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**Contextual factors influencing Thai  
immigrant women`s mental health, and  
their strategies to cope with mental health  
problems**

**A qualitative study of Thai immigrant women in Norway**

## **Abstract**

With a growing immigrant population, Norwegian society faces new challenges in provision of health care. Multicultural challenges are particularly visible in mental health care and immigrant women seem to be underrepresented in health care services for mental health problems. Thai migration to Europe has increased in the recent years, and Thai women are among the largest groups of immigrant women in Norway, with almost five times as many immigrant women as there are men. Identifying barriers to health care is an important step in addressing access to care for immigrant women. Knowing more about the factors that influence immigrant women's mental health and their coping strategies can help aid health care delivery and policy planning. The purpose of the study is to explore the contextual factors that influence Thai immigrant women's mental health and how they feel about consulting their GP for mental health problems.

Fifteen semi-structured interviews of Thai women living in Norway (31-55 years old), conducted by Melanie Straiton, were analysed in this qualitative study. The analysis was informed by the postcolonial feminism perspective, in order to address the view of Thai immigrant women in light of their gender specific reasons for migration.

The analysis revealed that gender, ethnicity, culture and socioeconomic status affects Thai immigrant in Norway's mental health. Power imbalances between them and their husband potentially maintain some of the women in subordinated positions. These factors may contribute to stress as well as influence their coping strategies. The women try to live up to expectations of them being a wife/partner, daughter, mother and/or a breadwinner, but face many challenges in Norway. Few of the women had consulted their GP for mental health problems, even though all the informants experienced some level of stress or distress. Many feel that their GP will not understand them and try to deal with stresses in life with alternative coping strategies, like religion and friends.

The study findings indicated that many Thai immigrant women live transnational lives and try to fulfil different roles and expectations. Health care providers should gain cultural competence in order to understand their challenges and their needs. Even though the women showed a great deal of awareness of how to cope with difficulties in life, all reported some

level of stress and stress, which indicates that their coping strategies may not be sufficient. Improving ways of help seeking is suggested as beneficial.

*Keywords:* Immigrant women`s mental health; Thais mental health; Postcolonial feminist perspective; Transnational marriages; Coping; GP

## **Acknowledgements**

The work with this thesis has allowed me to learn from Thai immigrant women in Norway and voice their experiences. I am very grateful to my informants who have taught me a lot about how it is to be an immigrant woman in Norway. Their openness has given me insight into their challenges and how they feel about seeking health care in Norway. I feel great respect for these women, who are kind, strong and resourceful. The study would not be possible without your strength and openness.

The process of writing this thesis has been very interesting and meaningful, but it has also demanded hard work. There are some people I especially want to thank for given me support through these intense last months. I owe a debt of gratitude to my supervisor Melanie Straiton who has inspired me, supported me and challenged me throughout the whole process; I am thankful for our productive and nice meetings and for your fast responses. I have learned a lot from you. I also want to thank my fellow student Sanjana Arora, who has participated in some of the meetings and shared her knowledge and inspiring observations. I will also thank my family and friends for being patient and given me time to write, as well as being interested in my work. And to my cohabitant, Pål Røsrud, thank you for sticking out with me the last months. I will also thank my colleagues at Norsk Friluftsliv for being flexible and given me time to write.

Oslo 11.05.16

Tone Jersin Ansnes

## Table of contents

Abstract .....	1
Acknowledgements .....	3
1. Introducing the thesis .....	6
1.1. Background .....	6
1.2. Research aim .....	8
1.3. Relevance of the study .....	8
1.4. Key concepts and definitions .....	8
Mental health and mental health problems .....	8
Primary health care services in Norway.....	9
Residence permit .....	10
Transnational marriages .....	10
2. Contextualizing immigration and mental health .....	11
2.1. Feminized migration .....	11
2.2. Thai migration .....	11
2.3. Thai immigrant women in Norway .....	12
2.4. Thai women’s mental health status .....	13
2.5. Immigrant women and their use of mental health services .....	14
2.7. Mental health services in Norway .....	15
2.8. Mental health services in Thailand.....	16
3. Research Questions .....	17
4. Outline of the thesis.....	18
5. Theoretical framework .....	18
5.1. Theoretical perspective – high-level theory .....	18
5.2. Postcolonial feminism .....	18
5.3. My position .....	20
6. Method .....	20
6.1. Method: Interview and possible ethical dilemmas .....	20
7. Methodology .....	22
7.1. Sample.....	22
7.2. Sampling method.....	23
7.3. Data collection.....	23
8. Analysis.....	23
8.1. Interview analysis in the theoretical perspective of postcolonial feminism.....	25
9. Ethical considerations .....	26
10. Findings.....	27

10.1 The women's experiences related to symptoms of distress .....	28
10.2. RQ 1: Which factors influence Thai women living in Norway's mental health? .....	29
Their family left behind and their financial responsibilities for them.....	30
Their relationship with their husbands or ex-husbands.....	33
Discrimination.....	36
Social isolation.....	37
Acculturation challenges in Norway.....	39
Factors leading to less stress.....	43
10.3. RQ 2: How do Thai women perceive consulting with their GP and how might this affect their willingness to seek help for mental health problems? .....	44
Health information.....	45
Unapproachable doctor.....	46
Expectations of the doctor as an expert.....	48
Cultural differences in labeling diseases.....	49
Long waiting time and costs of consultations.....	50
Communication difficulties.....	52
Specialist care obstacles.....	55
10.4. RQ 3: Which other factors influence Thai women's willingness to seek help for mental health problems?.....	57
Views on mental health and mental health problems.....	57
Stigma.....	59
Other coping strategies.....	60
The role of the family.....	63
11. Study limitations and strengths .....	65
12. Discussion .....	67
Factors influencing Thai women living in Norway's mental health.....	67
Perceptions about GP-consultations and how this affects their willingness to seek help for mental health problems.....	69
Other factors influencing Thai women's willingness to seek help for mental health problems.....	73
13. Structural implications .....	74
14. Conclusion.....	76
Appendix 1: Request for participation in a research project.....	91
Appendix 2: Interview Guide.....	93

# 1. Introducing the thesis

## 1.1. Background

Globalization makes our world increasingly multicultural (Campinha-Bacote 2003). This also applies to the Norwegian society, where the composition of the population is constantly changing. More than 600 000 immigrants, and 135 000 Norwegian- born to immigrants parents, live in Norway today, which make up around 15 percent of the population (Statistics-Norway 2015a). Immigrants, defined as “persons born abroad with two foreign parents”, make up around 13 percent of the population (Daustad 2009, 8, Statistics-Norway 2015a). Most immigrants in Norway come from Europe (57 %) and Asia (26 %). If we exclude Nordic citizens, most immigrants have migrated for family reunification (36 %), for work (33 %), as refugees (20%), or for education (11 %) (Statistics-Norway 2015b). In the last decades, an increased number of Norwegian men have married foreign women, and most commonly women from Thailand, Philippines and Russia (Lie 2004, 53-54). This makes the immigration from these countries more feminized. Thai women are among the largest groups of immigrant women in Norway, with almost five times as many immigrant women as there are men (Daustad 2009, 17).

It cannot be ignored that a growing immigrant population poses some challenges to politicians, local communities, as well as practitioners. The Norwegian Ministry of Health and Care Services has formed a new strategy to promote the challenges related to immigrants` health, and further steps to meet these challenges. It is called “Equitable health care - health for all: National Strategy on immigrants' health (2013-2017)”. The strategy emphasis that “all patients in Norway shall have equal access to health services, regardless of their diagnosis, residence, economy, gender, country of origin and ethnicity”. The patient`s needs shall be in focus (Helse- og omsorgsdepartementet 2013, 1 and 4). The strategy also emphasis that health professionals should gain cultural competence to meet the patient`s needs (Helse- og omsorgsdepartementet 2013, 4-5). These aspects are very important, considering that people living in Norway today have various practices and meanings, as well as beliefs (Sam 2006, 1268-1269). Variations in health beliefs can be a challenge for health care providers, who may lack cultural competence in order to understand the patient`s needs. The diversity of culture includes factors such as “the national of origin, religion, language, physical size, gender, age, and socio-economic status”, to mention some (Campinha-Bacote 2003). Further, communication difficulties may also act as a barrier for immigrants when consulting their

general practitioner (GP), and they might find it hard to frame their problems. This can potentially result in wrong diagnosis and treatment (Straiton et al. 2015, 15).

Multicultural challenges in the provision of health care are especially visible in mental health care. It is likely that your cultural background influence how you consider your own mental health, as well as your coping strategies (Helse- og omsorgsdepartementet 2013, 20).

Immigrants in Norway seem to cope with mental health problems differently than native Norwegians, and more seldom visit their GP for mental health problems (Erdal, Singh, and Tardif 2011, 486-487, Straiton, Reneflot, and Diaz 2014, 345). Especially immigrant women seem to rarely use health care services for mental health problems (Straiton et al. 2015, 18). At the same time, Norwegian studies have indicated that there is a tendency of more mental health difficulties among the immigrant population from low- and middle income countries, than the native population (Abebe, Lien, and Hjelde 2012, 60). We also know that women, and especially immigrant women, may be prone to power imbalances and stressors of low socioeconomic status, social isolation, and domestic abuse (Kotecha 2009, 70). These factors may lead to mental health problems, as well as affecting their access to care.

