده و یا نزد دوستانشان، مشکلات روانی را تجربه می‌کنند. هدف از این مطالعه به دست آوردن دانش بیشتر در مورد چگونه مردم از فرهنگ‌های مختلف بر این باورند که میتوان بر این نوع مشکلات به بهترین نوع ممکن غلبه کرد. یکی از اهداف پروژه این است که با ارائه درک بهتر، چگونه میتوان خدمات صحه و سلامتی روحی و روانی در کشور ناروی را بهتر کرد و آن را با احتیاجات و نیازهای افرادی که به این کشور مهاجرت میکنند، تطبیق داد.

این پروژه شامل چیست؟

این تحقیقات توسط گروه پژوهشی تنوع فرهنگی در جامعه و کار در دانشکده روانشناسی دانشگاه برگن برگزار میشود، و توسط شورای تحقیقاتی ناروی تامین مالی میشود. شما میتوانید در مورد گروه تحقیقات در وب سایت ما معلومات بیشتری کسب کنید (https://www.uib.no/fg/saw).

به عنوان یک شرکت کننده در این نظرسنجی، ابتدا از شما خواسته میشود که یک پاراگراف کوتاه درباره یک شخص را بخوانید. سپس چند پرسش برای شما در نظر گرفته خواهد شد که این شخص چگونه میتواند به بهترین نحو ممکن، با مشکلات خودش مقابله کند. همچنین از شما خواسته خواهد شد که به برخی سوالات درباره خود و تجربه خود در استفاده از خدمات مختلف صحه و سلامتی پاسخ دهید.

مشارکت در این پروژه داوطلبانه است. اگر میخواهید شرکت کنید، این دگمه را "من داوطلبانه در این تحقیقات شرکت خواهم کرد (jeg er villig til å delta i undersøkelsen)" فشار دهید که در پایین صفحه قرار دارد و بدین ترتیب شما به صفحه فرم سؤالات انتقال پیدا خواهید کرد. شما می توانید این رضایت خود را هر زمان باز پس بگیرید و پاسخ‌های خود را در هر زمان و بدون ارائه هیچ دلیلی قبل از پایان دادن به آنها متوقف کنید.

معلوماتی که شما ارائه میدهید چه خواهد شد؟

از آنجا که ما معلوماتی را جمع آوری نمیکنیم که اجازه دهد دقیقا هویت شما و پاسخ‌های شما شناسایی شود، این امکان وجود ندارد که بعد از پاسخ به آنها دوباره آنها را حذف کرد. هر گونه معلوماتی را که ارائه میدهید، به صورت کاملا محرمانه مورد رسیدگی قرار میگیرد، و شما نباید نام، شماره هویت ملی یا سایر معلوماتی را که به طور مستقیم با شما مرتبط باشد، ارائه دهید. نتایج در سخنرانیها و مقالات علمی در سطح ملی و بین المللی ارائه خواهد شد. این پروژه تا تاریخ ۲۰۲۱,٦,۱ ادامه پیدا خواهد کرد. پس از اتمام پروژه، میتوانید نتیجه‌گیری از نتایج آن را در وب سایت گروه تحقیقاتی پیدا کنید.

تصویب

ما بر اساس رضایت شما معلومات مربوط به شما را رسیدگی میکنیم.

از طرف دانشگاه برگن، مرکز تحقیقات داده های نروژی (NSD) این را در نظر گرفته است که رسیدگی به معلومات شخصی در این پروژه، مطابق با قوانین و مقررات مربوط به حفظ حریم خصوصی میباشد. کمیته پزشکی منطقه‌ای (REK) و سازمان پژوهشی مرتبط با صحه و سلامتی، این پروژه را مورد بررسی قرار داده‌اند، و از قبل آن را مورد تأیید قرار داده است.
۲۰۱۸/۱۷۹٤-۱. نمبر سند: ۱۰۷۸۸۸۷ دریافت سند: ۲۰۱۸,۹,۲۵.

معلومات ارتباطات

ما امیدواریم که شما مایل به شرکت در این تحقیقات باشید. و اگر سوالی دارید، لطفا با داکتر Vilde Aarethun با تلفن نمبر ۵۵۵۸۳۱۸٦، ایمیل: vilde.aarethun@uid.no یا داکتر Dixie Brea با تلفن نمبر ۵۵۵۸۹۱۵۰، ایمیل: dixie.brea@uib.no تماس بگیرید.

با احترام

Gro Mjeldheim Sandal

پروفسور، مدیر پروژه

Appendix 5 Invitation to participate in the online survey (in Norwegian)

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

Invitasjon til å delta i undersøkelse om psykisk helse

Foto: Colourbox

Mange mennesker opplever psykiske helseplager en eller flere ganger i løpet av livet. Vi ønsker å få en bedre forståelse for hvordan psykiske helsetjenester kan forbedres og tilpasses behovene til mennesker som kommer fra ulike land. Derfor trenger vil hjelp fra deg som er fra Syria, Somalia eller Afghanistan.

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, og du skal ikke oppgi navn, fødselsnummer eller annen informasjon som kan knyttes direkte til deg.
Har lyst til å delta i undersøkelsen? Gå inn på linken, eller scann QR-koden. Disse finner du på neste side.

Miljøfyrtårn

UNIVERSITETET I BERGEN

Kontaktinformasjon

Vi håper at du er villig til å delta i undersøkelsen. Om du har spørsmål kan du kontakte:

Prosjektleder og professor Gro Mjeldheim Sandal, telf 55588685, epostadresse: Gro.Sandal@uib.no

doktorgrad-stipendiat Vilde Aarethun, telefon 55583186, epostadresse: vilde.aarethun@uib.no

eller

doktorgrad-stipendiat Dixie Brea, telefonnummer: 55583216, epostadresse: dixie.brea@uib.no.

Lin til undersøkelsen: https://www.uib.no/fg/saw/127255/invitasjon-til-%C3%A5-delta-i-unders%C3%B8kelse-om-psykisk-helse

QR-kode

Arabisk Somali Dari Pashto

Appendix 6 Email invitation sento to organizations for participant recruitment

INVITASJON TIL SAMARBEID OM UNDERSØKELSE OM FLYKTNINGERS PSYKISKE HELSE

Jeg kontakter deg i forbindelse med vårt forskningsprosjekt «kliniske møter med flyktninger med psykiske helseplager». Prosjektet gjennomføres ved Universitetet i Bergen og er finansiert av Norges Forskningsråd. Målet med prosjektert er å bidra til en bedre forståelse av hvordan psykiske helsetjenester kan tilpasses flyktningers behov, med spesielt fokus på flyktninger fra Afghanistan, Syria og Somalia. Du finner mer informasjon om prosjektet her: https://www.uib.no/fg/saw/114416/hvordan-hjelper-helsevesenet-flyktninger-med-psykiske-plager

Som en del av prosjektet, gjennomfører vi en undersøkelse ved hjelp av elektroniske spørreskjema. Jeg håper at dere kan hjelpe oss å videreformidle spørreskjemaet til mulige deltakere i målgruppen. Deltakerne må være over 18 år og fra et av de overnevnte landene. Vi ønsker å understreke at undersøkelsen ikke spesifikt er rettet mot pasienter eller personer som allerede har psykiske lidelser. Alle personer over 18 år fra de respektive landene, er velkommen til å delta. Som deltaker i undersøkelsen vil man først bli bedt om å lese et kort avsnitt om en person. Deretter vil man få noen spørsmål om hvordan man mener at denne personen best mulig kan håndtere problemene sine. Til slutt blir man bedt om å besvare noen spørsmål om seg selv og sine erfaringer med bruk av ulike helsetjenester. Det er frivillig å delta i prosjektet, og man skal ikke oppgi navn, fødselsnummer eller annen informasjon som kan knyttes direkte til deltakerne.

Under finner du lenke til vår UiB-nettside hvor man kan få mer informasjon om undersøkelsen. Lenken er til spørreskjema på ulike språk.
https://www.uib.no/fg/saw/127255/invitasjon-til-%C3%A5-delta-i-unders%C3%B8kelse-om-psykisk-helse

Vi setter stor pris på samarbeid i forbindelse med å nå så mange som mulig i undersøkelsen.

Alle organisasjoner/foreninger som bidrar, vil bli invitert til en workshop hvor vi legger frem resultater fra undersøkelsen.

Ta gjerne kontakt med doktorgradsstipendiat Dixie Brea (dixie.brea@uib.no, 55 58 32 16) ved spørsmål eller for mer informasjon. Du kan også kontakte undertegnede.

På forhånd takk!

Med vennlig hilsen,
Gro Mjeldheim Sandal
Professor, Society and Workplace Diversity Research Group (leader)
Department of Psychosocial Science,
Christiesgt 12, 5015 Bergen,
Norway
Phone: +47 55588685

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

☐ Jeg er villig til å delta i undersøkelsen

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

- ☐ Jeg mottok en epost, melding eller brev fra forskerne
- ☐ Jeg mottok en henvendelse fra ansatte på introduksjonsprogrammet
- ☐ Jeg mottok en henvendelse/invitasjon gjennom sosiale medier (f.eks. Facebook)
- ☐ Jeg mottok en henvendelse fra noen på min arbeidsplass eller skole
- ☐ Venner eller andre som jeg kjenner fortalte meg om undersøkelsen
- ☐ Annet

Alder

- ☐ 19 år eller yngre
- ☐ Mellom 20 og 29 år
- ☐ Mellom 30 og 39 år
- ☐ Mellom 40 og 49 år
- ☐ Mellom 50 og 59 år
- ☐ Mellom 60 og 69 år
- ☐ 70 år eller eldre

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

- ☐ Jeg ble født i Norge
- ☐ 9 år eller yngre
- ☐ Mellom 10 og 19 år
- ☐ Mellom 20 og 29 år
- ☐ Mellom 30 og 39 år
- ☐ Mellom 40 og 49 år
- ☐ Mellom 50 og 59 år
- ☐ Mellom 60-69 år
- ☐ 70 år eller eldre

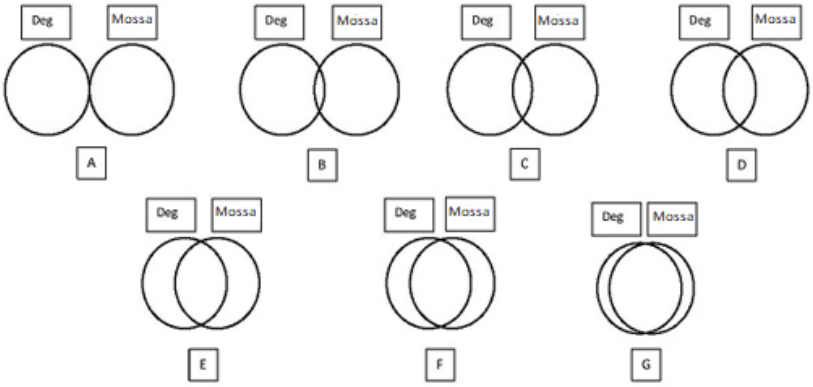
Kjønn

- ☐ Mann
- ☐ Kvinne

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

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

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



Deg = شما

Mossa = موسی

- ❑ A
- ❑ B
- ❑ C
- ❑ D
- ❑ E
- ❑ F
- ❑ G

Vi ber deg om å markere sirkelen som best beskriver hvor enig du er i følgende utsagn.

	Svært uenig	Uenig	Noe uenig	Noe enig	Enig	Svært enig
Mossa burde bruke urter og naturpreparater	❑	❑	❑	❑	❑	❑
Mossa burde gitt uttrykk for følelsene sine	❑	❑	❑	❑	❑	❑
Mossa burde skamme seg	❑	❑	❑	❑	❑	❑
Mossa burde drive mer fysisk trening	❑	❑	❑	❑	❑	❑
Mossa burde legge skylden på andre enn seg selv	❑	❑	❑	❑	❑	❑
Mossa burde hvile mer	❑	❑	❑	❑	❑	❑
Mossa burde være mer ute i naturen	❑	❑	❑	❑	❑	❑
Mossa burde ikke fortelle noen om hvordan han føler seg	❑	❑	❑	❑	❑	❑
Mossa burde bruke medisiner	❑	❑	❑	❑	❑	❑
Mossa burde ta seg tid til å reflektere over livet sitt	❑	❑	❑	❑	❑	❑
Mossa burde oppmuntre seg selv	❑	❑	❑	❑	❑	❑
Mossa har ingen grunn til å være trist	❑	❑	❑	❑	❑	❑
Mossa burde få seg et kjæledyr	❑	❑	❑	❑	❑	❑
Mossa burde begynne med yoga eller meditasjon	❑	❑	❑	❑	❑	❑
Det er ingenting galt med Mossa	❑	❑	❑	❑	❑	❑
Mossa burde finne seg en partner	❑	❑	❑	❑	❑	❑
Mossa trenger ikke å gjøre noe	❑	❑	❑	❑	❑	❑
Mossa burde be eller spørre noen andre om å be for ham	❑	❑	❑	❑	❑	❑
Mossa burde engasjere seg i fritidsaktiviteter for å få tankene bort fra situasjonen	❑	❑	❑	❑	❑	❑
Mossa burde få hjelp til å revurdere kostholdet sitt	❑	❑	❑	❑	❑	❑
Mossa burde få hjelp til å finne ut om han er offer for ondskapsfull trolldom eller onde ånder	❑	❑	❑	❑	❑	❑
Mossa trenger å forsone seg med Gud	❑	❑	❑	❑	❑	❑
Mossa trenger å revurdere sin livssituasjon	❑	❑	❑	❑	❑	❑
Mossa burde bruke alkohol eller andre stoffer (for eksempel marihuana eller khat) for å slappe mer av	❑	❑	❑	❑	❑	❑
Mossa burde holde seg hjemme og ikke arbeide inntil han føler seg bedre	❑	❑	❑	❑	❑	❑
Mossa burde gifte seg	❑	❑	❑	❑	❑	❑
Mossa bør unngå å tenke for mye	❑	❑	❑	❑	❑	❑
Mossa bør snakke med en han har tillitt til	❑	❑	❑	❑	❑	❑
Mossa burde sette seg noen utfordrende mål i livet	❑	❑	❑	❑	❑	❑
Mossas situasjon lar seg ikke løse	❑	❑	❑	❑	❑	❑
Mossa burde visualisere sine drømmer og forsøke å oppnå dem	❑	❑	❑	❑	❑	❑
Mossa burde snakke med noen fra sin etniske gruppe om situasjonen	❑	❑	❑	❑	❑	❑
Mossa burde forsøke å finne ut om dette er et vanlig problem i sin etniske gruppe	❑	❑	❑	❑	❑	❑
Mossa burde gjøre det samme som andre folk i hans etniske gruppe gjør når de har lignende problem	❑	❑	❑	❑	❑	❑
Mossa burde involvere andre i sin etniske gruppe for å løse problemet	❑	❑	❑	❑	❑	❑
Mossa bør unngå å være med mennesker generelt	❑	❑	❑	❑	❑	❑