International studies show that treatment of most mental health problems are delivered at the primary health care level, and *up* to half of those who consult their GP, have mental health difficulties (Ansseau et al. 2004, 53, Toft et al. 2005, 1178, Verhaak et al. 2012, 161). This means that GPs is likely to be the one who is recognizing mental health problems and the one who delivering the treatment. Untreated mental health problems can situate huge costs on the health services and the society (Straiton et al. 2015, 2). Special awareness to immigrants' mental health has been suggested, as untreated mental health problems seem to be higher among immigrants than the rest of the population (Abe-Kim et al. 2007, 93-94).

Researches has increasingly investigated immigrants' access to mental health care the recent years, but there is still limited research on how immigrants experience the treatment given (Calderón-Larrañaga et al. 2011, 432, Dyhr, Andersen, and Engholm 2007, 226, Nielsen et al. 2012, 260, Straiton, Reneflot, and Diaz 2014, 341, Straiton et al. 2015, 1). Therefore, we do not know how particular immigrant groups experience mental health care treatments. In addition, some of the literature considered in this field is out of date, which indicates that more research is needed in this field. The focus in this study will be on how Thai women



living in Norway feel about consulting their GP for mental health problems and which factors influences them in doing or not doing so.

## **1.2. Research aim**

The research aim is to get a better understanding of the factors influencing Thai immigrant women's mental health, how they perceive consulting their GP for mental health problems, and which other coping strategies they might use. Identifying barriers to health care is an important step in addressing access to care for immigrant women. The findings will give an indication of what can be done to make mental health care more accessible, and perhaps more appropriate, for a large group of immigrant women in Norway. Ultimately, the findings can inform prevention and intervention strategies for mental health among Thai immigrant women.

## **1.3. Relevance of the study**

With a growing immigrant population, the Norwegian society faces new challenges in provision of health care. Immigrants may experience difficulties in expressing their concerns, for instance because of language and cultural barriers, which can lead to wrong diagnosis and inappropriate treatment. Health care professionals will benefit from knowing more about cultural challenges in order to detect diseases and deliver appropriate health care.

Researchers often group immigrants together such as "Asians", which potentially masks variations by country of origin (Gonzalez et al. 2011, 52). This study will consider Thai immigrant women's experiences with their GP and factors influencing their willingness to seek help for mental health problems. Knowing more about how Thai immigrant women in Norway experience the primary health care services will aid policy planning. It is important to understand the barriers they may face and what can be done to reduce these.

## **1.4. Key concepts and definitions**

### *Mental health and mental health problems*

Since I am studying Thai immigrant women's experiences of mental health, as well as how they cope with mental health problems, I will define mental health and mental health problems in this section. The World Health Organization defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the

normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO 2014a). This definition indicates that even though you do not struggle with mental health problems, it does not mean that you have good mental health. Or seen from another point of view; if you suffer from mental health problems, you can still achieve moments of happiness (WHO 2014b, 12). Mental health problems can also be described as mental disorders, which are characterized by “a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others” (WHO 2015). WHO’s World mental health surveys (WMH) estimates that mental health problems affect between 18-36 percent of the people living in the world in a lifetime, and many more suffer from mental stress (Kessler et al. 2009, 25). It is important to acknowledge that mental health problems are characterised and sensed in various ways all over the world (Burnard, Naiyapatana, and Lloyd 2006, 743). In this study I will use the term mental health in relation to the informants’ experiences of satisfaction in life, and the term mental health problems when describing their mental health difficulties.

#### *Primary health care services in Norway*

Since I will consider the primary health care services in relation to mental health care, I will emphasize how the primary health services in Norway are built up. The health services in Norway are financed by the national budget, which are funded by the public. Regular medical consultations (subjected to a fee), emergency treatment and hospitalization is covered for all citizens. When visiting your general practitioner (GP) you must pay a patient fee, which today vary from approximately 140 NOK to 350 NOK. The health care services are divided into municipal and specialist health services (also called primary and secondary health services), where the municipal part includes the GPs and casualty clinics. The GP service make up a considerable proportion of the municipal health services, and the GP is likely to be the one who is diagnosing, as well as referring to specialist health care. In other words; most people will come in contact with the primary health care services when seeking medical care (Straiton, Reneflot, and Diaz 2014, 341-342, Helfo 2014, 2016). The Regular General Practitioner (RGP) scheme was implemented on a national basis in 2001. All Norwegians are assigned to a list of a GP, and thereby have one doctor to relate to. You can choose which GP you will be assigned to, as long as the GP has an available spot on her/his list (Magnussen, Vrangbæk, and Saltman 2009, 141).

### *Residence permit*

Residence permit is also an important aspect of this study and needs to be explained. The majority of the women in this study had married a Norwegian man and settled in Norway through family reunification. Family reunification can be defined as “a residence permit a foreigner receives on the basis of he/her family ties to a person who resides or intends to settle in Norway”. The person the immigrant wants to reunite with must be Norwegian or Nordic, or another position that makes the person entitled to family immigration. A permanent residence permit allows the person to live permanently in Norway (UNE 2013, 2015). However, foreign women, who arrive in Norway as a part of a family reunification, receive a residence permit for five years, conditioned by marriage. After five years, assuming they are still married, the women have the right to stay in Norway permanently (UDI).

### *Transnational marriages*

New communication technologies, as well as cheap and easy travels, contribute to increased migration and an escalation in transnational marriages (Charsley 2012, 5). A business in relation to transnational marriages has existed for many years, informed through mail and “advertisements”. Asian women, in particular, are told about opportunities in the West. With increased use of internet, the business has evolved. Online sites offer opportunities for Western men to meet non-Western women in the intention of marriage (Jones 2011, 21-22). This study will highlight the complexity of the transnational marriages between Thai women and Norwegian men, and I will therefore clarify how this relationship will be described. Transnational marriages between Western men and non-Western women are typically portrayed as “mail-order marriages”, and the “mail-order brides” are often seen as victims of exploitation. This approach contributes to permanent power imbalances and is misleading when trying to see the whole picture of such relationships. We must be careful not to view all these women as “victims, weak, poor and uneducated”. I choose to use the term “transnational marriages”, which is a less discriminating description of such relationships. Transnational is a concept that describes the relation between places and sees migration as a continuing process. I find this approach important when studying feminized marriage migration, since the couples often has families in different countries. In addition, this approach is much more flexible in terms of power-relations (Flemmen 2008, 115 and 116). The term “transnational marriages” place focus on globalisation created by the participants

themselves. It involves “sharing of economy, symbols and cultural traditions between the sending and the receiving communities” (Yang and Lu 2010, 25).

## **2. Contextualizing immigration and mental health**

### **2.1. Feminized migration**

Gender might be the most influencing factor on how you experience being a migrant. Today, women are migrating almost as frequent as men, but men and women do not always have the same reasons for migration and neither uses the same pathways in the process (Tangchonlatip and Richter 2011, 107). A woman who migrates to marry is not a new phenomenon. Relative to Thai women; many married American soldiers and emigrated to the United States during the Vietnam War in the late 1960s (Jirowong and Manderson 2001, 170). Women migrate for family reunification, but also for economic reasons, for self-fulfilment or as breadwinners for their family. The global labour market has become more feminized, with more need for labour in typically female sectors, such as household work, health care and in textile production, which also contribute to increased female migration (Tangchonlatip and Richter 2011, 107). In general, women’s role in migration has been underestimated. Acknowledging that women have diverse motivations for migration is especially important within migrant groups that are typically associated with trafficking and exploitation, like migrants from Thailand (Hofmann and Buckley 2012, 90, Plambech 2009, 45).

### **2.2. Thai migration**

Female Thai migration is increasing and is affecting the population trends in Thailand. This phenomenon can be seen in the relation to Thai women’s important role for their family’s economy, especially in the rural areas. They typically also help their parents financially, and are more likely than their brothers to send money back home if they migrate. Daughters are therefore more likely to migrate for better financial conditions (Tangchonlatip and Richter 2011, 107 and 110). Some Thai women marry foreign men and settle abroad. It is not normal to migrate because of poverty, but as a financial strategy. In this way their family is able to keep their socioeconomic standing (Plambech 2009, 37).

But even though Thai women have diverse motivations for migration, we cannot assume that their life is without challenges, or undermine that their migration may be rooted in power imbalances between genders. Neither can we ignore that some of the women are victims of

trafficking. Free will might be a relative concept for some Thai women, as they have many roles to fulfill (Plambech 2009, 45).

Thailand is regarded as “the centre of global sex trafficking and prostitution”, and Thai migration is often linked to these perceptions (Webster and Haandrikman 2014, 3). Women who migrate to marry are typically portrayed as either being exploiters of men or victims of prostitution or abusive men (Hedman, Nygren, and Fahlgren 2009, 44-45). The women who migrate to marry leave their families and social networks behind, and may be in a difficult situation of isolation, abuse and disempowerment. However, this is not the case for all, and we must be careful not to see these women as a homogenous group (Plambech 2009, 45).

### **2.3. Thai immigrant women in Norway**

As mentioned, Thai women are among the largest groups of immigrant women in Norway, with almost five times as many immigrant women as men. Most of them migrate for family establishment to Norwegian men (Daustad 2009, 17-18).

In the last decades, there has been an escalation in marriages between Norwegian men and foreign women, and especially women from Thailand, Philippines and Russia. Marriages between Norwegian men and Thai women increased from 50 new marriages in 1990 to 400 new marriages in 2001. Of all marriages between Norwegian men and foreign women who do not live in Norway by the time they get married, Thai women is the largest group (Lie 2004, 53, 55, 57). Numbers from The Norwegian Directorate of immigration show that 885 Thais got resident permit in Norway in 2015, after application for family reunification (UDI 2015). There is reason to believe that the majority of them were women applying for family reunification with a Norwegian man.

We know little about how Thai women experience emotional distress, or the barriers they may face when seeking help from a health professionals in Norway. Given the large number of Thai women in Norway who have left their familiar surroundings behind, it seem important to understand their experiences, their mental health care needs and the barriers they may encounter when seeking mental health care.

#### **2.4. Thai women's mental health status**

Mental health problems are commonly thought to be most relevant among immigrants who arrive as refugees, but no matter reasons for migration, immigrants experience separations from people they know and familiar surroundings (Jirowong and Manderson 2001, 168). Several factors may influence immigrants' mental health; like "age, gender, education, trauma, reason for migration, separations from family members, preparations before the migration, social support, integration, employment situation, economy, discrimination, feelings of disempowerment and cultural differences", among others (Helse- og omsorgsdepartementet 2013, 20).

Research concerning Thai women's mental health status is scarce. A survey carried out by the Department of mental health in Thailand in 2008 indicated that 2, 7 percent of Thai women, between age 15 and 59, have had an episode of "major depression", and 1, 2 percent have had a "generalized anxiety disorder" (Bhugra et al. 2016, 301-302). However, there is reason to believe that the prevalence of mental health problems is underestimated in Thailand, due to stigma and traditional beliefs (which I will get back to later in the thesis). A study from the United States has indicated 17, 3 percent of Asian immigrants experience any mental disorder during a lifetime (Takeuchi et al. 2007, 87). A Canadian study indicated that among 14, 5 percent of Thai immigrants in Canada had mental health problems. In the latter study, somatic complaints were identified as the most common symptom (Srirangson et al. 2013, 162 and 164). Studies from Norway highlights that there is a tendency of more mental health difficulties among the immigrant population from low- and middle income countries, than the native Norwegian population, which challenges what is known as "the healthy immigrant effect" – that immigrants are in average healthier than the native-born. This immigrant group seem to be more likely to suffer from acculturation difficulties, social isolation, poor economy, previous traumatic experiences and/or experiences of discrimination. The highest proportion of mental health problems have been found among immigrants from the Middle East (39 %) and the lowest among South-Asian immigrants (18, 9 %) (Abebe, Lien, and Hjelde 2012, 60 and 63). Still, the numbers are much higher than the studies of the Thai population living Thailand. This may indicate that migration is a high risk factor for mental health problems or that the numbers revealed in Thailand are too low. The literature in this field has not considered mental health of Thai immigrant women in particular, so we do not

have a specific description of the mental health status of this group. More research is needed in relation to the mental health of Thai immigrant women.

### **2.5. Immigrant women and their use of mental health services**

Studies in Norway have indicated that female immigrants in general consider their health to be poorer than the rest of the population, which also challenges what is known as “the healthy immigrant effect”. Immigrant women report more mental health difficulties than their fellow countrymen and the rest of the population (note: findings in a self-reported study) (Blom 2008, 3, McDonald and Kennedy 2004, 1613).

In addition, researchers in Norway have found an “underrepresentation” of immigrants, especially women, in acute psychiatric inpatient care (Berg 2009, 219-220). Immigrants seem to more seldom visit primary health services if they struggle with mental health problems (Straiton, Reneflot, and Diaz 2014, 345). Straiton et al. (2015, 11) have indicated that there exist differences in treatment options for immigrant women with mental health problems, compared with non-immigrant women, in the primary health care sector in Norway. Their study revealed that Thai immigrant women are less likely to receive conversational therapy than non-immigrant women.

Studies of Thai immigrant women in Norway and their use of mental health services are scarce. If we group Asian immigrants together we can find some studies related to the mental health service use, but primarily studies from the USA. North American studies indicate that Asian Americans use mental health services less than the general population (Abe-Kim et al. 2007, 93, Kim, Aguado Loi, et al. 2011, 107, Le Meyer et al. 2009, 1002-1003). One of the studies from the USA indicates that Asian Americans use mental health services half as much as American-born individuals. The study also highlights that Asian Americans born in the USA are more likely to use mental health services than foreign-born Asian Americans (Le Meyer et al. 2009, 1003). Spencer et al (2010, 2415) suggest that discrimination leads Asian Americans to use alternative coping strategies than health care for mental difficulties. Sentell, Shumway, and Snowden (2007, 290-291) highlight that individuals in North America with limited language proficiency has lower odds of receiving mental health care, and especially Asian Americans with limited language proficiency.

International studies suggest several barriers that may prevent immigrants from using mental health care services and receiving appropriate health care. Some of the barriers suggested are language difficulties, lack of information about the health system, costs of health care and availability of appointments (Li and Browne 2000, 145- 146, O'Mahony and Donnelly 2007, 1177, Scheppers et al. 2006, 329, Straiton et al. 2015, 18). Immigrant women may also have childcare responsibilities, which restrict their ability to access available mental services (O'Mahony and Donnelly 2007, 1178). Another barrier may be different understandings of mental health, which make the available services inappropriate (Bäärnhielm and Ekblad 2000, 448, Donnelly et al. 2011, 279). Fear of stigma also seem to cause barriers to seek mental health care among some immigrants groups (Brown, Abe-Kim, and Barrio 2003, 13, Ezeobebe et al. 2010, 196-198, Gilbert, Gilbert, and Sanghera 2004, 126).

There exist several cultural factors that might influence access to mental health care for Asian immigrants, as culture forms both the characterization and the awareness of mental health problems (Kramer et al. 2002, 228). Adaption to the new culture and language stands out as important factors affecting access to care, but also religious beliefs and spirituality influence Asian immigrants` use of mental health services. The predominant religion in Thailand is Buddhism, and most Thais keep a spiritual understanding of the causes of diseases. In the traditional belief system, karma is a central aspect; which assumes that problems in this life are a consequence of bad decisions in past life (Choowattanapakorn 1999, 97, Chamrathirong et al. 2010, 1856, Kramer et al. 2002, 228). These factors may create cultural obstacles for receiving appropriate care.

As we can see, there are several factors that may explain the “underrepresentation” of immigrant women in psychiatric inpatient care and the tendency of delay in recognitions of symptoms and help seeking. One important identified barrier for help seeking is the lack of appropriate mental health providers (Leong and Lau 2001, 202-203, Ngo-Metzger, Legedza, and Phillips 2004, 114). Other strong factors are social stigma and language barriers (Golberstein, Eisenberg, and Gollust 2008, 392, Kramer et al. 2002, 230).

## **2.7. Mental health services in Norway**

Before I specify how Thai immigrant women in Norway use the primary health care services, and how they feel about consulting their GP for mental health problems, I will specify the



mental health services in Norway are built up. As already noted, the Norwegian Ministry of Health and Care Services emphasises that all patients in Norway shall have equal access to health care (Helse- og omsorgsdepartementet 2013, 1). The National Mental Health Programme focuses on the primary health care services in relation to mental health, and puts effort into improving “availability, accessibility, quality and organization of mental health services and treatment on all levels” (WHO 2011a).

The mental health part of the primary health care services includes nurses, psychologists and centres and housing. The GP is the one who detects and treat most people who suffer from mental health problems, through either conversational therapy or medication, as well as refer to the specialist services if needed. The specialist mental health services include Psychiatric Outpatient Service (DPS) in the districts and psychiatric hospitals (Helsedirektoratet 2008).

## **2.8. Mental health services in Thailand**

I have no intentions of comparing the mental health services in Thailand and the mental health services in Norway, but I will emphasize how the mental health care is delivered in Thailand. The intention is to have in mind what kind of mental health care the women are familiar with from Thailand, to be able to see the whole picture of how the women feel about consulting their GP for mental health problems in Norway. Experiences from your home country are likely to influence your expectations of the services given in the host country (Helse- og omsorgsdepartementet 2013, 20).

In Thailand, mental health is a part of the primary health care services, but an actual treatment of mental disorders has not yet been seen available at the primary level. The official mental policy plan was revised in 2008, and included “a shift of services and resources from mental hospitals to community mental health facilities” (WHO 2011b). The mental health care services has been centralised with large psychiatric hospitals and few community places or treatment facilities. The priority of the financial resources has been the psychiatric hospitals; day treatments or residential mental care at the community level has not existed (WHO 2006, 8 and 24). The centralisation may contribute to stigmatization of mental health problems. Also the doctors at the primary health care clinics report that there exist stigma in relation to mental health problems, and few refers their patients to mental health specialist care (WHO 2006, 15).

Like in every other part of the world, culture also influences the Asian health system, and affects how they characterize and sense mental health problems (Kramer et al. 2002, 227). Many different treatments of mental health problems are available in Thailand, and it often seem to be a combination of the “modern” and the “traditional” treatment in the rural areas, and more “modern” treatment in the cities. Studies have showed increased incidences of “Western” treatment, such as counselling (Burnard, Naiyapatana, and Lloyd 2006, 748).