Hvis du hadde hatt det sånn som Mossa, i hvilken grad ville du ha handlet slik som det står beskrevet nedenfor

	Ikke i det hele tatt	Litt	Ganske mye	Veldig mye
Jeg ville ha gjort ting for å få tankene bort	❑	❑	❑	❑
Jeg ville ha konsentrert meg om å gjøre noe med situasjonen jeg er i	❑	❑	❑	❑
Jeg ville ha sagt til meg selv: «Dette er ikke sant»	❑	❑	❑	❑
Jeg ville ha brukt alkohol eller andre stoffer for å føle meg bedre	❑	❑	❑	❑
Jeg ville ha fått sympati eller støtte fra andre	❑	❑	❑	❑
Jeg ville ha gitt opp å prøve å takle det	❑	❑	❑	❑
Jeg ville ha gjort ulike ting for å prøve å gjøre situasjonen bedre	❑	❑	❑	❑
Jeg ville ha nektet å tro at dette skjer med meg	❑	❑	❑	❑
Jeg ville ha sagt ting for å få de ubehagelige følelsene til å forsvinne	❑	❑	❑	❑
Jeg ville ha søkt hjelp og råd fra andre	❑	❑	❑	❑
Jeg ville ha brukt alkohol eller andre stoffer for å klare å komme gjennom det	❑	❑	❑	❑
Jeg ville ha prøvd å se ting i et annet lys for å se mer positivt på situasjonen	❑	❑	❑	❑
Jeg ville ha kritisert meg selv	❑	❑	❑	❑
Jeg ville ha prøvd å lage en plan for å takle situasjonen	❑	❑	❑	❑
Jeg ville ha søkt trøst og forståelse hos noen	❑	❑	❑	❑
Jeg ville ha gitt opp	❑	❑	❑	❑
Jeg ville ha prøvd å se noe positivt i situasjonen	❑	❑	❑	❑
Jeg ville ha prøvd å spøke med det	❑	❑	❑	❑
Jeg ville ha gjort noe for å la være å tenke mindre på situasjonen	❑	❑	❑	❑
Jeg ville ha akseptert situasjonen som den er	❑	❑	❑	❑
Jeg ville ha gitt uttrykk for de negative følelsene mine	❑	❑	❑	❑
Jeg ville ha prøvd å finne trøst i troen eller religionen min	❑	❑	❑	❑
Jeg ville ha prøvd å få råd og hjelp fra andre om hva jeg skal gjøre	❑	❑	❑	❑
Jeg ville ha lært å leve med det	❑	❑	❑	❑
Jeg ville ha tenkt mye på hva jeg skulle gjøre	❑	❑	❑	❑
Jeg ville ha hatt skyldfølelse	❑	❑	❑	❑
Jeg ville ha bedt eller meditert	❑	❑	❑	❑
Jeg ville ha prøvd å se det humoristiske i situasjonen	❑	❑	❑	❑

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	Svært mye
Plutselig skremt uten grunn	❑	❑	❑	❑
Føler du deg engstelig	❑	❑	❑	❑
Føler du deg svimmel eller kraftløs	❑	❑	❑	❑
Nervøs eller urolig	❑	❑	❑	❑
Hjertebank	❑	❑	❑	❑
Skjelving	❑	❑	❑	❑
Føler deg anspent eller opphisset	❑	❑	❑	❑
Hodepine	❑	❑	❑	❑
Anfall av redsel eller panikk	❑	❑	❑	❑
Rastløshet, kan ikke sitte rolig	❑	❑	❑	❑
Føler deg slapp og uten energi	❑	❑	❑	❑
Anklager deg selv for ting	❑	❑	❑	❑
Har lett for å gråte	❑	❑	❑	❑
Tap av seksuell interesse/opplevelse	❑	❑	❑	❑
Dårlig appetitt	❑	❑	❑	❑
Vanskelig for å sove	❑	❑	❑	❑
Følelse av håpløshet mht. framtiden	❑	❑	❑	❑

Føler deg nedfor	❑	❑	❑	❑
Føler deg ensom	❑	❑	❑	❑
Har tanker om å ta ditt eget liv	❑	❑	❑	❑
Følelse av å være fanget	❑	❑	❑	❑
Bekymrer deg for mye	❑	❑	❑	❑
Føler ikke interesse for noe	❑	❑	❑	❑
Føler at alt krever stor anstrengelse	❑	❑	❑	❑
Føler at du ikke er noe verd	❑	❑	❑	❑

Stort sett vil du si at din helse er:

- ☐ Utmerket
- ☐ Meget god
- ☐ God
- ☐ Nokså god
- ☐ Dårlig

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

- ☐ Ja
- ☐ Nei

Har du barn?

- ☐ Ja
- ☐ Nei

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

- ☐ En storby
- ☐ En forstad eller utkanten av en storby
- ☐ En liten eller mellomstor by
- ☐ Et bygdesentrum
- ☐ Et spredtbygd strøk

Hvor knyttet til Norge føler du deg?

- ☐ Jeg føler en ekstremt nær tilknytning
- ☐ Jeg føler en veldig nær tilknytning
- ☐ Jeg føler en moderat tilknytning
- ☐ Jeg føler en svak tilknytning
- ☐ Jeg føler ingen tilknytning i det hele tatt

Hvor ofte føler du deg som en fremmed i Norge?

- ☐ Aldri
- ☐ Sjeldent
- ☐ Av og til
- ☐ Ofte
- ☐ Alltid

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

- ☐ Jeg vil definitivt bo i Norge resten av livet
- ☐ Jeg vil sannsynligvis bo i Norge resten av livet
- ☐ Jeg er usikker på om jeg vil bli i Norge eller om jeg vil flytte til et annet land
- ☐ Jeg vil sannsynligvis flytte til et annet land
- ☐ Jeg vil definitivt flytte til et annet land

Hvor ofte føler du deg isolert fra det norske samfunnet?

- ☐ Aldri
- ☐ Sjeldent
- ☐ Av og til
- ☐ Ofte
- ☐ Alltid

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

- ☐ Veldig vanskelig
- ☐ Ganske vanskelig
- ☐ Hverken vanskelig eller lett
- ☐ Ganske lett
- ☐ Veldig lett

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

- ☐ Veldig vanskelig
- ☐ Ganske vanskelig
- ☐ Hverken vanskelig eller lett
- ☐ Ganske lett
- ☐ Veldig lett

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

- ☐ Ringe etter en ambulanse
- ☐ Oppsøke legevakten
- ☐ Gå til fastlegen
- ☐ Spørre en leder på jobb
- ☐ 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).*

- ☐ Under 150.000 kr
- ☐ 150.000 kr – 249.999 kr
- ☐ 250.000 kr - 349.999 kr
- ☐ 350.000 kr - 449.999 kr
- ☐ 450.000 kr – 549.999 kr
- ☐ 550.000 kr – 749.999 kr
- ☐ 750.000 kr – 999.999 kr
- ☐ 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	☐	☐
10.000 kroner	☐	☐
100.000 kroner	☐	☐
500.000 kroner	☐	☐

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
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ Mer enn 15

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

- ☐ I lønnet arbeid (eller midlertidig fraværende)
- ☐ Under utdanning (som ikke er betalt av arbeidsgiver, eller midlertidig fraværende)
- ☐ Arbeidsledig og aktivt arbeidssøkende
- ☐ Arbeidsledig, ønsker en jobb, men er ikke aktivt arbeidssøker
- ☐ Varig syk eller funksjonshemmet
- ☐ Pensjonert
- ☐ Hjemmeværende, passer barn eller andre personer
- ☐ Annet

Har du en eller flere norske venner?

- ☐ Nei
- ☐ Ja, jeg har én norsk venn
- ☐ Ja, jeg har flere norske venner

Har du en eller flere afghanske venner i Norge?

- ☐ Nei
- ☐ Ja, jeg har én afghansk venn i Norge
- ☐ Ja, jeg har flere afghanske venner i Norge

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

- ☐ Aldri
- ☐ Én gang i uken
- ☐ 2-3 ganger i uken
- ☐ 4-6 ganger i uken
- ☐ Hver dag
- ☐ 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?

- ☐ Aldri
- ☐ En gang i året
- ☐ En gang i måneden
- ☐ En gang i uken
- ☐ 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?

- ☐ 0
- ☐ 1 til 2
- ☐ 3 til 6
- ☐ 7 til 14
- ☐ 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?

- ☐ Aldri
- ☐ En gang i året
- ☐ En gang i måneden
- ☐ En gang i uken
- ☐ Omtrent hver dag

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

- ☐ Kun negativ
- ☐ For det meste negativ
- ☐ Blandet negativ og positiv
- ☐ For det meste positiv
- ☐ 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:

- ☐ Veldig godt
- ☐ Godt
- ☐ Nokså godt
- ☐ Ikke så godt
- ☐ 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.

- ☐ Veldig godt
- ☐ Godt
- ☐ Nokså godt
- ☐ Ikke så godt
- ☐ Ikke godt i det hele tatt

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

- ☐ Har ikke fullført noen utdanning
- ☐ Barneskole eller grunnskole 1-6 år
- ☐ Barneskole eller grunnskole 7-8 år
- ☐ Barneskole eller grunnskole 9-10 år
- ☐ Videregående skole 1-2 år
- ☐ Videregående skole 3 år
- ☐ Videregående skole 4 + år
- ☐ Universitet eller høgskole 1-2 år
- ☐ Universitet eller høgskole 3-4 år
- ☐ Universitet eller høgskole 5+ år
- ☐ Universitet eller høgskole ph.d.

Her følger en serie spørsmål som går forskjellige sider ved livet. Hvert spørsmål har flere valgmuligheter. Marker alternativet som passer best for deg.

Har du følelsen av at du egentlig ikke bryr deg om det som foregår rundt deg?

1 Svært sjelden eller aldri ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Svært ofte ❑

Har du noen gang blitt overrasket over oppførselen til folk du trodde du kjente godt?

1 Aldri skjedd ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Alltid skjedd ❑

Har det skjedd at mennesker du stolte på har skuffet deg?

1 Aldri skjedd ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Alltid skjedd ❑

Hittil har ditt liv var preget av

1 Ingen klare mål eller mening i det hele tatt ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Svært klare mål og mening ❑

Har du følelsen av å bli urettferdig behandlet?

1 Svært ofte ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Aldri ❑

Har du følelsen av å være i en uvant situasjon og ikke vite hva du skal gjøre?

1 Svært ofte ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Svært sjelden eller aldri ❑

Dine daglige gjøremål er

1 En kilde til dyp glede og tilfredstillelse ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 En kilde til smerte og kjedsomhet ❑

Har du svært blandede følelser og ideer?

1 Svært ofte ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 Svært sjelden eller aldri ❑

Har det hendt at du har følelser du helst ikke ville hatt?

1 Svært ofte 2 3 4 5 6 7 Svært sjelden eller aldri

Mange mennesker, selv de med sterk personlighet, føler seg noen ganger som «tapere» i visse situasjoner. Hvor ofte har du følt det slik?

1 Aldri 2 3 4 5 6 7 Svært ofte

Når noe har skjedd, har du stort sett følt at

1 Du har overvurdert eller undervurdert viktigheten av det 2 3 4 5 6 7 Du vurderte tingene på riktig måte

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Explanatory models of post-traumatic stress disorder (PTSD) and depression among Afghan refugees in Norway

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Abstract

Background: The current situation in Afghanistan makes it likely that we are facing a new wave of Afghan refugees, warranting more knowledge about how to deal with mental health problems among them. This study aims to gain more knowledge on Explanatory Models (EM) of depression and post-traumatic stress disorders (PTSD) among Afghan refugees resettled in Norway.

Methods: We conducted six gender-separated, semi-structured focusgroup interviews based on vignettes with Afghan refugees (total N = 27). The vignettes described a fictional character with symptoms of either depression or PTSD symptoms in line with DSM-5 and ICD-10 criteria.

Results: The findings showed that EM varied with gender, age, generation, and migration stories. Participants suggested different potential causes, risk factors, and ways of managing symptoms of depression and PTSD depending on the context (e.g., in Norway vs. Afghanistan). In describing the causes of the depression/PTSD in the vignettes, females tended to emphasize domestic problems and gender issues while males focused more on acculturation challenges. The younger males discussed mostly traumatic experiences before and during flight as possible causes.

Conclusion: The practice of condensing a single set of EMs within a group may not only be analytically challenging in a time-pressed clinical setting but also misleading. Rather, we advocate asking empathic questions and roughly mapping individual refugee patients' perceptions on causes and treatment as a better starting point for building trusting relationships and inviting patients to share and put into practice their expertise about their own lives.

Keywords: Refugees, Explanatory models, PTSD and depression, Afghan refugees

Background

While many groups of refugees have consistently shown high prevalence of mental health problems [1–4], underutilization of mental health services, alternative help-seeking preferences, and different illness explanatory models have consistently posed barriers for effective treatment [5–7]. Earlier research has documented variations in the way refugee groups explain and view mental health problems [8, 9]. Discrepancies in understanding conceptions of mental health may hamper the recognition of mental health problems in patients from other societies, with the risk of misdiagnosis or treatment failure.

The current situation in Afghanistan in the fall of 2021 makes it likely that we are facing a new wave of Afghan refugees, warranting more knowledge about how to deal with mental health problems among them. In this article, we investigate explanatory models (EMs) of post-traumatic stress disorders (PTSD) and depression among Afghan refugees settled in Norway. We argue for a need

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to venture beyond notions of static cultural models, since culture is often characterized by intra-cultural variations (differences within a cultural group related to e.g., geography, education, gender and occupation); a dynamic interplay between individual agency and social processes; and renegotiations of cultural understandings and interpretations with others [10, 11]. Thus, we propose a need to improve our understanding and identify how refugee groups perceive and prefer to cope with mental health problems in dynamic, fluid, and multiple ways.

Explanatory models

The concept of illness explanatory models (EMs) has been employed to ensure culturally sensitive care, enhance therapeutic alliances between professionals and patients, and improve our understanding of help-seeking paths, treatment compliance, and receptivity to health promotion messages [12–14]. A string of seminal works in medical anthropology throughout the 1970's (e.g., [15–17]) led to the recognition that patient-doctor interactions are transactions between EMs that may often diverge from each other in terms of explanations, expectations and goals [18]. Kleinman [19] defined EMs as notions about an illness episode and the treatment employed by those involved in a clinical process, including patients, their families, and their doctors. With the aid of a series of qualitative questions, Kleinman attempted to bring to light variations in beliefs about causes for a patient's illness and ideas about treatment and outcomes, as a clinical tool.

Finding that differences in perceptions about symptoms and treatment may cause patients to underutilize public health services or drop out of treatment [5, 20, 21], a great deal of research has focused on mapping explanatory models among various ethnic groups, refugees, and migrants [8, 22–24]. Many studies in this field have found that mental health problems such as depression and PTSD are often perceived as resulting from psychosocial causes rather than physical or biological [24], and that participants in these studies often prefer to cope with their problems by relying on e.g., family, social networks, traditional healers, and religious practices, rather than professional treatment inside public health services.

The concern that a lack of understanding of perceptions of mental health problems in low-income and war-torn countries may represent a barrier towards effective treatment for refugees, has led to a revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Consequently, in DSM-5 *cultural concept of distress* is used to distinguish cultural traits of mental health experiences including cultural explanations or perceived causes, as well as cultural idioms of distress and cultural syndromes [25]. Nevertheless, being able to map and identify clear-cut models of people's explanations of illnesses and preferred ways of treating them, is still problematic. Kleinman [19] maintained that EMs among patients, their families, and doctors may each be multiple. Subsequent research found that EMs may consist of a variety of often contradictory explanations that may be held at the same time, rather than a coherent set of beliefs [11, 26, 27]. Kleinman [28] argued against the formalism, specificity, and boldness of explanatory models. The idea that people are equipped with static illness-related templates has been challenged by studies that have found considerable intra-cultural differences, for instance, differences related to geography, education, gender, and occupation [29–32].

Furthermore, perceptions of illness and treatment preferences have been found to be transient and inconsistent among patients across time [33], and may vary according to social context, i.e., person presenting different EMs at home, at work, and in the doctor's office [11]. Studies have also found that professional biomedical EMs may influence popular ideas about illness in several ways, making unclear distinctions between professional and lay person's EMs [34]. Moreover, positive experiences from encounters with public mental health services, or beliefs and practices in the country of settlement, may improve the use of public mental health services [7, 35]. Consequently, there is a need for a better understanding of how these kinds of dynamic processes may also influence EMs among refugees.

Explanatory models among Afghan refugees

In the current study, we explore explanatory models of PTSD and depression among Afghan refugees resettled in Norway. We investigate variations in EMs related to gender and age and pose the question of how processes of migration and acculturation may influence the Afghan EMs of depression and PTSD. Research has consistently shown high prevalence of, and comorbidity between PTSD and depression in refugee populations, including Afghans [2, 4, 36–41]. A survey conducted in Afghanistan suggested that one out of two Afghans (50%) is suffering from psychological distress and one out of five (20%) is impaired in his or her role because of mental health problems [42]. The report concluded that Afghan people are very much exposed to trauma and PTSD is frequent in contrast to other disorders such as clinically significant major depression disorders or generalized anxiety [42].

Studies among Afghan refugees resettled in various parts of the world report a variety of ways to cope with mental health challenges, including confronting stressors, helping others, social support, focus on the future, religion, exercise, avoidance, positive thinking,

and professional help, among others, although informal help-seeking seems to be preferred [5, 43–46]. The same variation applies to attributed causes of stress. For instance, a study among Afghan refugees in New Zealand found that sources of stress included factors such as cultural clashes, resettlement issues, economic concerns, lack of trust, separation from family, homesickness, lack of work, and worry about family in war zones [45].

However, although populations of Afghan refugees have steadily increased in Western countries in the recent decades, there is a paucity of studies on EMs among Afghans related to specific diagnoses such as PTSD and depression. A study among Afghan refugees in California found that respondents perceived that depression, often expressed as *afsurdagi* (Dari for grief, low mood, and sadness), was caused by a variety of factors including traumatic experiences, cultural adjustment challenges and conflicts, interpersonal challenges, uncertainty about the future, loss of identity and having chronic diseases [29]. The study also found gender divergences, in which women tended to associate depression with more somatic items [29]. Furthermore, a study in Australia suggested poor understanding of mental health symptoms, differences in health care information and treatment practices between Afghans and the mainstream population [47]. Another study in Australia on causes of, and risk factors for PTSD showed that experiencing traumatic events, coming from a war-torn country, as well as family problems were cited as causes among Afghan refugees [48]. In summary, these studies suggest that EMs among Afghan refugees are multiple, divergent, and influenced by traumatic experiences, migration, and acculturation factors, rather than being a static, coherent set of cultural beliefs.

The number of Afghan refugees in Norway has tripled since 2006 [49]. Recent research shows that 20.4% of Afghan refugees in the country reported mental health problems in the form of depression and anxiety [39]. Moreover, Afghan refugees are among the minority groups reporting most problems related to solitude in Norway [50]. Although mental health services have improved in this millennium, they are still sparse in Afghanistan [51–53]. However, many of Afghan refugees may have had previous experiences with mental health services in for example refugee camps, influencing their EMs about PTSD and depression. Moreover, all newly arrived refugees in Norway also enroll in an obligatory full-time introductory program for up to 2 years, which often includes a focus on health and mental health, as well as public health services in the country.

To this background, the current study aimed to investigate EMs of depression and PTSD among Afghan refugees in Norway. Considering previous research, which suggest that EMs are fluid, multiple, and subject to change according to social context, we aimed to gain more knowledge about potential intra-cultural variations in the EMs (specifically related to gender and age), and to invite our participants to reflect on the extent to which their EMs may have changed because of the migration to another country.

Methods and materials

Participants

The study included six gender-separated focus group interviews (FGIs) with two to six participants and one individual interview (since the remaining participants did not show up for that FGI). Participants were recruited from the 2-year compulsory introductory program for refugees in three municipalities in Norway and adult educational programs. The inclusion criteria were that they were refugees from Afghanistan, above the age of 18, and had lived more than 6 months in Norway. A minimum of 6 months residence time in Norway was chosen as a cut-off because it takes up to 6 months for newly arrived refugees to formalize their settlement status and get full access to Norwegian education and health services. Staff in the programs facilitated the recruitment by identifying and inviting potential participants, providing them with information about the study. As part of the process, suitability for participating in group interviews with a focus on mental health was considered, based on the possible risks that discussions could bring about significant discomfort and sensitive topic. There was no mental health assessment of participants prior to participation in the FGIs.

A total of 27 Afghan refugees between the ages of 18 and 47 (15 females and 12 males) resettled in Norway participated in this study. Table 1 presents information about the groups. Most of the participants had a spouse from Afghanistan. Except for two participants who had Pashto as their main language, the native language of participants was Dari. The duration of stay in Norway ranged

Table 1 Focus group participants (N = 27)

Focus group	Age range	Gender	Group size	Vignette character
1	19–42	Female	4	PTSD
2	18–20	Male	5	PTSD
3	35–37	Male	4	Depression
4	25–30	Female	5	Depression
5	31–47	Male	2	Depression
6	29–37	Female	6	Depression
Individual interview	34	Male	1	PTSD

from 1 to 14 years. Table 2 shows the demographic characteristics of the participants.

Procedure

The focus group interviews took place during February, March, and August of 2019. The FGIs were conducted using a vignette displaying a fictional person suffering from symptoms of either PTSD or depression in line with ICD-10 (*Classification of Mental and Behavioral Disorders*) and DSM-5 (see Additional file 1: Appendix) [25, 54]. The gender of the vignette character was matched to the participants (males or females) to facilitate identification. The vignettes were adapted from previous research on explanatory models among refugees [24, 47, 55, 56]. The vignettes were translated from English to Dari and Pashto by a professional translation service and back-translated to the Norwegian by interpreters participating in the focus group interviews. The interviews took place within the facilities belonging to the municipality (i.e., library, classroom, and facilities of the introductory program). Licensed interpreters of the same gender as the participants attended the interviews. Questions were asked in Norwegian and translated to Dari or Pashto by the interpreters. Most participants had basic Norwegian language skills and could choose to answer in Norwegian or in their native language. The interpreters translated the answers given in Dari or Pashto into Norwegian and helped clarify potential misunderstandings.

Before the interviews, the interpreters explained their role and assured confidentiality. The interpreters read aloud the consent agreement in the native language of the participants, making sure that everyone understood the content. Next, the interpreters read the vignettes out loud in the native language of the participants (Dari or Pashto). After eliciting the groups' initial responses and thoughts about the situation of the vignette character, the major follow-up questions were: What, if anything, do you think is wrong with Mossa/Zarina? What could be the reason Mossa/Zarina is feeling the way he/she does? If you were his/her friend, what would you recommend him/her to do? And why? Does he/she have a disease? Do you think Mossa/Zarina can get help from the public health sector? If yes, how? If not, why not? Do you think there are differences in how people in Afghanistan and Norway think about this situation?

Closed questions were followed up with more open questions. The interviewers urged free discussion, still making sure that all groups covered the main topics, that all members were to some degree active, and that the discussion was centered. The participants were never encouraged to reveal personal information but were asked to imagine that they were friends of the vignette character. The interview guide was based on previous research [19, 57], and further developed in cooperation with an Afghan research associate.

Three members of the research team (authors one, two, and four) were present during the interviews. Authors two and four, both clinical psychologists, conducted the interviews. The interviews lasted 1.5–2 h and were video- and audio-recorded. No compensation was given to the participants. Coffee, tea, and snacks were served during the interviews.

Table 2 Socio-demographic characteristics for focus group participants (N = 27). Missing data are due to no response from the participants on some of the characteristics. Two female participants were both employed and currently studying in Norway

Socio-demographic characteristics	Males N = 12	Females N = 15	Total N = 27
Age			
18–25 years	5	4	9
26–30 years		4	4
31–35 years	3	2	5
36–40 years	3	4	7
41–45 years		1	1
46–50 years	1		1
Current situation			
Employed	-	2	2
Unemployed	-	13	13
Student (attending Norwegian language course)	7	2	9
Family status			
Married	6	13	19
Single	5	–	5
Other (separated, divorced, widowed)	1	-	1
Educational level			
Less than high school	1	4	5
High school diploma	5	2	7
College degree or higher	2	-	2
Language			
Dari	11	14	25
Pashto	1	1	2

Ethics

The data collection was approved by the Norwegian Regional Ethical Committee (Reference number: 2018/1794 and 2018/2115), and the Norwegian Center for Research Data (Reference number: 602214). All methods used were performed in accordance with the relevant guidelines and regulations. Before the interviews started, the participants were orally informed about the purpose of the study, that participation was voluntary, how data would be handled in all phases of data collection and

publication, and that confidentiality would be protected. They were also informed that they could leave the interview at any time without explaining the reason. All participants signed a consent agreement in Dari or Pashto before the interviews started and were encouraged not to reveal information that had been shared with other participants during the interviews to other people. One participant was excluded from the interview due to being underage. One FGI became an individual interview as the other invited participants did not show up.