### **3. Research Questions**

This study will highlight factors influencing Thai women living in Norway’s mental health, how Thai women perceive consulting with their GP for mental health problems, as well as which factors influence their willingness to seek help. Straiton et al (2015, 11) have explored treatment alternatives in primary health care for immigrant women with mental health problems, compared with non-immigrant women in Norway. This quantitative study identified treatment differences between the countries of origin, especially when it comes to conversational therapy. Thai immigrant women were less likely to have experienced conversational therapy than non-immigrant women. The study suggested cultural differences and low language proficiency as possible explanations for the variations. Previous studies concerning access to mental health care among immigrants have mostly categorized immigrants in large groups like “Asians”, which makes it difficult to see important differences within the group. Advises has been given for future research in this field, namely separate consideration for each group, and special focus on immigrant women with low language proficiency (Straiton et al. 2015, 11 and 18). Low language proficiency is associated with lower use of mental health care (Sentell, Shumway, and Snowden 2007, 291). Thai women are among the largest groups of immigrant women in Norway, with almost five times as many immigrant women as there are men (Daustad 2009, 17- 18). I have therefore considered Thai women to be an important group for further investigation, concerning access to mental health care and experiences of primary health care in Norway.

The research questions in my thesis will be explored on the basis of qualitative interviews of Thai women living in Norway, and the findings will be compared with relevant literature in this field. The research questions are presented here:

- 1) **Which factors influence Thai women living in Norway's mental health?**
- 2) **How do Thai immigrant women perceive consulting with their GP and how might this affect their willingness to seek help for mental health problems?**
- 3) **Which other factors influence Thai women's willingness to seek help for mental health problems?**

#### **4. Outline of the thesis**

In the following chapter I will outline the theoretical framework, hereunder the postcolonial feminism. I proceed with discussing the method and methodological choices in chapter six and seven. In chapter eight I will review the analysis approach, followed by the ethical considerations in chapter nine. I further aim to draw and discuss the findings in chapter ten. I continue with a review of the study limitations and strengths in chapter eleven. In chapter twelve I will discuss the findings, followed by structural implications in chapter thirteen, and the conclusion in chapter fourteen.

#### **5. Theoretical framework**

##### **5.1. Theoretical perspective – high-level theory**

A theoretical perspective is a philosophical stance determining a context for the method, methodology and the analysis (Crotty 1998, 3). My theoretical perspective will inform my study throughout the whole process. I will hereunder view my research within the postcolonial feminism perspective, because I want to address the view of Thai women migrating to Norway, in light of their gender specific reasons for migration.

##### **5.2. Postcolonial feminism**

*Post colonialism* is a theoretical perspective, which challenges Western science and draws the attention to inequities related to gender, ethnicity and socioeconomic status, and can be seen as social differences affecting non-Western people (Racine 2003, 95-97). Historically, the Western world has dominated some non-Western territories, economically and military. The concept of colonialism is a critical way of looking at the construction of the Western and the non-Western, which some might say is shaped by the Western self-representation (Dhawan 2012, 50). There exist many other expressions to describe non-Western parts of the world, as a contrast to Western, like for instance "the Orient", "the Other" and "the South". I choose to

stick to the term “non-Western” in this study, and I will emphasize that this term is adopted as a historical description and not in a discriminating way.

As mentioned, some parts of the Western history include the colonization of non-Western countries. Colonized countries have been, and still are, affected by this economic, political and cultural interrelation (Weedon 2002). Unlike its Southeast Asian neighbours, Thailand has not been colonized by a Western nation. However, historians argue that they have been “indirectly colonized”, economically and culturally, by Western powers from the mid-nineteenth century. Thailand has close ties to Europe and the United States. The challenges today might therefore be similar to postcolonial settings; being affected by the West, and yet keep their traditions? (Grol-Prokopczyk 2013, 93).

*Postcolonial feminism* addresses inequalities related to power relations, especially between the genders (Racine 2003, 96). It emerged in response to Western mainstream feminism, which tends to overlook inequalities concerning socioeconomic status, ethnicity and locations of women. Postcolonial feminism is an important branch of post colonialism, as postcolonial women’s lives and understandings may be different from the Western women’s (Mishra 2013, 129).

My chosen perspective addresses health problems related to ethnicity and gender, and connect them to “historical, economic, political, social and cultural factors”. It explores how subordination is experienced in the everyday lives of non-Western women. One important question is whether Western academics like me, can speak about these experiences, without misrepresenting them. It has been argued that if a researcher is careful to analyse in the Western viewpoint, the postcolonial women’s experiences can be conveyed (Racine 2003, 96-97). The strength of this perspective in my research is that it can address barriers from the informant’s view: for example what barriers the Thai women encounter when they consult their GP.

I choose to take this gendered perspective, since immigrant women seem to be at further social disadvantage than immigrant men (Blom 2008, 3). In addition, migration is an old phenomenon for women. The number of female migrants and their “gender-specific” intentions for migration highlights the tendency of increased feminized migration (Plambech

2009, 32). As noted in the paragraph about feminized migration; gender may be the most influencing factor on how you experience being a migrant. Within the postcolonial feminism perspective I will examine how contextual factors, together with ethnicity, gender, culture and socioeconomic status influence Thai immigrant women's mental health, and their coping strategies. The aim is to better understand the informant's stories through gender, cultural, social and political structures.

### **5.3. My position**

Within the postcolonial feminist perspective, I am speaking from a particular manifested position, and it is crucial that I, as a researcher, examine my social position. It has been important to reflect on the impact of imposing my cultural and academic background in the study. I am a 31 year old woman from Norway, and I am a master student with a health and social science educational background. I am almost a "typical" Western woman. In this perspective, I will focus on representing the data without contributing to "othering" the informants' knowledge. This has required studying the literature in this field and seeing through the eyes of the informants. However, speaking from anyone else's view always involves some interpretation, and it has therefore been important to make the process transparent. This applies both to the informants and the group the informant represents (McEwan 2001, 102, Ozkazanc-Pan 2012, 578). I will therefore thoroughly describe the method, methodology and the analysis of my study. Regardless of my embodied position, Chris Weedon (2002) emphasizes that all postcolonial feminists add knowledge and make existing power imbalances visible, wherever they are located.

## **6. Method**

In this chapter I will describe how the data in this study has been gathered. A method is a technique to collect knowledge related to the research question (Crotty 1998, 3). Semi-structured interviews has been the method in this study.

### **6.1. Method: Interview and possible ethical dilemmas**

I am taking part in a project carried out at the Division of Mental Health at the Norwegian Institute of Public Health (NIPH), led by post-doc candidate Melanie Straiton. I have analysed fifteen semi-structured interviews of Thai women living in Norway, conducted by Melanie Straiton. In the semi-structured interviews, an interview-guide (see appendix 2) was made, but

the guide was adaptable depending on the dynamics of the conversation, and the informants had a good deal of flexibility in how to reply. The purpose of this approach was to provide insights into how Thai immigrant women experience the health services in Norway. Topics of focus in these interviews were differences in the health system between Norway and Thailand, experiences of going to the doctor, cultural perceptions of mental health, help-seeking for mental health problems and what might inhibit or promote their help seeking and access to appropriate care. Probe questions were also used, e.g. questions about the role of language, social support and their relationship to the GP. With this method, I got access to the informants' view; how they feel about visiting primary health care services for mental health problems. This data can contribute to understandings of how contextual factors and barriers influences access to health care. Even though the interviews were already conducted, I have been obliged to have a deep understanding of how the data is collected, the challenges, the advantages and the steps along with it, to get the most out of the material.

The goal in this qualitative study has been to view the informants' experiences and their understandings, rather than scientific explanations. A research interview can be seen as an "inter-view" with the intention to produce knowledge through conversations, which means that the interaction between the interviewer and informant construct the knowledge. The research interview is nevertheless a professional conversation with some form of structure and a purpose. And since the researcher is in charge of the situation, the research interview is not a conversation between balanced parts (Kvale and Svend 2009, 1-3).

The knowledge produced in qualitative interviews is related to the social relationship between the researcher and the informant, which may lead to ethical issues. The researcher wants to create interesting data material, but it is crucial to also focus on the integrity of the interview and the informant. Related to this study, it has been important to consider this commitment in situations where I do not share the informants' view and my own perceptions are being challenged. Being bounded to your own views can potentially result in wrong interpretations. The qualitative interview seeks to bring into light both facts and meanings, but the meanings are often challenging to pick up. To achieve this, I have tried to understand what is being said "between the lines". However, it has also been important to be aware of that I might be

affected by my own perspectives and my research questions, when investigating the data (Kvale and Svend 2009, 16 and 30, Bryman 2012, 491-493).

## **7. Methodology**

In this chapter I will explain how the study has been shaped, by clarifying the methodology. The methodology portray the design behind the method (Crotty 1998, 3). I will take a closer look at the sample, the sampling method and the data collection in this section.