Data analysis

The interviews were transcribed verbatim in Norwegian, masking the identity of the participants, and reviewed by the first author and a research assistant. All transcriptions from the focus group interviews were coded and analyzed following the principles of thematic analysis [58]. All authors coded data separately to improve truthfulness, searched for and identified themes marking up suitable categories both manually and with the software program NVivo [59]. The analysis focused on causal explanations, ideas about coping, and treatment options associated with PTSD and depression. Codes were identified, developed into broader categories, and thematically clustered. Quotes were selected to describe the themes and each theme was explored and organized by gender. The quotes selected had been translated from Dari and Pashto to the Norwegian language during the interviews and transcription. The quotes presented in this article were translated into the English language by the research team. Several themes emerged from each of the main categories, sometimes unique for either the PTSD or depression interviews.

Results

We have organized the findings of explanatory models of PTSD and depression among Afghan refugees in Norway into two sections, separated by gender: (1) Themes related to causes and risk factors; and (2) Themes related to managing symptoms. Where relevant, we will discuss differences related to vignette type (PTSD or depression).

Causes and risk factors

Females

Female participants used the terms *depression* (for both the depression and PTSD vignettes), *stress* (depression vignette), and *trauma* (PTSD vignette) in both Norwegian and English languages to describe the condition of the vignette character. Several of them furthermore expressed that they recognized the situation of the vignette characters from their personal experience: "I have the same problem as Zarina, I carry the same story. I experienced the same."

The females emphasized that the described symptoms may derive from several causes depending on the person or social context. For instance, one of them said:

> *It varies from person to person. Some have problems. For instance, they have problems with their families, with their children, they are sick themselves. When children are sick, they are concerned all the time about the one who is sick. When you are concerned all the time, you naturally start to forget yourself. You think it is a difficult everyday life. Perhaps they […] experienced war, it varies from person to person. And perhaps some might have problems with their husband, their home in their family.*

The generally unstable and insecure situation in Afghanistan was also considered a cause of distress after resettling in Norway: "It says here [referring to the vignette], that she has family from Afghanistan. Maybe she lost somebody in her family in Afghanistan. It is not safe there. There has been a war there, and it is terrible there. Maybe she thinks about it."

Despite this emphasis on multiple possible causes depending on the context, a repeated theme was how the vignette character's symptoms could relate to gender issues. Several plausible causes discussed, included forced marriages, often at a young age (e.g. "She must have been forced to marry this man"); gender roles (e.g. "They are not allowed to go out without family or relatives"); domestic violence (e.g. "Most of them in Afghanistan have experienced a situation in their lives …domestic violence… if they have faced that in their home country, obviously, they're going to feel like Zarina"); harassment and violence against women (e.g. "If she gets pregnant out of wedlock, she will be rejected by her family, and she will be killed. She will be seated in the middle of a room in front of men, and they will throw stones at her"); and social control and generational conflicts (e.g., "All the time the parents must decide"). Participants also emphasized that these types of causal factors could depend on whether the woman came from urban or rural areas in Afghanistan.

The practice of social control as a source of distress for women could also continue after resettling in Norway: "Maybe mom and dad say that she must wear hijab, or she disagrees with her parents. That she had to wear a hijab, or she had a boyfriend and wanted to marry a man she wanted." One woman commented that a likely reason for the depression of the vignette character was that her parents had not given her sufficient insight into what is culturally appropriate among Afghans. The participants noted that the vignette character with depression

lived in a different city from her parents and that her distress could be related to guilt (e.g., "She has a guilty conscience. She can't help her parents") and feeling disconnected (e.g., "I think she has lost contact with her parents"). Work overload could exacerbate feelings of social isolation. One commented: "She's worked for 5 years and now she can't take more work. She has lost sleep as well. She has no time for friends or her sister."

Males

Similar to the female participants, males associated the vignette character's problems with their own and stressed that the problems may have several causes. However, different themes emerged compared with the women, and there were also differences between the depression and PTSD vignettes. While the females emphasized gender-related issues regarding both vignettes, the males in the depression FGIs emphasized acculturation challenges, while the younger men in the PTSD FGI, emphasized experiences before, and during flight, and the concerns associated with being an asylum-seeker.

Some of the participants in the depression groups identified the vignette character's condition as *depression.* However, they had several notions of *depression.* Participants noted that mental health problems differ from somatic diseases (e.g., "There is when you are ill physically, and then there are other ways, when you are depressed, you are mentally ill"), and that conditions of depression may differ in terms of severity: (e.g., "I thought he [Mossa, the vignette character], was a little depressed. Not so deep, in the first stage. In that condition, we can quickly help these people. If we don't help them quickly it can get worse." Importantly, several participants also commented that depression is a condition not observed in Afghanistan, since people there often have what they considered more serious mental health problems due to trauma and the hardships of living:

> *In Afghanistan, I would say we don't have this issue. If somebody has depression, we do not have it in Afghanistan. I am not very conservative or cautious, but why don't we have it? Because many are in shock. Many cannot carry on. We have many psychological problems, but they are not because of depression.*

The groups recognized that depression is reflected in cognitive patterns of self-blaming and faultily attributing negative events to personal inadequacies. For instance, one commented: "If I have a friend, and then today he is not friends with me, maybe it is because I was a bad person before [referring to the way of thinking of depressed people]. I believe that it is not true because all people have problems, but some can distance themselves." One group emphasized that a traditional view among Afghans is that problems or poor health are somehow deserved. One said: "We think if you are a bad person then everything follows. If you have an allergy, that is because you're a bad person, for example. It is the culture that we have. The old, especially older people think a lot like that." Religious beliefs could also impose feelings of guilt contributing to depression according to some participants, but none of the participants endorsed spiritual explanations to mental health problems [e.g., being a bad Muslim].

Consistent with the view that depression mostly emerges after resettling, many of the possible causes discussed were challenges associated with acculturation. One participant mentioned: "It is not just him that is under pressure. It is all refugees who are in this country. They are under pressure because of the language, lack of work, communication problems, and so on." Financial problems in exile were also highlighted as contributing to mental health problems. Loneliness and feelings of being disconnected were mentioned by several of the men recognizing that the vignette character was unmarried and lived alone, e.g. "Most Afghans who have problems here, it is because they live alone" and "they cannot explain the problems they have. They just have it inside them and that makes them depressed."

It was emphasized that cultural confusion could amplify mental health problems. One mentioned that young men could have problems related to how they approach Norwegian women because they carry with them gender norms from the Afghan culture:

> *Because of low education or not having an education in the home country, they have not read about this country or laws. So, for example, if he sees a girl without a scarf in his home country, he thinks she is a whore or something. And then he thinks that those who are here are exposed in the same way. And when afterwards he sees that no, it is not like that here, and he will be depressed.*

Intergenerational and family conflicts due to acculturation challenges were also mentioned, e.g., "Because children who are born in this country, they want the same culture as their [Norwegian] friends. And there may be a little crash and constantly there may be arguments with the parents." Another cause associated with the adaptation to a new country included the harsh climate in Norway: "He should go on a journey because in the Norwegian climate you can quickly become sad."

The younger participants in the PTSD group identified the vignette as related to trauma ("It is mental problems, trauma"). The discussion centered on experiences before, and during the flight as causal factors; and stressors after resettlement as exacerbating or maintaining PTSD

symptoms. Comments about the vignette character often intermeshed with their personal accounts. Memories about violence, war and fear could continue to haunt the vignette character after resettling in Norway. One commented:

> *I don't like to watch social media. Many things happen in our home country that we can watch immediately on TV or social media. Bombing and people dying happen almost every day. It is painful to see and listen to. Maybe it is my family who is dying. He [the vignette character] has experienced it. Something which has impacted him.*

One of the participants, referring to his own experience said: "People are afraid that when you're asleep, people will come and kill you." The group discussed how encounters during flight could cause these kinds of symptoms from the vignette character. One commented that the vignette character's symptoms may have been caused by "What he has experienced there [on the way from Afghanistan to Norway]. This may continue in his thoughts and lead to the problems that he has in Norway." Several mentioned feeling vulnerable and unprotected during flight, e.g., that the symptoms may have been exacerbated by "injections and some drugs he may have been given […] perhaps somebody wanted him to develop mental problems." After arriving in Norway, the possibility of having asylum applications rejected and being returned to Afghanistan was also mentioned as a stressor: "Lately there have been many rejections. He might be forced to return. Many Afghans are returned. So, it could be because of many rejections, and [what is written] in the media about it." Mental health problems were also considered to be amplified by rumination related to the atrocities and difficult living conditions faced by people in Afghanistan: "He can for instance think about poor people, think about people there and that there has been a war for so long."

Managing symptoms of depression and PTSD

Females

The females' discussions about managing symptoms of PTSD and depression were relatively similar. As with causes and risk factors, it was emphasized that ways of managing symptoms depended on the context, with a major distinction between the situations of women in Norway and Afghanistan. A repeated theme was that women in Afghanistan have no other choice than persisting living under very difficult conditions, such as domestic violence. One woman said: "She will just tolerate the burden by herself." Help-seeking sources outside the family were of little use:

> *I heard there are organizations, but they are not working. They agree when [family members from both] families are there, but when the wife is back to her husband's house, she is facing the same problem. There is no way. So, she will be facing it until she is dead.*

Also, according to the participants, admitting to emotional problems in Afghanistan would run a risk of being branded "*crazy*," an attitude that would hold them back from seeking help.

Talking to a trusted person emerged as the primary advice they would give to the vignette character independent of whether she had symptoms of depression or PTSD and whether she is in Norway or Afghanistan. Clearing her mind of negative thoughts and feelings was an essential part (e.g., "It often helps to tell others what someone has in their heart… it helps a lot, and one could feel relieved"). Talking to one's husband, a family member, or friend was the first choice (e.g., "If she has a family, a sister or a brother, or the oldest daughter, she could talk to close relatives").

However, situations were discussed in which the woman could not talk to other Afghans due to taboos about mental health problems, shame, or cultural practices, e.g., an unmarried woman having slept with a man. In those instances, turning to a doctor, psychologist, or other health professionals were seen as particularly helpful, since they have a duty of confidentiality and are not permitted to disclose information. Also, otherwise, most of the women thought that a psychologist could help Zarina, e.g. "I think she needs to talk to a psychologist. Empty her heart. Everything she has inside must come out." However, some women objected and commented that psychologists often only offer medication in form of treatment. One of the females had personal experience from seeing a psychologist in Norway after losing her parents and concluded that "Psychologists do not help. Only family and friends."

Furthermore, emphasizing the role of family for positive mental health, getting married and starting a family was seen as a good way for the unmarried vignette character to manage symptoms of depression (e.g., "She needs to find a good man"; "She needs to find a boyfriend so there is a change in her life"). Several commented that becoming pregnant and having another child (for married women) could help to regain hope for the future and keeping the mind busy and away from difficult thoughts and emotions. Other ways of managing the symptoms were also considered as potentially useful depending on the assumed cause of the condition of the vignette character. When being over-worked was suggested as a possible explanation,

finding time for herself (e.g., "She needs to think about herself."), going on holidays, enjoying more time and relaxation with friends, and keeping herself busy were important measures.

Males

Similar to the female participants, the males presented with the depression vignette, highlighted that managing the symptoms depended on the context. When discussing the possibility that the causes could be linked with isolation and loneliness, measures such as reconnecting with family and socializing with friends were highlighted as essential. One male mentioned how visiting the home country had led to a profound transformation in a friend suffering from depression. Also, as in the female FGIs, males discussed getting married to overcome the situation (e.g., "If he is in need to get married, he must get married or find someone in his life. Most Afghans have problems here because they live alone").

Regardless of what caused the symptoms, talking to family or a friend they trust, were seen as the first step towards treatment and recovery. One of the most important forms of support provided by a friend could be to guide the person to seek help from a GP, who could help him recognize he has a problem. One of the males talked about having been prescribed medication for a similar condition to the vignette character. Nonetheless, barriers for contacting public health care system were also discussed, including that a 15-min appointment would be too short for the GP to understand the problem; lack of trust (e.g., that childcare services would take away their children); and that most psychologists lack an adequate understanding of the background of Afghan refugees.

Some also discussed other ways of managing the symptoms of depression, including religion (e.g., "Maybe religion would have helped him"), setting goals (e.g., "He should have a goal in life or find one"), and having a job, like the vignette character. Thus, the participants in the depression FGIs did not prescribe a single set of responses and help-seeking options but suggested multiple ways that the vignette character could deal with his problems.

The young men in the PTSD group emphasized that engaging in distracting activities such as sports, hiking with friends, or having a job could alleviate feelings of distress. Avoiding revoking memories or being exposed to upsetting information by e.g., limiting use of social media was seen as essential measures. One mentioned how it could be helpful to release difficult emotions; "He can go to another place where he can get that aggression out… Scream or something. Get everything out. It helps to relax."

While participants recognized that not everyone wants to talk about their problems, sharing thoughts and feelings about past experiences was seen as vital to overcome symptoms of PTSD. One participant commented:

> *Talking to others and not being alone, perhaps not being too much on social media, seeing a psychologist helps when you need it. We think that's also very important. And not carrying too much inside and using the opportunities to talk to someone and how you feel - and if you go to think about things for yourself, then you get a little bit, you don't feel better right? You just feel worse. So, I think it is very important to share what you must carry. And don't hide it inside. Too often it doesn't go away.*

The young men in the PTSD FGI had arrived in Norway as unaccompanied minors who did not have family in the country. Some of them described difficulties in developing friendships with Norwegian youth at their age: "*When I went to junior high school, I was very happy to make Norwegian friends, but …. they did not talk much to me…, so eventually I lost interest.*" The gap in experience was also seen as a barrier in talking to Norwegians: "*It is difficult for Norwegians to understand such problems. Because they do not have them. And we Afghans understand.*" Thus, turning to friends, family, or other people from Afghanistan was considered most helpful as they could most easily identify with and understand the situation. However, they also reflected on the fact that sometimes this help was not available to them, and that some of them had sought and received valuable support from adult professionals such as social workers, teachers, or psychologists who had become part of their lives in Norway in one way or another.

Discussion

Our study is the first to examine explanatory models of depression and PTSD among Afghan refugees in Norway, building on previous studies, which suggest that EMs are fluid, multiple and subject to change according to social context [19, 29, 60]. The findings supported our expectations that EMs are characterized by intra-cultural variations based on factors such as gender and age. All participants stressed that there might be many potential causes, risk factors, and ways of managing symptoms of depression and PTSD depending on the context. To the extent that we found recurring themes, they varied among distinct categories of participants, e.g., with females emphasizing domestic problems and gender issues as possible causes, in contrast with males who tended to emphasize acculturation challenges and loneliness. The perceived association between depression and

resettlement was salient in that several males claimed that depression hardly exists in the Afghan context. The younger males focused most on traumas experienced before, and during flight in their causal interpretation.

Furthermore, participants maintained that there are different options for managing symptoms in Afghanistan and Norway, e.g., with females discussing how the situation of the vignette character would have to be endured in Afghanistan, while in Norway, there were other ways of managing the symptoms. Nonetheless, although women recognized that they have more freedom of choice in the Norwegian context, gender-based social control persisted even after resettlement in Norway that contributed to symptoms of depression.

The findings of our study share both similarities and differences with previous studies among Afghan refugees across the world (see [5, 43–46]. An inclination towards a preference for informal help sources seems to be a shared finding across studies, also those involving other minority groups [55, 61]. Likewise, the emphasis on the value of family as an institution converges with findings from other studies [22, 29]. For example, participants noted that moving away from parents and remaining umarried at the age of 27 (referring to the vignette character) could amplify mental health problems due to guilt and feeling disconnected. Findings such as poor understanding of mental health symptoms among Afghan refugees in Australia [47], or the tendency among Afghan refugee women in California to associate depression with more somatic items [29], could not be replicated in our study. Rather, most interview groups quickly identified the condition of the vignette character as depression, and it was commented that depressed individuals typically view undesirable occurrences in life as having internal, stable causes. This is in line with contemporary research on cognitive patterns associated with vulnerability to depression [62]. Thus, overall, our study supports the notion that it is misleading to think about EMs as a single set of coherent cultural explanations (that may be applicable for refugee groups from the same nation across countries of settlement) [19].

One of the inherent problems with EMs as a concept, is that there is a risk for a too strong focus on (often exotic) cultural practices at the expense of understanding the influence of social context [14]. The perception that illness needs to be understood within the perspective of the forms of treatment available within a cultural system initially attracted empirical studies in cultural contexts where the interplay between shamans, oracles, orthodox medicine, divinations, bonesetters, herbalists, practitioners of western medicine and others came into focus [19]. However, more recent studies have found that mental health disorders are more often attributed to social factors such as material living conditions and relationships than to spiritual or supernatural factors [63, 64]. Similarly, our study suggests that the social context, i.e., separation from family, domestic relationships, war, flight, and resettlement challenges, seems to have contributed strongly to shape the EMs of the Afghan refugees in Norway. For instance, in line with previous studies among unaccompanied minors in Norway [65], the focus group consisting of young men arriving in Norway as unaccompanied minors stressed that lack of Afghan friends and family, and difficulties in building friendships with Norwegian youths creates a situation in which talking to professional adults (e.g., social workers, psychologists and medical doctors) is the best alternative. Likewise, for the females, turning to health care professionals was seen as particularly useful when experiencing problems that could be difficult to discuss with family and social network due to taboos or cultural norms. The implication is that the EMs of these refugees seems to reflect a realistic assessment of treatment options available to them in the current social setting in exile, more than a cognitive model of cultural perceptions brought with them from the country of origin [55]. It should be recognized that some of the coping patterns described by the young men in the PTSD focus group are general characteristic for people exposed to trauma, including avoidance of emotional experiences and situations that bring about reminders of trauma. Thus, withdrawing from social media as described by these young men should be seen as a normal response to highly distressing life experiences.

Overall, how the refugees interpret and prefer to manage mental health problems are influenced by their encounters with Western mental health systems and services throughout the migration experience. Several of them used the term depression to describe the condition of the vignette character although a simple translation of this word is not available in Dari or Pashto (the native languages of the participants). Despite the dearth of mental health services in Afghanistan [53], many of the refugees had previous experiences with NGOs offering mental health services during, and after flight. They had learned about the Norwegian health system during the compulsory introduction program for newly arrived refugees and they had experiences from personal consultations with the Norwegian health system, including psychologists and GPs. Clearly, these experiences, along with acculturation challenges and other migration-related experiences had contributed to shaping their EMs. Again, this observation supports the need for more focus on the relationship between social processes and cultural practices and perceptions [9, 14].

However, an assessment of the validity of our findings is warranted. Although participants, to a varying degree, were conversant in Norwegian, much of the discussions between them were in their native language (mostly Dari). In terms of cultural validation, the Afghan interpreters and a research assistant from Afghanistan gave cultural insight during the process including commenting on the relevance and validity of the vignettes to Afghan refugees settled in Norway. On the other hand, possible bias associated with the use of interpreters needs recognition. The quality of the translations was vital for the obtained data, and any inaccuracies or misapprehensions may possibly have resulted in errors in our interpretations [66, 67]. We acknowledge that the interactions between the Afghan refugees and professional psychologists moderating the FGIs may have involved transactions between EMs in its' own right, in that the participants deliberately downplayed more "exotic" cultural perceptions in favor of a more "western" explanatory framework. This kind of power issue comes into play in research interview settings in general [68]. Our participants based on our perception, hardly discussed any rich, "exotic" cultural palette of causes and treatment options. They also seemed reluctant to discuss the role of religion in much depth. With the current anti-Islamic rhetoric in the public discourse, this is understandable. However, participating in a focus group interview about their views and experiences contributed to create a setting that invited reflections and reassessments of what causes mental health problems and how to deal with them. Expressing that they identified with the vignette character, further supports the trustworthiness of the findings from the study.

This is further strengthened by the fact that the participants also discussed EMs in rural Afghanistan, contrasting them with their own perceptions of living in exile in Norway. This kind of process is also consistent with contemporary understandings that culture involves a dynamic interplay between individual agency and social processes, renegotiations of cultural understandings, and interpretations of cultural meanings with others [10]. Studies have found that with acculturation, the EMs of ethnic groups evolve and move towards the majority culture [69], which corroborates with the present study. However, more research is warranted on the influence of migration experiences and social context on refugee EMs.

One possible bias of this study is that we did not have a balanced sample of participants in terms of age, education, and family situation in groups discussing PTSD and depression vignettes. The participants in the male focus group discussing the PTSD vignette were younger (between the ages of 18–21) high school students, and had arrived in Norway as unaccompanied minors. Also, they were single, while members of the other groups were married, except for one male. Furthermore, the limited size of the sample warrants follow-up quantitative studies to identify more categorical patterns. Future research may consider eliminating some of the two vignette characters' background differences that could potentially influence interpretations beyond the mental health symptoms presented. Specifically, the PTSD vignette character had a flight background, was married, and had children, while the depression vignette character was single, and no information about immigrant background was given (although the character had a common Afghan name). Notably, the present study did not include a clinical sample based on diagnosed psychopathology. The high incidence of depression and PTSD among refugees suggests that a large proportion will either experience these conditions themselves or within their family. Past research [56] indicates that in communal societies, family members are influential for health services utilization and treatment preference. Thus, we argue that the views of lay people might be informative for how the Afghan refugees deal with mental health problems.

This study has important clinical implications. With the inclusion of cultural concepts of distress in DSM-5, the importance of dealing with potential divergences in the EMs of patients and professionals is recognized, and several instruments for mapping EMs have been developed across the years (for an overview, see [70]). However, in clinical practice these methods are seldom applied due to time constraints and unfamiliarity with social science methods among many professionals such as psychiatrists [70, 71]. We advocate that the idea of systematically developing an explanatory *model* in the sense of condensing a single set of causal explanations and treatment preferences may not only be analytically challenging in a time-pressed clinical setting but also misleading [27]. The empirical diversity evident in our study and others may make it more appropriate to talk about *maps* rather than *models* [19].

The concept of models may be too static to convey the fluid status of perceptions among patients. There are risks that tentative and uncertain perceptions explored by individuals may become reified and made definitive in the shape of a coherent explanatory model [27]. Our study demonstrates that there is not a single accurate and generalized explanatory model representing Afghan perceptions on causes and treatment, and that individual perceptions are likely to continue to change across time. A map in the shape of a snapshot in time of various avenues of thought and less fixed possibilities may provide a more relevant framework for exploring options with the patient.

Kleinman [28] maintained that he aimed to establish a method to promote clinical self-reflexivity and improve clinical communication using open-ended questions and negotiations Our participants' perceptions about depression and PTSD as related to trauma and challenging life circumstances did not deviate from how natives or health professionals could think about such diseases. They did not indicate that these mental health diseases were associated with stigma. Yet, the participants had reservations about the ability of professionals to understand the situations of Afghan refugees. By asking empathic questions and roughly mapping the patients' perceptions, professionals may have a better starting point for building trusting relationships with refugee patients and invite them to share and put into practice their expertise in their own lives.

Abbreviations

FGI: Focus group interview; EM: Explanatory models; DSM-5: Diagnostic and statistical manual of mental disorders; ICD-10: International classification of diseases and related health problems.

Supplementary Information

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Additional file 1. PTSD and depression vignettes. The FGIs used a vignette displaying a fictional person suffering from symptoms of either PTSD or depression in line with ICD-10 and DSM-5.

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Authors' contributions

Authors D.B.L., G.M.S., and V.M. conducted the interviews. Author D.B.L. created Tables 1 and 2. Authors D.BL., G.M.S., and E.G., had the main responsibilities for the data analysis. All authors contributed to the revision and writing of the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials

The data are available from the corresponding author on reasonable request.

Declarations

Ethical approval and consent to participate

The data collection was approved by the Norwegian Regional Ethical Committee (Reference number: 2018/1794 and 2018/2115), and the Norwegian Center for Research Data (Reference number: 602214). All participants read and understood the provided information about the study and their voluntariness in participation. A written informed consent to participate in this study was obtained from all participants. All methods used were performed in accordance with the relevant guidelines and regulations.

Consent for publication

Not applicable.

Competing interests

The authors declare that they do have no competing interests.

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Psychological distress among Afghan refugees in Norway as a function of their integration

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Background: Often, refugees are susceptible to mental health problems due to adversities experienced before, during, and after the flight. Through a cross-sectional study, the present study examines the relationship between different aspects of integration and psychological distress among Afghans living in Norway.

Methods: The participants were recruited through e-mail invitations, refugee-related organizations, and social media platforms. The participants (N=114) answered questions about integration across multiple dimensions (psychological, social, navigational, economic, and linguistic) in line with the Immigration Policy Lab index (IPL -12/24). Hopkins symptoms checklist (HSCL-25) was used to assess psychological distress.

Results: Based on hierarchical multiple regression analysis, both the psychological dimension (0.269 p<0.01) and the navigational dimension (0.358 p<0.05) of integration predicted psychological distress.

Discussion/Conclusion: The results suggest that the psychological aspects of integration, such as being part of a community, having feelings of security, and a sense of belonging, are beneficial for the mental health and well-being of the Afghans in Norway and contribute further to other aspects of integration.

KEYWORDS

Afghans, integration, acculturation, depression, anxiety, refugees, psychological integration

1. Introduction

Conflict, social unrest, war, and other extreme experiences can adversely affect refugees' mental health and increase vulnerability to depression, anxiety, and post-traumatic stress disorder (PTSD) (e.g., Kirmayer et al., 2011; Henkelmann et al., 2020; Schlechter et al., 2020). Also, experiences after the flight or forced migration, such as lack of access to health services combined with substandard living conditions, unemployment, and language barriers, might increase the risk for mental health problems (Fazel et al., 2005; Lindert et al., 2009; Jakobsen et al., 2011; Kirmayer et al., 2011; Nickerson et al., 2017; Kartal et al., 2019). Because of these circumstances, refugees may experience reduced quality of life, affecting their well-being, and preventing them from integrating into the host country (Haj-Younes et al., 2020; Walther et al., 2020; Gagliardi et al., 2021). The lack of access to adequate healthcare, support from friends and family, and difficulty navigating a new country can all add to the mental health burden experienced during migration. Despite improvements in refugee groups' mental health and well-being, the connection between pre- and post-migration determinants, mental health, and integration, is still poorly understood (e.g., Fjeld-Solberg et al., 2020; Haj-Younes et al., 2020; Opaas et al., 2020; Strømme et al., 2020). A deeper understanding of pre-migration determinants, such as mental health problems and integration outcomes, might be needed. The perspectives,

processes, and contexts of refugee mental health and integration are crucial to a deeper understanding of the complexities and nuances involved. The burden of mental health problems and integration continues to be a major concern for refugee groups and policymakers in Norway; therefore, a comprehensive approach to researching refugee mental health and integration in Norway is necessary. Even though the protective and official status that the term refugees entail, and following an inclusivist view (Carling, et al. 2014; 2017), refugees are included as a particular group of migrants in this study.