### **7.1. Sample**

The research questions will be answered through qualitative data obtained via semi-structured interviews with fifteen Thai immigrant women. The inclusion criteria required the women to be between 18-65 years, been living in Norway for at least one year and have visited their GP in the last year. One of the informants had been in Norway for 30 years; the rest of them had been in Norway in average 8.2 years (2.5 -15 years). They had an average age of 39.8 years (31-55 years old). Seven were currently married and seven were divorced or widowed. Ten of them had children, of whom 5 had children who were born in Norway. Ten of them were employed and/or studying and five of them had higher education. I chose to include the interview of the woman who had been in Norway for 30 years, even though her time in Norway exceeded the inclusion criteria. She was quite informative and has been used for background information about culture and mental health perceptions, but less in relation to health care experiences, barriers to the use of health services and adjustment issues.

The informants scored on average 1.8 (range 1.3- 2.3) on HSCL-10, which is a measure of psychological stress symptoms. Scores over 1.85 suggest that the person is experiencing mental health problems (Strand et al. 2003, 1). Six out of the fourteen who completed this test, scored above cut off.

The majority of the women in this study said they had moved to Norway because they had met a Norwegian man and married him. The rest of the women came to Norway as au pairs (a person who helps a family with child care or house work in exchange for household), refugees or daughters. Many of the women explained that they had met their husband while he was on vacation in Thailand. Few of the women indicated that they married a Norwegian man and

migrated to Norway because of poverty, but many of the women expressed that they hoped for a better life in Norway and wanted to secure their family financially.

## **7.2. Sampling method**

The selection of group was done in a non- probability form of sampling, called purposive sampling. The informants were not chosen on random basis, but rather in a strategic way. Recruiting was initially done through the Thai Women Association Norway and key personal contacts. Informants were further recruited via the snowball method, and all were asked to identify other women suitable for the study. All potential informants were contacted via letter/email and/or telephone and informed about the project (see appendix 1). A suitable time and place for the informants was then arranged with those who wished to participate.

## **7.3. Data collection**

The informants completed some background information, including their length of time in Norway, education level, employment status, languages they speak and a measure of emotional distress (HSCL-10), before the interviews. A translator was present during the interview for those who were not proficient in either Norwegian or English (two of the women). The interviews were also recorded and transcribed.

## **8. Analysis**

In this chapter I will describe how I have analysed the data from the transcribed interviews. The analysis is developed after the interviews have been conducted and transcribed (Kvale and Svend 2009, 193). According Kvale and Svend (2009, 192-193) is it important to recognise the interviews as living conversations and not just transcripts, when analysing transcribed interviews. It is also important to remember that the statements in the text are co-authored by the interviewer, and that the informants may be affected by the interviewer.

The data from qualitative interviews are rich, and it can be challenging to accomplish true analysis (Bryman 2012, 565). One way to start is to separate the data material to manageable pieces, a technique called coding (Schwandt 2014, 30, Bryman 2012, 575). I chose to use this technique, and I started out with comparing and contrasting various parts of the data and later named them using a code or a category.



By using codes in the analysis I could generate an overview that helped me interpret the data. When developing the codes I considered what these pieces of the data referred to and what kind of topic they suggested. I chose an open coding approach, where I arranged concepts, which I further grouped and named as themes in the analysis. It was important to be open-minded in the coding process, as it provides guidelines for the rest of the analysis (Bryman 2012, 569 and 575).

I chose an inductive approach for the analysis, which means that I worked with the true language of the informants when coding the data material. In this way I went back and forth between the data and the codes to find the meaning of the codes as they continue through the data material. I moved from specific observations to broader meanings. This approach is also called a “bottom-up” approach, in the meaning that you start with specific observations to detect patterns, and end up developing some general conclusions or theories (Bryman 2012, 26, Schwandt 2014, 31).

There are things to be aware of when coding large data material. It can be tempting to code in an explanatory and simple way, rather than to code with the intention of developing an understanding. It is easy to look at codes as “fixed” and “unchangeable”, and in this way ignore that they come from living conversations (Schwandt 2014, 31). Critics of the coding approach worries about losing what is being said, by taking it out of its context, which may results in fraction of data (Bryman 2012, 578). The coding process of the analysis have to be open for revision (Bryman 2012, 568). The codes identified in this study were therefore constantly compared and investigated.

During the analysis, I have used the analyse program “Nvivo” as a support tool. It has helped me to organize the data and code what is being said. The reason to use “Nvivo” was to save time, see connections and make it easier to search through data. The aim has been to reduce data by coding, and further see commonalities and contrasts. I started out the analysis by reading through all of the interviews one time, without taking notes, and then one time with taking short notes in the margin. The notes were just used as first thoughts. I continued with analysing the interviews through “NVivo”. I read through the interviews several times and put what was being said into different codes. To avoid being affected by previous coding, I started out every reading without codes, but listed the codes up a long as I read. In the end I used all

the codes that I had listed in the previous readings and wrote them down before I went through the interviews one more time. With this method, I started out with an open-coding and made sure that every aspect was taken into account in the end. The analysis were not completed after this, but kept on while I searched through relevant literature related to the findings.

After the process of coding of the data, I made an index of central themes and subthemes, which I got from the encoded data material. A theme can be understood as a group of codes, which prepare the basis for the theoretical understanding of the data (Bryman 2012, 580). “Nvivo” made it easier to look for relevant themes, but I also needed to go back and forth to the transcribed interviews to find the collected codes in the correct context. I was also observant of statements that did not fit in, for instance statements that went against what the majority said, to emphasize every aspect. The establishment of themes is a step further from coding data. When building up the themes, special attention was given to aspects of mental health, like stress, sadness, challenges and coping. In the end of my analysis I focused on what the women said about the main themes, and what it indicates in terms of wider social attitudes and norms.

As said, an inductive approach was used throughout the analysis. This means that the theory is an outcome of the research. However, inductive processes often involve a bit of deduction (hypotheses that must be tested to empirical study). Theoretical reflections in my study made me search for previous research that could support or contradict the theory. This can be described as an iterative approach, which means going back and forth between theory and the literature available in the field (Bryman 2012, 24-26). I will emphasize that my analysis has been inductive, but with an iterative element to strengthen the trustworthiness of the findings.

### **8.1. Interview analysis in the theoretical perspective of postcolonial feminism**

It is also important to acknowledge that my theoretical perspective of postcolonial feminism has influenced my data analysis. Within this perspective I have kept in mind that I want to address the Thai women’s point of view. With an open-coding approach I chose to be open-minded when searching for themes and in the process of understanding what was being said. This approach helped me generate new ideas and trying to see through the informants’ eyes. I also had to be careful with viewing the women’s social world different than they do. Within

my theoretical perspective, it has been important to dissociate from prejudices, which could have blinded the research. When describing the women's experiences in Norway it has been important not to contribute to "othering" them or their transnational relationships.

Postcolonial feminism guided me to be aware of the immigrant women's perspective and their experiences of power imbalances in my analysis.

## **9. Ethical considerations**

When analysing private lives and trying to indicate what it means in terms of wider social aspects, it is important to consider the ethical issues which comes along (Kvale and Svend 2009, 62-63). I will follow this concern by giving some examples of ethical issues in different stages of the research and how these concerns are met in this study.

When deciding on the theme of the study, it is important to make sure that the study intends to improve the circumstances examined (Kvale and Svend 2009, 63). This issue is met by the intention of informing prevention and intervention strategies for mental health care among Thai immigrant women in Norway. The findings will give an indication of what can be done to make mental health care more accessible, and perhaps more appropriate, for Thai immigrant women.

Further, when designing the study, it is important to think about confidentiality and possible consequences for the informants, e.g. that they experience stress or changes in their self-understanding. When it comes to transcription, the written text should be true to the informants' statements, and in the analysis there is a question of how deeply the interviews can be analysed. Confidentiality must be maintained when reporting, and the consequences for the informants and the group they belong must be considered (Kvale and Svend 2009, 63). This research was ethically approved through the Regional Committees for Medical and Health Research Ethics, West Norway, before the interviews took place. Informants were given extensive information about what the participation would involve. Participation was voluntary and the informants were asked to sign an informed consent form. The interviewer was sensitive to the women's emotions during the interview and had training in qualitative interviewing and active listening. The interviewer had volunteered at Oslo Crisis Centre, and had experiences with and understanding for women who had experienced domestic abuse. Following the interview, the women were debriefed and if it appeared that someone needed

psychological support, the interviewer assisted them in making contact with an appropriate service. Informants could withdraw from the study at any time and request the interview to be deleted from the record.

Confidentiality in qualitative research means that the identity of the informants must not be made public (Kvale and Svend 2009, 72-73). Confidentiality has been emphasised to the women. Care has been taken when writing up the analysis to ensure that the women are not identifiable. In my analysis, I have not stated exactly how many experienced the different aspects. When citing the informants, I have chosen to highlight aspects which many of the women experienced. In this way many of the women will recognize themselves, without anyone being identified. The informants will be contacted when the research is finished and they will get the chance to read a pop-abstract of the thesis. They will also be informed about where they can find the complete master thesis and any publications of study.