1.1. Successful integration

Integration is a concept embedded in different perspectives of the migration process. Research has indicated that migration might be associated with positive mental health outcomes (e.g., sense of belonging) (Beiser and Hou, 2017; van der Boor et al., 2020). However, migrants, including refugees, are more likely to experience reduced social support, decreased life satisfaction, and difficulty accessing necessary services than the major population (Thapa et al., 2007a; Ziersch and Due, 2018; Walther et al., 2020). Refugees, as migrants, invariably undergo adaptation upon resettlement in a new society. Acculturation describes this process of transition and adaptation, referring to the "cultural and psychological change resulting from contact between cultural groups and their members" (Berry, 2003, p. 27). Acculturative stress emerges from conflicts when individuals must adjust to a new culture of the host society and can involve feelings of uncertainty and mental health challenges (Berry, 2021). The process of acculturation may alter the psychological (e.g., behaviors), cultural (e.g., language or religion), social (e.g., ethnic discrimination), and biological (e.g., resistance to diseases) circumstances (Graves, 1967; Berry, 2021) of different migrant groups. Berry's (2017) model of acculturation suggests four strategies: *Integration* (interest in maintaining both the original culture and from the larger society), *Assimilation* (when individuals do not wish to maintain their cultural identity and seek daily interaction with the larger society), *Separation* (avoid interaction with others and hold onto the original culture), and *Marginalization* (neither interest in own's culture nor the host society) (23). Each acculturation strategy can mitigate and/or mediate the relationship between migration and mental health depending on how much the acculturating individual emphasizes heritage and/or the settlement culture (Berry, 1997). Individuals will eventually adjust to new situations and changes, and identifying these changes may be necessary to explore (Bhugra et al., 2021). Hence, exploring Berry's (2021) integration strategy embodies a theoretical concept that can also be debated but is still grounded in the process of adaptation and psychological distress even though other acculturation strategies may be embedded in the migration process. This study focuses on the relationship between different forms of integration (as antecedents) and psychological distress (as an outcome) among Afghan refugees living in Norway.

A successful outcome in the host societies may involve "doing well" in the sociocultural context (e.g., daily cultural living) and "feeling well" in the psychological aspect (e.g., sense of well-being) (Masgoret and Ward, 2006). In the literature, different integration aspects have been measured in several ways (e.g., Sam and Berry, 1995; Birman and Taylor-Ritzler, 2007; Rudmin, 2009; Harder et al., 2018b). The present study draws on the Immigration Policy Lab's index (IPL-12/24) developed by Harder et al. (2018a) which measures integration from a multidimensional perspective.

To begin with, Harder et al. (2018b) defined integration as "the degree to which immigrants have the knowledge and capacity to build a successful, fulfilling life in the host society (…) rather than the degree to which they have shed their cultural heritage" (p. 2). The latter part of this definition is consistent with Berry's (1997) idea of cultural maintenance and the sociological view of assimilation (Gordon, 1961; Zhou, 1997; Alba et al., 2012). As Harder and colleagues explain (2018b), the common goal of measuring successful integration is hindered by differences in methods and definitions of integration (p. 11483). The IPL-12/24 index includes six dimensions: political, psychological, social, navigational, linguistic, and economic (Harder et al., 2018b). These dimensions capture different aspects relevant for strengthening the capacity of migrants to establishing a fulfilled life in the new society. With the aid of these dimensions, several studies have been conducted regarding inclusion, assessing the level of integration and help-seeking behaviors among migrants, including refugees (Harder et al., 2018b; Kunwar, 2020; Harris et al., 2021; Passani et al., 2022). To our knowledge, studies using these measures of integration in relation to psychological distress among refugee groups have not yet been conducted in Norway, and hence the focus on the present study.

Migrants, including refugees, are in daily interactions with members of the larger society (Lansford, 2011). These interactions form the basis for integration into the host society. Integration aspects among migrants can be assessed by identifying cultural and socio-economic factors and their behavior and relationship with the host country, for example by addressing basic needs, education, and finding employment (Sheikh and Anderson, 2018; Joyce, 2019; Brell et al., 2020; Stempel and Alemi, 2020). For instance, social integration (Liamputtong and Kurban, 2018; Brydsten et al., 2019; Ali et al., 2021) of migrants in Norway has been associated with good mental health (Dalgard and Thapa, 2007; Thapa et al., 2007b). Among different migrant groups, Harder et al. (2018b) have tried to capture the social aspect (e.g., daily interactions, social ties, feelings of connectedness, and sense of belonging) from both the psychological and the social dimensions of integration in the IPL-24. Other integration indicators include how migrants, including refugee groups, adapt and navigate the host society system (e.g., language use and finding basic services). Integration into the host society includes access to various types of services, such as appropriate use of medical assistance, as Harder et al. (2018b).

1.2. Afghans living in Norway

Most Afghans in Norway came either as refugees or asylum seekers (SSB, 2020; UNHCR, 2022). For this study, we focused specifically on the Afghan population living in Norway. According to the Norwegian Living Conditions Report (2018) on the situation of migrants in Norway, 16 % reported mental health problems. This number might be lower than the actual prevalence. Due to political status (e.g., refugees and asylum seekers) in the migration process, some refugees may be reluctant to discuss mental health problems with health professionals based on worries that might impact

Abbreviations: HSCL-25, Hopkins symptoms checklist; IPL-12/24, Immigration policy lab; PTSD, Post-traumatic stress disorder.

residence permits (Paniagua and Cuéllar, 2000; American Psychiatric Association, 2013). Distinctly, among the migrant groups, Afghan refugees reported more significant psychological distress and living conditions pitfalls and more mental health problems than other migrant groups (Jakobsen et al., 2017; Straiton et al., 2017; Barstad, 2018; Tronstad et al., 2018). Afghanistan has endured conflicts and wars for many years, and many Afghan refugees have settled in different countries, carrying traumas and mental health problems (Alemi et al., 2017; Slewa-Younan et al., 2017; Ahmad et al., 2019; Mobashery et al., 2020). Afghanistan is among the countries with the highest refugee and asylum seeker status in Norway (UNHCR, 2022), and the changed political situation in Afghanistan since 2022 might further increase the number. Consequently, Afghans fleeing to other countries for safety will have a harder time returning home, increasing the number of asylum seekers and refugees and the mental health burden.

Reportedly, three of four Afghans who came to Norway as refugees and 25 % that has arrived through family reunification, were over-represented in single households and were younger than other migrant groups (Tronstad et al., 2018, p. 30). The mental health problems of Afghan refugees, particularly among younger people, may go untreated, mainly due to the underutilization of mental health services (Anstiss and Ziaian, 2010; Satinsky et al., 2019). The employment rate among Afghans in Norway in 2018 was 62% (higher in the 25–44 age group) compared to other migrant groups (3.1%) (Tronstad et al., 2018, p. 30). Even with a high employment rate, Afghan refugees may still struggle to access mental health services, highlighting the need for further research and outreach. There are also gaps between the dominant and non-dominant groups regarding higher education, for example, household income and language skills (Tronstad et al., 2018). A study of mental public health outcomes found that rates of depression were higher five years after resettlement when living in poor socio-economic conditions (Priebe et al., 2016). Recognizing these disparities highlights the importance of better support systems and resources for refugee groups to integrate successfully into their new communities.

To our knowledge, this is the first study to examine how different dimensions of integration are related to psychological distress among Afghans in Norway. Based on Harder et al.' (2018b) definition of successful integration, we hypothesize that psychological distress may be associated with all the six aspects of integration suggested by Harder and colleagues. Overall, the different dimensions of integration will be negatively related to psychological distress, i.e., the higher the integration, the lower the psychological distress. Not being nor feeling integrated into the host society may contribute to poor mental health.

2. Method

2.1. Participant characteristics

With a cross-sectional study design, the current study was part of a broader survey for refugee groups residing in Norway. One-hundred-and-fourteen participants from Afghanistan took part in this study with ages ranging from 18 to 70 years (36% females) with a mean age of 0.36 (SD = 0.482). Over half (53%) of the participants were between the ages of 20 and 29 years. A more detailed socio-demographic description is presented in Table 1.

2.2. Sampling procedure

The study was reviewed and approved by the Norwegian Center for Research Data (NSD notification form: 602214). We included a

TABLE 1 Sociodemographic characteristics of the population sample.

Sociodemographic Characteristics	n	%
Gender	0.36 (0.482)	
Males	73	64%
Females	41	36%
Age[a]	2.61 (0.956)	
Age upon arrival in Norway[b]	3.64 (1.023)	
Level of education[c]	0.96 (0.854)	
Have not completed any education	4	3.7%
Primary school	17	15.6%
Secondary school	35	32.1%
Secondary or university education	53	48.6%
Current life situation[d]	2.45 (0.938)	
Unemployed (actively/not actively looking for a job)	19	17%
In school	40	35.7%
In paid work	37	33%
Other	16	14.3%

$N = 114$. [a]Age was collected in ten-year brackets (1–7). Min.1 – Max.6.
[b]Age upon arrival was collected in ten-year brackets (1–7) Min.1 – Max.6.
[c]Level of education was collected in different alternatives recoded in 4 items. Min.1 – Max.4. Missing $n = 5$.
[d]Other (Permanently sick or disabled, retired, doing unpaid work, looking after children or other persons). Missing $n = 2$.

convenience sample of Afghan adults residing in Norway. Data collection was conducted in two waves: the first wave in the fall of 2019 (September through December), and the 2nd wave in the winter and spring of 2021 (December through April). Data collection was paused during the spring, summer, and fall of 2020 due to the various restrictions put in place at the peak of the Covid-19 pandemic. Most participants (66%) were recruited during the second wave of the data collection (i.e., during the winter and spring of 2021).

A total of 492 individuals opened the survey link. Of these, 271 (55.1%) consented to participate. However, a number of participants did not answer the compulsory questions (e.g., age, age upon arrival in Norway, and gender), and did not proceed further. Participants born in Norway were excluded. A total of 114 (42%) responded to the HSCL-25 scale (i.e., psychological distress) and 112 (41,3%) to the IPL12/24 scale (i.e., integration). There were no missing data points in these scales.

Based on our sample size, we did a sensitivity power analysis (G*Power 3.1.9.6) for multiple regression with 8 predictors to detect a small effect for the selected scales (t-tests for linear multiple regression). A sample of 114 participants would be sensitive to effects of above Cohen's d = 0.07 with 80% power (alpha = 0.05, two-tailed) (Faul et al., 2009; Bartlett, 2022).

The link to the survey was disseminated *via* flyers and e-mail invitations through different institutions in Norway working with refugees, especially in larger cities of Norway. We also distributed the survey through social media platforms using Facebook ads with categories following standard considerations[1] to increase participation in the second wave. Informed consent was obtained by all survey participants by ticking off a consent form at the start of the survey. Participants in the survey were not compensated but could participate in a voluntary lottery with the possibility of winning a gift card (NOK500). Participants were also informed that they could contact their general practitioner and municipality refugee health team if they needed to talk to someone after participating in the survey.

The data collected included Norwegian, Dari, and Pashto language versions of the questionnaires. All scales used in this study were translated to Norwegian (except for the HSCL which was available in Norwegian), and the languages of Afghanistan (Dari and Pashto) by a professional translation agency. Translations were revised and back translated by the research team and a research assistant from Afghanistan. The survey was pilot tested prior to the launch of the survey.

2.3. Measures

2.3.1. Psychological distress

Depression and anxiety were assessed with the Hopkins Symptoms Checklist (HSCL-25) (Derogatis et al., 1974). The HSCL-25 consists of 10 items about anxiety symptoms and 15 items for depression and somatic symptoms. Each item is rated from *not at all* (1) to *extremely* (4). Cronbach's alpha for the entire HSCL-25 was 0.95 (0.91 for the anxiety subscale and 0.94 for depression and somatic symptoms subscales). The Hopkins symptoms checklist has been previously used in refugee and asylum seeker populations, including Afghans (Strand et al., 2003; Ventevogel et al., 2007; Jakobsen et al., 2011).

2.3.2. Dimensions of integration

2.3.2.1. Immigration policy lab

The integration questionnaire, Immigration Policy Lab index (IPL-12/24) (2018a; 2018b), assesses six aspects of integration: psychological, linguistic, economic, social, navigational, and political. The scale used in the present study included 20 items from 5 of these IPL-12/24 dimensions. The political dimension of integration was considered less relevant to the aim of the study, and therefore these questions were not included. The dimensions of integration for the current study consisted of interpersonal factors, awareness of general proprieties, and the ability to handle basic requirements in Norway, among others (Harder et al., 2018a). The IPL-12/24 has been validated in international studies (Harder et al., 2018b, p. 11483). In the present study, Cronbach alpha coefficient for the economic (0.62) and navigational (0.35) dimensions were low. Therefore, only single items from these scales were included for the analysis, together with the psychological, social, and linguistical dimensions of integration. The latter dimensions, respectively, had Cronbach alpha 0.72, 0.77, and 0.87. More information about these dimensions follows below.

2.3.2.2. Psychological integration

The psychological dimension included four items that tried to capture the respondents' feelings of connection with Norway, their wish to continue living there, and their sense of belonging in the host country (e.g., "How connected do you feel with Norway?," scoring from *I do not feel a connection at all* (1) to *I feel an extremely close connection* (5)).

2.3.2.3. Social integration

This dimension sought to capture the participants' social capital, social interactions, and social ties. Three items from the IPL-24 were included in the analysis that targeted the frequency of social interaction (e.g., "In the last 12 months, how often did you eat dinner with Norwegians who are not part of your family?"). From *never* (1) to *almost every day* (5).

2.3.2.4. Linguistic integration

The linguistic dimension of integration questions included four components of English communication (i.e., reading, listening, writing, and speaking). The Norwegian survey only used two of these items capturing the ability of reading and speaking the Norwegian language. The two items were: "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." From *very well* (5) to *not well at all* (1).

2.3.2.5. Selected single items

The economic integration questions captured measures of household income and the ability to meet different levels of unexpected expenses. For the navigational dimension, the measures tried to capture the ability to manage basic needs. Due to the low Cronbach alpha (below 0.60) for both dimensions, we selected single items to represent these dimensions (e.g., "What is your household

1 https://www.facebook.com/business/ads

TABLE 2 Hierarchical regression results for psychological distress.

Variable	B	95%CI for B		SE B	β	R^2	$\triangle R^2$
		LL	UL				
Step 1						0.032	0.032
Constant	66.7***	51.1	82.5	7.91			
Age	−0.925	−4.33	2.47	1.71	−0.05		
Education	−3.46	−7.27	0.344	1.92	−0.17		
Step 2						0.214	0.182
Constant	10.7	−22.5	43.8	16.7			
Age	−0.181	−3.53	3.17	1.69	−0.01		
Education	−1.65	−5.83	2.52	2.10	−0.08		
Household income[a]	−0.51	−2.30	1.29	0.907	−0.06		
Current household[a]	−1.63	−4.35	1.09	1.37	−0.11		
Navigational	2.62	0.70	4.53	0.97	0.28***		
Psychological	9.56	−3.14	15.9	3.23	0.27**		
Social	2.83	−3.56	9.22	3.22	−0.08		
Linguistic	1.23	−2.27	4.74	1.77	−0.07		

CL, Confidence Interval; LL, lower limit; UL, upper limit. The model in the second step is significant ($p = 0.002$) (F (106,100) = 3.856, $p < 0.0005$). *$p < 0.05$. **$p < 0.01$. ***$p < 0.001$. [a]Single items from the Economic dimension of integration = household income and current household; and Navigational = "How difficult or easy would it be to see a doctor" and "How difficult or easy would it be to search for a job."

total annual income?" and "What is your current household? (with estimate alternatives) for the economic; and "How difficult or easy would it be for you to search for a job and see a doctor?," scoring from *very difficult* (1) to *very easy* (5) for the navigational).

2.3.2.6. Socio-demographic factors

Socio-demographic factors included age, gender, age upon arrival in Norway, current life situation, and educational level. The descriptive statistics showed a positive skew, and the distribution was clustered in the center (e.g., more younger adults answered the survey). The economic dimension of integration also measured a description for *current life situation* referring to the participants' status in Norway (e.g., unemployed, in school or in paid work). This item was included in the socio-demographic characteristics and not selected for the regression analysis (see Descriptives in Table 1). Questions regarding their political status (e.g., refuge or asylum seeker) were excluded from the survey.

2.3.2.7. Statistical analysis

The online survey was created using the SurveyXact online survey platform.[2] A report and data set were exported from the SurveyXact to SPSS statistical software program (IBM Corp, 2020). We started with the preliminary analysis and examining the intercorrelations between all study variables. The study relied on the item-total score correlations in evaluating individual responses to the HSCL-25, based on the full 25 items instead of subscales (Lhewa et al., 2007; Lee et al., 2008; Vindbjerg et al., 2021). Next, hierarchical regression analysis was conducted to examine the ability of the different integration variables in predicting psychological distress (measured by HSCL), after controlling for age and education. Due to the lack of significance, gender was not included in the regression analysis. Scores on psychological, social, and linguistic integration and the single items of the navigational and economic scales were included as predictors in the analysis. We also calculated 95% confidence intervals for the regression coefficients based on robust standard errors (see Table 2).

3. Results

3.1. Preliminary analysis

3.1.1. Socio-demographic variables

Demographic statistics are presented in Table 1. The relationships between psychological distress (HSCL-25) and the socio-demographic variables (IPL-12/24) were investigated using Pearson correlation coefficients. Our analysis ensured no violation of the normality assumptions. Age and education correlated negatively with psychological distress. An independent samples t-test was conducted to compare the psychological distress scores between males and females. The result showed no significant difference in score for males (M = 52.90, SD = 16.2) and females, M = 53.46, SD = 18.8; t (112) = −1.66, $p = 0.86$ (two-tailed).

3.1.2. Psychological distress and integration

Both the psychological, the social dimension and the single item of the navigational dimension of integration correlated positively with psychological distress ($r = 0.269$; $r = 0.049$; $r = 0.358$, respectively). Conversely, the linguistic and the economic dimensions of integration showed negative correlations ($r = -0.067$; $r = -325$ and $r = -0.727$, respectively), $N = 114$, $p < 0.001$ (see Table 3).

Hierarchical multiple regression was performed to assess the ability of the dimensions of integration to predict psychological

2 www.surveyxact.no

TABLE 3 Descriptive statistics and correlations for study variables.

Variable	*n*	*M*	SD	1	2	3	4	5	6	7	8	9	10
1. Psychological distress HSCL	114	53.1	17.153	–	0.485[a]	0.060	−0.193*	0.269**	0.049	−0.067	0.358**	−0.152	−0.166
2. Gender[a]	114	0.36	0.482	0.485		–							
3. Age[b]	114	2.61	0.956	−0.049									
4. Education[c]	109	0.96	0.854	−0.172	0.019	0.065	–						
5. Psychological integration[d]	113	2.61	0.477	0.269**	−0.152	−0.047	−0.006	–					
6. Social integration	112	2.59	0.48426	0.049	−0.078	−0.117	0.165	−0.042	–				
7. Linguistic integration	110	3.97	1.016	−0.067	−0.200*	−0.138	0.409**	−0.017	0.135	–			
8. Navigational	113	5.91	1.835	0.358**	0.006	0.056	0.429**	0.064	−0.045	0.250**	–		
9. Economic Household[e] income	112	3.16	1.924	0.325*	−0.038	0.206*	0.186	0.048	0.080	0.310**	−0.305**	–	
10. Economic Currently household[e]	112	1.69	1.201	0.727*	−0.124	−0.118	0.065	0.086	0.070	0.218*	−0.284**		–

**$p < 0.01$. *$p < 0.05$. Correlation is significant at the 0.01 level (2 -tailed). Pearson product–moment correlations between measures of dimensions of integration and psychological distress (HSCL). A Kruskal-Wallis Test revealed a statistically significant difference psychological distress (HSCL) among the different income levels in household income from the economic dimension of integration (Gp1, Min. $n = 27$: 100000NOK, Gp8 Max. $n = 3$: 1250000), $x^2\ (n = 114) = 13.96$, $p = 0.052$. In addition, a Mann–Whitney *U* test revealed significance difference in the household income levels ($U = 10$, $z = -2.111$, $p = 0.035$, $r = -0.02$). No significance difference for current household in the economic dimension $U = 247$, $z = -0.114$, $p = 0.90$, $r = -0.01$.

[a]Females higher than males $r = 0.016$. The magnitude of the difference in the means (mean difference = −0.55, 95%CI: −7.2 to 6.2) was very small (eta squared = 0.002).

[b]Age was collected in ten-year brackets (1–7). Min. 1 – Max. 6.

[c]Level of education was collected in different alternatives recoded in four items. Min.1 – Max. 4. Missing $n = 5$ (4.4%).

[d]Items for the psychological dimension of integration were reversed.

[e]Single items for the economic dimension of integration (1) Household income collected in 1–8 income brackets Min. 1 – Max 8. Kruskal-Wallis Test (0.325* $p = 0.052$) and (2) Mann–Whitney *U* test (0.727* $p = 0.035$) results when correlated with HSCL.

distress (HSCL) after controlling for the sociodemographic variables (age and education). Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity, and homoscedasticity. Age and education were entered at Step 1, explaining 3% of the variance in psychological distress. After entry of the single predictors of the economic and navigational dimensions and the three dimensions of integration (psychological, social, and linguistic) in Step 2, the total variance explained by the model as a whole was 21.2%, F (9,99) = 2.96, $p < 0.004$. Thus, the predictors explained an additional 18% of the variance in psychological distress after controlling for age and education (R squared change = 0.18, F change (6,99) = 3.762, $p < 0.001$). In the final model, only two predictors were significant, the single item of the navigational dimension (i.e., How difficult or easy would it be for you to search for a job and see a doctor?) (beta = 0.28 $p < 0.010$) and the psychological dimension (beta = 0.27 $p < 0.004$) (see Table 2).

4. Discussion

This study explored how different aspects of integration are related to psychological distress among Afghan refugees living in Norway. Following Harder et al. (2018a), we examined whether the level of psychological distress (assessed with HSCL-25) might be associated with various aspects of integration. Our conceptualization allowed us to assume that psychological distress might be a function of different aspects of integration rather than focusing on integration as a unitary global concept.

Our analysis revealed that only the psychological dimension of integration contributed significantly to psychological distress. However, the portion of explained variance was modest. Neither the social nor the linguistic dimensions made a significant contribution in explaining psychological distress. These dimensions had low correlation with psychological distress. The single item used to measure the navigational dimension of integration significantly contributed to explain psychological distress. The results suggest that the psychological dimension of integration seems to be a better predictor of psychological distress with a favorable outcome among Afghans. Our findings align with previous research showing that feelings of connection with the new country are important for mental health outcomes (Dalgard and Thapa, 2007; Kashyap et al., 2019; Strømme et al., 2020). Thus, our results suggest that the risk for psychological distress might be reduced when refugees feel connected to the Norwegian society.

There were moderate inter-correlations between most of the integration scales. Feeling connected and not isolated from the Norwegian society may enhance other aspects of integration, such as contacting the local community, learning how to navigate the system, and seeking basic needs (Harder et al., 2018b). Although the direction of effects cannot be established by correlations, it is possible that the psychological dimension of integration could act as a facilitator for successful integration. Within the psychological dimension, refugees who feel safe in the host country can self-regulate and gain agency, contributing to successful integration, also in the other dimensions of integration (Harder et al., 2018a,b). On the other hand, other aspects of integration, such as language skills, may also facilitate the psychological connectedness, for example, by giving motivation for employment and social network.

In this study, a positive psychological dimension of integration may reverse the outcome of psychological distress if one never feels isolated or as an outsider in Norway. In the adaptation stage the affective and emotional issues are often the last to be addressed when accepting and acknowledging cross-cultural differences (Bhawuk et al., 2006). As a result, integration may go beyond cross-cultural tolerance, and individuals may become multicultural in their way of thinking and being (Bhawuk et al., 2006; Huynh et al., 2011; Landis and Bhawuk, 2020). The adaptation process is

characterized by empathy and cultural diversity leading towards integration. For example, Afghans may reach out to others from their own country or turn to other migrant groups for social support when they find themselves in similar situations or need help navigating the system instead of or in addition to their Norwegian counterparts.

The non-significant effects for the linguistic dimension of integration in our study do not necessarily indicate lower proficiency in the Norwegian language nor that Afghans are less likely to identify with the Norwegian culture. However, not being able to speak the language and communicate with others could be somewhat of a burden that can hinder everyday interactions (e.g., not knowing how to meet basic needs nor accessing services can lead to feelings of isolation that can worsen refugees' mental health). Feeling safe and connected to the Norwegian society, on the other hand, might help refugees develop the motivation to learn the language and search for work. The significant (negative) contribution of the individual element of navigation on psychological distress suggest that knowing how, when, and where to seek help might be relevant for mental health; despite certain barriers (e.g., cultural traditions, stigma, discrimination) that may prevent Afghans to navigate the system. Previous studies on integration have been supported in aspects related to these dimensions (e.g., Dalgard and Thapa, 2007; Thapa et al., 2007a; Straiton and Myhre, 2017; Walther, 2021).

When comparing the dimensions of integration (Harder et al., 2018b), we found that despite the non-significant results from some of the predictors, reaching a certain level of integration with, for example, the psychological dimension can be considered a sign of successful integration. Connecting with Norwegian society, regularly speaking the Norwegian language, getting along in the community, and seldom feeling like an outsider strengthens the integration process and the individual's ability to act. These references are consistent with several core integration areas identified previously, such as employment, education, social connections, rights acquisition, language, cultural knowledge, and stability as facilitators (e.g., Ager and Strang, 2008). Nonetheless, inaction in mental health situations (e.g., refusing treatment or not accepting a diagnosis) could affect a person's ability to navigate the system, leading to for example, the underutilization of health services. In addition, good health status, reliable access to health care, and support for health outcomes were widely viewed as essential resources for active engagement in the new society (Ager and Strang, 2008). Local channels could also mitigate several factors by promoting mental health information (e.g., formal and informal information in different languages) or facilitating integration with behavioral training (community services from health institutions or voluntary organizations) (Bhawuk et al., 2006; Straiton and Myhre, 2017; Tschirhart et al., 2019).