## **10. Findings**

The format of this chapter will reflect the three research questions which have focused this investigation. Research question 1: *Which factors influence Thai women living in Norway's mental health?* will be addressed by highlighting different factors influencing the informants mental health. Research question 2: *How do Thai women perceive consulting with their GP and how might this affect their willingness to seek help for mental health problems?* will be outlined by describing how the informants experience consultations with their GP and how they feel about consulting their GP for mental health problems. Research question 3: *Which other factors influence Thai women's willingness to seek help for mental health problems* will address the informants' view on mental health and alternative coping strategies they might use. The three research questions will form one subchapter each. Within each subchapter I will discuss some aspects of the findings. The focus will be on how the women's experiences can be understood and I will further relate these findings to the literature available in this field. This approach will help me to maintain the postcolonial feminism perspective and reflect upon the themes from the Thai women's point of view. Before I focus on the research questions, I will stress how the informants in this study experience symptoms of distress, which I see as important background information. The findings in my analysis will not be taken out of numbers; I will rather seek meanings of different aspects of the informants' life. The goal is to find the meaning in the women's perception of mental health, GP-consultations

and their alternative strategies to cope with mental health problems. However, I have looked for both similarities and inequalities in the interviews, and I have therefore clarified if the statements have been expressed by many or few of the women. I have looked into previous research related to the themes, to find support or contradictions for the findings. At the end of the thesis I will draw a general discussion, some structural implications and a conclusion related to the most important findings.

### **10.1 The women's experiences related to symptoms of distress**

This study shows that many Thai immigrant women likely talk about their physical health problems. The informants in this study typically described their physical problems, but were less concerned about the mental aspect of their health: *I don't think I have a psychological problem, I think I only have problems in my neck*. When the interviewer asked about their mental health, most of the women had difficulties with understanding the term "mental health". However, after explaining the term, all of the women expressed some level of stress or distress. A few of the women expressed concerns about both their physical and mental health: *Really, I'm no good inside, I'm troubled by the neck and the back and bad lungs and everything. But I must try to hold myself*.

This study suggests that many Thai women find it more natural to talk about their physical health problems than their mental health problems. Similar findings have been found in an American study of Asian patients who suffered from depression; which indicate that it is more common to complain about physical health problems than mental health problems (Soonthornchaiya and Dancy 2006, 682). My study also suggests that the women were not familiar with the term "mental health", and they did not have a similar word for it in Thailand.

Nevertheless, all of the women in this study reported some level of stress after the interviewer explained the term "mental health". And near half of the women reported complaints related to distress, which correspond with the HSCL-10 test they did ahead of the interview. This test revealed that six of the fourteen women scored above the cut off, which suggest that these women are experiencing mental health problems. The women described a mix of concerns such as sadness, overthinking, guilt, social withdrawal, sleeping problems and feeling of helplessness. The women used expressions like *I'm sick in the head, I'm thinking a lot and*

*I'm sad* when they were asked about their mental health. Some expressed that they were scared and did not know how to cope with the thoughts in their head:

*I don't know, I know I'm sick in the head, I'm just scared like that. I don't know how one can help me, like that. Can't stop the thoughts that is coming, I think a lot. I have told the doctor many times, must not think he says.*

Near half of the women in this study said they had sleeping problems and some expressed that stress was bothering them. Their feeling of stress was typically linked to work, economy and the future: *I think, I'm a bit stressed. Stressed about working and.....Also the thought about the future and how to thrive in Norway, how we shall live well here.* Others were concerned about headache, boredom, tiredness, loneliness, low concentration and low self-esteem.

Many of the women in this study found it challenging to cope with the sadness, guilt, sleeping problems, feeling of helplessness, low self-esteem, stress, loneliness, and social withdrawal they experienced. Much of their worries were linked to living abroad and their future in Norway. Despite all this, very few of the women in study reported that they had visited their GP for mental health issues, and even fewer had received specialist mental health care.

Similar findings have been found in international studies. Studies in Sweden and Canada have indicated that social isolation and low social trust may affect Thai immigrant women's mental health (Fernbrant et al. 2014, 2, Srirangson et al. 2013, 163). With regard to common symptoms of distress, an Asian study has investigated the symptoms of patients with major depression disorder (MDD). The study revealed that the most severe and common symptom among the Thai patients was sleeping problems. Thai MDD patients also commonly referred to "feeling lonely", "feeling blue" and "worrying to much" (Bhugra et al. 2016, 301-303). These expressions of distress were also recognizable in this study.

## **10.2. RQ 1: Which factors influence Thai women living in Norway's mental health?**

So far in my analysis I have shed light on the informants' mental health status. These findings do not directly answer my research questions, but is important knowledge to bring into the research questions. The first research question I will answer is *Which factors influence Thai women living in Norway's mental health?* I will first stress which factors the informants see

as most influencing on their mental health while living in Norway, and then outline what other studies in this field have indicated. I will also explore what the informants see as acculturation challenges in the Norwegian society, as it may influence their mental health.

The women saw social determinants as the most influential for their mental health. They were concerned about their family left behind and their financial responsibilities for them, their relationships with their husbands or ex-husbands, and the feeling of social isolation.

*Their family left behind and their financial responsibilities for them*

The majority of the women in this study said they often talked to their family in Thailand, and that they missed having them close. Many emphasized that the role of the family was very different in Norway. They expressed that it was less common with strong family ties in Norway, that family relations were much closer in Thailand: *The societies in Thailand and Norway are much different, because in Thailand you have a full family. Everyone have to help, help together. In Norway you only have yourself.* They also found Norwegian families to be less supportive for each other: *In Thailand we are used to helping family, parents and relatives, but not in Norway. We don't have NAV (social benefits) in Thailand. We have to help each other.* The absence of family members was difficult for many of the women as they lacked the support they needed. This resulted in feelings of loneliness and some, feeling unsettled, questioned their decision to stay in Norway:

*I travel every year to Thailand to visit. After I got problems with my health, I miss Thailand [cries]. Like what I am I doing here, I think. But I think; I raise children, because I have children here. Only mum and dad in Thailand. And I have my husband here. Like 50/50.*

The majority of the women also explained that they have responsibilities for their family in Thailand while living in Norway. The broad impression is that the women are expected to send money back home. They highlighted that the society in Thailand is different and that everyone have to look after each other. Children are obliged to look after their mum and dad when they get older, since they do not receive any pension. When they retire, they do not get anything. It is not unlikely to send 2000 NOK or 3000 NOK monthly to their parents back home. The women expressed that many Thais migrate to work so they can help their family in Thailand. The harder they work, the more money they can send home, like this woman puts it:

*In Thailand when prices goes up, you work, but you don't earn a lot, and that is a bit difficult. Therefor most people want to go abroad and work. And save some, and help their family in Thailand. Here, if you work a bit harder or extra, you can have a bit more money to help your family in Thailand.*

A few of the women also felt that they did not take proper care of their family back home since they only sent them money: *They are old in Thailand now, mum and dad. I think that I haven't taken care of them. Only money. I can't take care of them and live here. And they can't take of me when I have problems with my health, because they live so far away.* The majority of the women in this study have children and some had to leave their children in Thailand. A few were struggling with the feeling of not taking care of their children they had left behind, and when they tried to bring their children to Norway, they were told that they did not have enough money to take care of them here:

*I have a child in Thailand. I want to go and get him. I have applied the embassy and the police. You have so little money, they say. Not go and get the child together with mum. It is a problem now, child lives alone in Thailand. No family. Before I had siblings who helped, now everyone is dead. He lives alone, big problem, lonely and thinks of his mum. Maybe I will try to find a lawyer. It doesn't feel right.*

This separation may contribute to feelings of guilt of not taking “proper” hands-on care of their children and sense of failure in their role as a mother. It also indicates that immigration policies can potentially deny these women a right to family life. Structural barriers like this may affect the women`s mental health.

Some of the women struggled with the differing expectations from their husband and their family left behind, and expressed that the different cultures caused problems for them. Their Norwegian husbands often did not understand why they had to send money back home and it was a source of conflict in their relationship: *Some men in Norway marry Thai women and some doesn't understands why the Thai woman has to send money to their family. It creates a problem.* Their impression was that in Norway you only take care of each other as husband and wife, but in Thailand you have look after everyone in your family. They felt



responsibilities for their family left behind and it was difficult that their Norwegian husband did not understand their obligations:

*Everyone who moves here, I would say every Thai woman who moves here, provides her family in Thailand. It is kind of my responsibility, yes my mother shouldn't strive so much, to live there, while I live here. It is a culture thing, you know, that the children should [take care of their parents]. But what is difficult is that it is different cultures, so it is not often that the men here in Norway understand why we have to pay there, when we live here. So it is very difficult for me and for others.*

Even though the majority of the women said they had responsibilities for their family in Thailand, it was not the case for everyone. A few of the women said that they did not have responsibilities for their family in Thailand. Their reasons for not having responsibilities for their family back home, were typically that their siblings took care of their parents or that their parents were no longer alive:

*No, I don't have any responsibilities for my family in Thailand. My brother earns almost the same as what I earn here. They earn very well in Thailand, but it is inflexible to work there. He works 9- 12 hours every day. And only ten day vacation. But earns as much as when I work 6 hours here. He earns well, and therefore I have no responsibilities for them.*

The broad impression is that those who do not have any responsibilities have been “freed” from their obligations, as they previously had financial responsibilities for their family.