Social ties between Afghans and language barriers may not interrupt the adaptation process, especially if collective feelings of attachment to Norway are positively involved (de Smet et al., 2019; Frounfelker et al., 2020). Some experiences may include feelings of security and social support from family, friends, and the Norwegian society, contributing positively to the integration process. These experiences have been confirmed in previous research through focus group interviews with some refugee groups in Norway (Markova and Sandal, 2016; Aarethun et al., 2021; Brea Larios et al., 2022). Some intercultural training on refugee integration could be conducted to improve successful integration (Bhawuk et al., 2006; Landis and Bhawuk, 2020). In reports on different generations and migrant groups, we could find positive results (Brekke et al., 2021; IMDi, 2021; Bhawuk, Landis & Lo in Sam and Berry, 2006; Strømme et al., 2020), and often socioeconomic factors among other indicators were related to the psychological well-being (of resettled refugees) (Li et al., 2016). Not feeling isolated from Norway can provide some relief from a previous traumatic event.

The associations between psychological distress and integration have important implications for future prevention and integration efforts. The particular significance of the psychological dimension and the single navigational item compared with the non-significant results, suggest other mechanisms for successful integration. While our study suggests that only the psychological dimension is related to psychological distress this result points to potential benefits of measures facilitating inclusiveness. For instance, training of migrants, including refugees, emphasizes behavioral outcomes such as affective and emotional aspects, and cross-cultural tolerance from both dominant and non-dominant groups as part of the adaptation process (Bhawuk et al., 2006; Doucerain, 2019; Landis and Bhawuk, 2020).

5. Limitations

The present study had some limitations. First, the psychological distress measure is not a diagnostic tool, nor does it distinguish between different mental health conditions in refugee groups. This study focused on Afghans as a national group living in Norway, and the native population, i.e., Norwegians were not used as a point of reference to compare success in Norwegian society. Even though results have been interpreted with caution, causal conclusions are not drawn from these results from the cross-sectional study. In contrast to the results of this present study, previous research has indicated significant effects on, for example, on social integration (Dalgard and Thapa, 2007; Abebe et al., 2014).

Our study included five dimensions of integration, however, only three dimensions (psychological, social, linguistic) and two single items drawn from the economic and navigational dimensions (due to the low internal consistency and low Cronbach's alpha), were included in the analysis. We, performed a classic multiple linear regression analysis, and the test results confirmed the findings with some of the claims supported by the data. The IPL team has previously done studies among larger immigrant groups in the United States; other dimensions in this study could have been collected with a larger group of Afghan participants with refugee backgrounds or from other refugee groups in Norway (Harder et al., 2018a,b). Future studies should replicate our findings on a larger and more heterogeneous sample.

There were more males than females, and the majority were relatively young. Participation in the survey could have been restricted due to difficulties accessing and completing the survey. Most of our participants were young adult males, and lower participation in the survey may be associated with difficulties in

accessing and completing the survey (e.g., lower education (non-literacy) among potential participants or lower social media use among females), which may not help achieve the required number of participants. Whether the findings suggested that it holds for younger or male participants than for females, responses hold a relevant case for this study. The questions applied to all Afghans living in Norway (in terms of the categories selected for the Facebook ads and inclusion criteria relevant to the Afghan population), and the survey ruled out questions directed specifically to the respondents (e.g., information on refugee status). Anonymity and participant protection played an important role.

The study also had difficulties collecting sufficient data and recruiting participants. Interpretation bias may affect future predictions and decisions in psychology research; however, caution is warranted when interpreting data from small samples (Hekler et al., 2019). During the first wave of covid and after the pandemic breach, data collection may have affected the responses. However, despite the low response rate before the pandemic, some questions could influence the answers – in this case, questions from the social and linguistic dimensions of integration – given the non-significant contribution. Nevertheless, unforeseen circumstances may have required some adjustments to data collection, such as cluster sampling. Furthermore, people with lower digital literacy might have been excluded from a self-administered online survey, reducing the likelihood of participation among those with lower education levels and language proficiency. The results of our study may underestimate the non-significant effects and may not favor those who feel connected to the Norwegian society over those who integrate with the other dimensions of integration. For example, displacement time (number of years) could be considered when analyzing the different aspects of successful integration. In the survey, this question was not included. Instead, only the age at which subjects arrived in Norway was collected in ten-year brackets. The factor aspect can also be considered through other statistical analysis. Nevertheless, the data has yielded valuable responses and contributed to the research study. For a deeper understanding of pre- and post-migration determinants and identify effective strategies to improve the mental health and well-being of refugees, further research could consider the target population, the duration of stay in Norway, the setting and time of analysis, and the pandemic situation.

6. Conclusion

Integration gathers different perspectives of the migration process. The current study has shown that the psychological dimension of integration can predict psychological distress affecting the Afghans' adaptation process in Norway towards successful integration. After the migration process, the relationship between integration and psychological distress could influence the path to successful integration, with the psychological dimension contributing to the sense of belonging in Norway. Afghans can adapt better and improve their mental health if they feel connected and have a sense of belonging in the Norwegian society. The different understanding of integration goes hand in hand with the different dynamics presented. However, using only one integration dimension to explain successful integration may pose certain issues for refugee integration in the Norwegian society and integration policies. In refugee settlement, integration is a central concept that plays out in different aspects in different contexts. This could be addressed in cross-cultural trainings to further explore and develop integration appropriate for the migration process. Despite this, integration is still measured in labor market activities, educational attainment, and social environments in the community. After the rapid withdrawal of U.S. and NATO forces from Afghanistan at the end of 2021, a new wave of Afghan refugees could emerge. The situation in Ukraine also challenges the Norwegian society and other immigrant groups with another wave of refugees. A balanced discussion of integration policy and advanced mental health training are crucial (e.g., interventions and prevention options to reduce symptoms of mental health problems in Norwegian health care facilities - from screening to referral in centers and clinics when screening is positive).

Mental health care services are often difficult to access for refugees. Providing information about entitlements and available services, facilitating social integration, developing outreach programs, and training professionals to work with these groups are all best practices for developing effective mental health care. Integration plays a vital role in all forms of migration, but refugee groups face most challenges despite current support programs. It is essential to develop programs that consider interactions and opportunity structures to understand the integration process better. Refugee integration should expand beyond focusing on homogeneity and heterogeneity to influence and build structures that shape refugee integration. The different dimensions of integration are a starting point to help develop more information for future migration policy.

Data availability statement

The raw data supporting the conclusions of this article will be made available from the authors, without undue reservation.

Ethics statement

The studies involving human participants were reviewed and approved by Ethics committee/IRN of the Norwegian Center for Research Data (NSD) Notification form: 602214. The participants provided their written informed consent to participate in this study.

Author contributions

DBL, DS, and GS contributed to the revision and writing of the manuscript and had primary responsibilities for the data analysis. DBL created the tables. All authors contributed to the article and approved the submitted version.

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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.

Publisher's note

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Doctoral Theses at The Faculty of Psychology, University of Bergen

1980	Allen, Hugh M., Dr. philos.	Parent-offspring interactions in willow grouse (Lagopus L. Lagopus).
1981	Myhrer, Trond, Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
1982	Svebak, Sven, Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
1983	Myhre, Grete, Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, Rolf, Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, Ragnar J., Dr. philos.	Neuropsychological effects of diving.
1984	Kolstad, Arnulf, Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, Tor, Dr. philos.	Neuropsychological assessment in alcohol dependence.
1985	Hellesnes, Tore, Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, Wenche, Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
1986	Hagtvet, Knut A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, Finn K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
1987	Aarø, Leif E., Dr. philos.	Health behaviour and sosioeconomic Status. A survey among the adult population in Norway.
	Underlid, Kjell, Dr. philos.	Arbeidsløyse i psykososialt perspektiv.
	Laberg, Jon C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, Fred, Dr. philos.	Essays on explanation in psychology.
	Ellertsen, Bjørn, Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
1988	Kaufmann, Astrid, Dr. philos.	Antisosial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, Reidar J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, Odd E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
1989	Bråten, Stein, Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, Bente, Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
1990	Flaten, Magne A., Dr. psychol.	The role of habituation and learning in reflex modification.
1991	Alsaker, Françoise D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, Pål, Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, Inger M., Dr. philos.	Psychoimmuniological stress markers in working life.
	Faleide, Asbjørn O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
1992	Dalen, Knut, Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, Inge B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, Mary E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, Anne M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
1993	Larsen, Svein, Dr. philos.	Cultural background and problem drinking.
	Nordhus, Inger Hilde, Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, Frode, Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, Ragnar, Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, Bjørn Helge, Dr. psychol.	Brain assymetry and facial emotional expressions: Conditioning experiments.
1994	Tønnessen, Finn E., Dr. philos.	The etiology of Dyslexia.
	Kvale, Gerd, Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.
	Asbjørnsen, Arve E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.

	Bru, Edvin, Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, Eli T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, Birte F., Dr. philos.	Det flytende kjønnet. Om lederskap, politikk og identitet.
1995	Sam, David L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, Inger-Kristin, Dr. philos.	Component processes in word recognition.
	Martinsen, Øyvind, Dr. philos.	Cognitive style and insight.
	Nordby, Helge, Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, Arild, Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, Wencke J., Dr. philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, Wibecke, Dr. philos.	Subjective conceptions of uncertainty and risk.
	Aas, Henrik N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, Stål, Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
1996	Anderssen, Norman, Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.
	Einarsen, Ståle, Dr. psychol.	Bullying and harassment at work: epidemiological and psychosocial aspects.

1997	Knivsberg, Ann-Mari, Dr. philos.	Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
	Eide, Arne H., Dr. philos.	Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
	Sørensen, Marit, Dr. philos.	The psychology of initiating and maintaining exercise and diet behaviour.
	Skjæveland, Oddvar, Dr. psychol.	Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
	Zewdie, Teka, Dr. philos.	Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
	Wilhelmsen, Britt Unni, Dr. philos.	Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
	Manger, Terje, Dr. philos.	Gender differences in mathematical achievement among Norwegian elementary school students.
1998 **V**	Lindstrøm, Torill Christine, Dr. philos.	«Good Grief»: Adapting to Bereavement.
	Skogstad, Anders, Dr. philos.	Effects of leadership behaviour on job satisfaction, health and efficiency.
	Haldorsen, Ellen M. Håland, Dr. psychol.	Return to work in low back pain patients.
	Besemer, Susan P., Dr. philos.	Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
H	Winje, Dagfinn, Dr. psychol.	Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
	Vosburg, Suzanne K., Dr. philos.	The effects of mood on creative problem solving.
	Eriksen, Hege R., Dr. philos.	Stress and coping: Does it really matter for subjective health complaints?
	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999 **V**	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.
H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.

	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000 V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001 V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002 V	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.
	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.

	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003 V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004 V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.
	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.

	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
2004 H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005 V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
2005 H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
2006 V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.
	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.

	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consiousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
2006 H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
2007 V	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr.psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints
	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work

	Thuen, Elin Marie, Dr.philos.	Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
2007 H	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
2008 V	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
	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, skoleledereres 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
	Anda-Ågotnes, Liss Gøril	Cognitive change in psychosis
	Finserås, Turi Reiten	Assessment, reward characteristics and parental mediation of Internet Gaming Disorder
	Hagen, Susanne	«Helse i alt kommunen gjør? ...» - *en undersøkelse av samvariasjoner mellom kommunale faktorer og norske kommuners bruk av folkehelsekoordinator, fokus på levekår og prioritering av fordelingshensyn blant sosioøkonomiske grupper.*
	Rajalingam, Dhaksshaginy	The impact of workplace bullying and repeated social defeat on health complaints and behavioral outcomes: A biopsychosocial perspective
	Potrebny, Thomas	Temporal trends in psychological distress and healthcare utilization among young people
2021 V	Hjetland, Gunnhild Johnsen	The effect of bright light on sleep in nursing home patients with dementia
	Marquardt, Lynn Anne	tDCS as treatment in neuro-psychiatric disorders. The underlying neuronal mechanisms of tDCS treatment of auditory verbal hallucinations.

	Sunde, Erlend	Effects of light interventions for adaptation to night work: Simulated night work experiments
	Kusztrits, Isabella	About psychotic-like experiences and auditory verbal hallucinations. Transdiagnostic investigations of neurobiological, cognitive, and emotional aspects of a continuous phenomenon.
	Halvorsen, Øyvind Wiik	Aktørskap hjå norsklærarar i vidaregåande skule – Ein sosiokulturell intervjustudie
	Fyhn, Tonje	Barriers and facilitators to increasing work participation among people with moderate to severe mental illness
	Marti, Andrea Rørvik	Shift work, circadian rhythms, and the brain. Identifying biological mechanisms underlying the metabolic and cognitive consequences of work timing, using a rat model.
	Thomassen, Ådne Gabriel	Hardiness and mental health in military organizations. Exploring mechanism and boundary conditions.
	Husabø, Elisabeth Bakke	Implementation of indicated anxiety prevention in schools
	Hagatun, Kari	The Educational Situation for Roma Pupils in Norway. Silenced Narratives on Schooling and Future.
	Herrero-Arias, Raquel	Negotiating parenting culture, identity, and belonging. The experiences of Southern European parents raising their children in Norway.
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