The findings in the study indicate that many Thai immigrant women struggle between different expectations of their husband and their family left behind and that resolving this cultural difference is challenging. The women experience that the role of the family is not as important in Norway as they are used to in Thailand. They lack support from their new family in Norway and they miss having their own family close. The findings indicate that most Thai immigrant women have financial responsibilities for their family left behind, and many struggle with feelings of guilt for not supporting their family well enough. This study suggests that the women experience different expectations in their roles as wife/partner, daughter, and

mother, while living abroad. Different cultural expectations and the feeling of not being able to meet these expectations may affect their mental health.

The findings confirm international studies regarding Thai immigrant women. A study of Thai immigrant women in Australia highlights that the majority of the women often to their family members in Thailand, while living abroad (Jirowong and Manderson 2001, 178).

Furthermore, the reason to migrate is often closely linked to the opportunity to send money to their family left behind (Plambech 2009, 40). According to Plambech (2009, 38-39), it is a general acceptance for Thai women to leave their children behind when they marry a foreigner and move to another country. In these cases, it is usually their mother who takes care of their children when they migrate. Many Thai women migrate to fulfill important economic needs within the family context, and is hence looked upon as good mothers or daughters, who sacrifice themselves for their children and their families (Plambech 2009, 40). Even though many Thai women migrate out of free will, it doesn't necessarily means free choice between different financial alternatives. Many are in the host country to fulfill important financial needs within their family (Plambech 2009, 40). This role may cause stress and lead to feelings of guilt if the expectations are not met, in addition to many other challenges the women meet while living abroad.

#### *Their relationship with their husbands or ex-husbands*

Feelings of disempowerment were relevant for some of the women in this study. Having moved to a foreign country with different culture, language and rules placed many in a position of reliance on their husband, especially in their early stages of marriage. Feelings of dependency are connected to social and economic structures, but also to their conditioned residence permit. The findings indicate that their relationship with their husband or ex-husband is crucial for their experience of living in Norway and their mental health.

Transnational marriages present many challenges and is an important influencing factor for the women's mental health: *I get tired of adapting to a new culture. My husband is from another culture, he doesn't understand everything I do, and find it weird. But for me it's normal.* This following comment pictures what the women suggested was a typical scenario of the transnational relationship:

*Thai girl marries a Norwegian man and comes and lives together with the man. She doesn't have a job, since she got pregnant first and goes to school a bit after. Goes to Norwegian course, only a few hours. Doesn't speak Norwegian well, just listening to her husband, stay at home. If she has problems and wants to move out and divorce her husband, she cannot talk to social or NAV, doesn't understand.*

This comment shows how these women can potentially be dependent on their husband. In addition, the conditional residence permit may contribute to the dominating role of the husband. A foreigner who is married to a Norwegian, can obtain a residence permit for five years, conditioned by marriage (UDI). In this way, the husband may hold a great deal of power over her. She may not speak the language, may not have information about the Norwegian welfare system, and in some cases may feel trapped in an abusive relationship, in order to obtain permanent residency.

The majority of women in this study also expressed that they had expectations about their marriage and their life in Norway, which often were not met. Many had hoped for a better life in terms of a warm and caring husband, a good job and better economic conditions, and in this way provide security for their family left behind. The impression is that many of the women had pictured they would climb the socioeconomic ladder when they moved to Norway. For many it turns out not to be the case and some experience that their socioeconomic status is lower than back home, after comparing themselves to the Norwegian society. Their husband may not be in such a good economic situation as they thought, their education may not be recognized here, they may find it hard to gain employment, their husband may be older and they may not feel comfortable in his social network, and in addition, he may hold a great deal of power over her. Unmet expectations may affect the women's experience of living abroad in a transnational marriage, make them feel vulnerable and affect their mental health. Some described that their husband had found a new Thai woman and they were kicked out of the house, without a family in Norway, money or a place to stay. In these cases, the women found themselves in a vulnerable situation and being alone led to great difficulties:

*Many Thais live here, and they don't have any education. When they come to Norway, it becomes another reality for them. And culture between the wife and the husband, there are many who live together without getting to know each other first. They met, they got married,*

*came here and it became difficult. And not everyone is nice to them. They marry because of fashion, maybe. This house has a Thai wife. She treats him like a king. And then the man finds a new Thai woman and it makes big problems for them.*

This comment highlights how they may strive to be a good and agreeable wife to avoid being kicked out, and suggests how power imbalance can be presented in transnational marriages. The desire of obtaining permanent residency can “force” these women to stay in the relationship. In addition, minority women often lack the same network as Norwegian women, which put them in an even more vulnerable position if exposed to violence. Their financial situation is often poor, due to employment difficulties, so their possibilities of supporting themselves, and their families at home are limited (Smaadahl, Hernes, and Langberg 2002, 23).

A few of the women also felt that their husband was controlling - that he did not want her to go out and meet friends, increasing her social isolation and dependency on him:

*The first year everything was nice. So I could do everything for him. He could change me, like that. But after I lived with him for a while, I felt I couldn't contact my Thai friends... He said, it is fine, you can have friends, but he does the opposite, like in a way I feel he is controlling me.*

A very few of the women in this study mentioned things that could be related to marital violence, in terms of threats or psychological violence. None of the women mentioned experiences with exploitation in Norway, but some of them told about things that had happened to other Thai women. However, a very few women in this study said they had been visiting refugee shelters for domestic abuse. These findings illustrate the vulnerable situation some may be in.

Yet, the women in this study also demonstrate their strength and resourcefulness in dealing with difficult relationships. Some were active in fighting against power imbalances. A few had demanded divorce from their husband. Many of those who had problems in their transnational marriage drew on their Thai network to get support and help with practical issues, like legal services.

Even though some of the women felt dependent on their husband, it is important to highlight that this was not the case for everyone. Like mentioned earlier, we must be careful not to see the women as a homogeneous group, where for example, all the Asian women are assumed to be victims. Some of the women also talked very positively about their husbands and expressed that their husband helped them with learning the language and entering the work force: *I don't know why I can speak Norwegian, but at home I speak Norwegian with my husband. If there are difficult words, he explains me in English. So now I speak Norwegian and I have a job. And if people ask me something, I can answer better, so now I thrive.*

The findings indicate that some Thai immigrant women in Norway may be in a particularly vulnerable situation, because of power imbalances affecting them as women and immigrants. The majority of the women in this study came to Norway because they married a Norwegian man. A residence permit conditioned by marriage may lead to even larger power imbalances and contribute to the dominating role of the husband; since if she is not the obliging wife he expects, she could risk deportation. Feelings of vulnerability and dependency on their husband may have strong impacts on their mental health.

The vulnerable situation some Thai immigrant women may be in has also been recognized in other studies. Marie-Claire Belleau's (2003, 602) study of non-Western women married to American men in the USA, revealed that in many cases, the non-Western women experienced being under control of their Western husband. In some cases the need for control led to violence. And some felt socially isolated from the society. Factors that made some of the women stay in the relationship, despite being abused, were isolation, lack of language proficiency, lack of social support, poor economy, stigma attached to failed marriage, and the fear of being deported (Belleau 2003, 603). Empirical studies have also showed that the age difference between the Western husband and his wife often are between twenty to fifty years, which may lead to challenges (Belleau 2003, 602, Webster and Haandrikman 2014, 22).

### *Discrimination*

A few women in this study said they had experienced discrimination or harassment in Norway. Some had experienced discrimination related to their ethnicity when they applied for jobs: *When you send an application, they see your name, and just put it away. Because it*

*doesn't say "Kari" [popular Norwegian name]. Many tell me to maybe change my name, but then you lose your identity, you know. A few others had experienced harassment and unpleasant comments with assumptions of them being prostitutes:*

*Sometimes when I'm on the subway, [other minority men] come and touch my leg. They ask if they can go and drink coffee with me or if I can eat dinner at their place tonight. I answer: no, I have dinner at home. One said: Thai woman just bom, bom, only think about money. I find this unpleasant.*

These statements indicate that there exist discriminating reactions and attitudes towards Thai women in the Norwegian society. The first comment illustrates that some of the women experience that their ethnicity is a hindrance when applying for jobs. The second comment illustrates that there exist assumptions of them being sex workers, which they find unpleasant to deal with. These preconceptions maintain immigrant women in subordinate positions, which again restrict their freedom and their ability to obtain better standard of living. Discrimination is here suggested to affect their mental health by lowering their self-esteem and their social position.

International studies indicate that discrimination is a strong predictor for mental health problems. Discrimination shapes a person's view of the world and may hinder the person's influence over her/his own environment (Kessler, Mickelson, and Williams 1999, 224, DuBois et al. 2002, 1586). Studies in the United States have also found connections between discrimination and mental health problems among Asian Americans (Bhui et al. 2005, 449, Gee 2008, 651, Gee et al. 2007, 1992).

### *Social isolation*

Near half of the women in the study said that social isolation was a challenge for them in Norway and that they felt lonely. They emphasized that the society in Norway is different from the society in Thailand. In Thailand they had a full family, but in Norway they only have themselves: *When I lived in Thailand my network was big, here my network is much smaller. Many in Norway doesn't have their extended family. If you have problems, if you get problems, who do you go to? Who can I talk to?* Some of the women did not have many close friends either, and found it hard to find new friends, because everyone else lived a busy life

and had other things to do. A few of the women expressed that their Thai friends were not real friends and that gossip in the Thai community was a problem: *No, I don't have friends. I have Thai, but they are not real friends. We can talk, but cannot trust and share problems.* Some also struggled to fit in with their husband's friends. The age difference was often a contributing factor that made it challenging to become close friends with the wives of her husband's friends:

*The Norwegians I know, they're older than fifty years. And they have responsibilities as a grandmother and things like that. My husband is fifty years now and have friends who are fifty and older. And we are not getting close friends when they look at me as a child. I don't know what to talk about and stuff like that.*

It is also important to mention that a few of the women in this study said they had a large social network in Norway. They emphasized that they had worked many places and got friends through work. A small minority expressed that they felt it was like home, because they had both a temple and friends: *I like Norway 100 percent. I have a temple here, have friends, have a lot a people who come and talk and eat together, just like in Thailand.*

However, the broad impression is that many Thai women experience social isolation while living in Norway. Many lack close friends, as well as an extended family, to turn to in case of difficulties. Some are married to older men and their husband's social network does not necessarily fit their demeanor, because of the age difference. In addition, some feel that their Thai friends are not real friends, since gossip is a problem. This study suggest that social isolation affects Thai women living in Norway's mental health. Many struggle with separation from their large social network in Thailand, and in addition have a very small social network in Norway. It is known that social isolation or lack of social support is associated with worse mental health, and can potentially affect a person's well-being and lead to mental health problems (Pedersen, Andersen, and Curtis 2012, 42 and 43, Mushtaq et al. 2014, 3). Previous international studies have indicated that social isolation and low social trust are strongly related to poor mental health amongst Thai immigrant women (Fernbrant et al. 2014, Srirangson et al. 2013, 163).

It is also known that many Asian countries are portrayed as a family- and group oriented societies. Family, friends and ethnic community play a great role. If a crisis occurs, they can usually count on support from their extended family and social network. Moving from a socio-centric society to an egocentric society, like many Western countries, may lead to distress. Additionally, many tend to have little social support from their new family. Previous studies show that Thais often try to establish social networks within Thai communities in their new country, by visiting the Buddhist temple and shops and restaurants operated by Thais. Many find interactions with other Thais supportive, but some experience gossip in the Thai network, which may make them feel insecure in this network as well (Kramer et al. 2002, 231, Lauber and Rössler 2007, 159,168, Jirowong and Manderson 2001, 178).

#### *Acculturation challenges in Norway*

Many of the women in this study used the term “everything is new” when describing the acculturative challenges in Norway. Everyone mentioned at least one, and some described several challenges. The most common challenge was language, followed by work, economy and culture. Other challenges mentioned were the climate, the Norwegian food and their children growing up in Norway. All in all they experienced a lot of challenges in Norway: *It is not easy to learn new language, new work, new school, new everything you know, it is not easy.*

A few women described a feeling of being culturally hybrid (in-between). They were struggling with holding on to their ethnicity, while at the same time meet the expectations of the Norwegian society and their husband’s culture. Many found this very challenging in the beginning, but adapted though time. Some said they were able to adjust; not quite Norwegian, but a bit half and half. This illustrates how acculturation can affect mental health.

Acculturation challenges can be described as cultural and psychological changes, which arise when cultures meet (Helse- og omsorgsdepartementet 2013, 20). Integration is therefore also about finding the right balance of values and behaviors one takes from each culture. The findings also shows that transnational relationships can be challenging in itself and an influencing factor for a person’s mental health, as mentioned in the section about their relationships with their husbands or ex-husbands.



The acculturation challenges Thai immigrant women experience, may affect their well-being and self-confidence. Moving to a new country creates psychological challenges and several factors affect the women's ability to adapt in the new environment. These factors can be related language barriers and employment, which requires efforts and adjustments. In the following paragraphs, I will outline what the women said about language and employment as acculturative challenges affecting their mental health.

### Language

The majority of the women mentioned language as a huge barrier in Norway. The reading of the transcribed interviews also revealed large variations in the language proficiency. The women experienced that their lack of language proficiency gave them low self-esteem and made them hesitant to start a conversation. They said they did not know how to ask or answer: *I do not speak Norwegian, not well. Do not have Thai friends. I'm becoming better in Norwegian, but not perfect, very difficult for me. Very difficult to find work.* The women emphasized that language was the key to participating in society. Language also played an important role in their marital relationship; the women with low language proficiency felt disempowered and dependent on their husband. Some also experienced that their husband did not give them support in learning the language:

*Language is everywhere, it is locked if you do not know language, and your [door] is locked. If you know language you open the key there, you see what's inside, you see better, you understand much more possibilities. But my husband stopped me.*

The findings indicate that language is a huge challenge for Thai immigrant women in Norway and affects their mental health in terms of low self-esteem in social settings and disempowerment in their relationships. In addition, some women experience that their husband does not support them in learning the language. It must be noted that this is not the case for everyone, as others had good help from their husband in learning the language.

Previous studies have also indicated that language proficiency is a crucial determinant for the immigrants' economic and the social integration in their new country. It affects their financial integration by occupational choice, employment status and wage, and may act as a signal of strangeness, enabling discrimination. The degree of dissimilarity of the mother tongue of

immigrants affects the learning process of the language (Isphording and Otten 2014, 31). Thai is much different from Norwegian, and it may therefore cost a lot of effort from them to learn Norwegian.

### Employment

Over half of the women in this study also mentioned employment as a big challenge in Norway. Many of the women told that they had a professional work position when they lived in Thailand, but their qualifications were not recognized in Norway. The impression is that some were in a worse financial situation in Norway than in Thailand and that they struggled to find a job they are qualified for: *My education is not recognized here and I cannot work as a nurse.* The interviews also revealed that this struggle affects their feeling of self-worth and their mental health. Most of the women in this study were working and earning money, but many had part time jobs and did not get as much work as they wanted to. To make ends meet, many of the women had multiple jobs. Half of the women said they were working with cleaning as a main job or as an additional job. The others were working as a health assistant, language teacher, kindergarten assistant, office worker and a few held a professional position. The latter half was typically the ones who had a professional occupation in Thailand. Some were overqualified for their work here in Norway, but seemed resigned to it; rationalizing that they still earned a lot better here in Norway than in Thailand, and therefore better able to support their families back home:

*I used to work [in Thailand], so I try to find a job and then got a job as cleaning lady, I think a bit like – oh my God. I was the head of the department I worked for in Thailand and earned very well, and here it is like all the way down. But then I think: this I can handle. Because here you earn more than there, even though it is just a cleaning job. Here you get paid for an hour what you earn in one day in Thailand.*

Many of the women were faced with continual short term contracts with a varying number of hours. This made their income unpredictable. This was especially prominent amongst the women who worked as a language teacher: *I work as a mother-tongue teacher. The percentages are unstable. Before it was 100 percent for one year, then 80, 51 and 47 percent.* In addition to difficulties with finding a suitable, permanent and predictable job, a few of the women expressed that they lacked support from their husband to develop their skills, which

also can be reflected of the power imbalances in the relationship: *[My husband] did not support me in going to school, it costs money. I said I would like to go to school and learn more, and he said: no, you have gone to school for many years in your country.*

The findings in this study show that many Thai immigrant women in Norway find it challenging to find employment and many are overqualified in their current job. Their qualifications may not be recognized here and may require further education to customize their education to the Norwegian educational system. Taking time out for further study implies a loss of earnings which, given their responsibilities family back home is not an option. This shows how structural barriers in the Norwegian society possibly maintain immigration women in subordinate positions. Not getting support for further education may hinder the women from climbing the socioeconomic ladder. The experience of not getting their qualifications recognized may lower their self-esteem, lead to disempowerment, hopelessness and feelings of worthlessness, and hence affect their mental health. The findings also revealed some kind of resignation from some of the women, by almost accepting that they are not good enough and have lower status than others. The impression is that some almost accept that they have jobs they are overqualified for - because they are immigrant women. Many of the informants also said they faced difficulties to obtain permanent jobs with fixed hours. The findings suggest that unpredictable jobs and financial instability leads to worries for the women. The consequences may be coupled with childcare responsibilities in the role as a mother, which may make unpredictable workdays even more complicated. A few women also expressed that they lacked support from their husband to further educate themselves so their qualification from Thailand can be recognized in Norway. This might suggest that the husband uses his control to hinder her from having the employment she wants, and may be another instance of power imbalances, as the husband in this way maintains his wife in a dependent position. Low-paid and unpredictable jobs keep the woman in a vulnerable situation. The findings indicate that many of the women have high expectations of their financial situation in Norway; that they will climb the socioeconomic ladder. But this is not the case for everyone and some experience a lower socioeconomic status here than in Thailand.

The findings in this study are supported by international studies of Thai immigrant women. A study in Australia indicated that lack of language proficiency, lack of recognition of their Thai

qualifications together with scarce work experiences were all barriers for the women to gain employment and slowed down the process of settlement. For some, these factors led to anxiety, frustration and disappointment (Jirowong and Manderson 2001, 176-177). A study in Canada shows that most Thai immigrants work in low-paid sectors, such as restaurants and cleaning. In many cases, their job is only temporary and provides low income. To compensate for this, many Thai immigrants hold multiple jobs (Srirangson et al. 2013, 157-158). The same study indicated that having multiple jobs were strongly associated with increased risk of mental health problems (Srirangson et al. 2013, 163). The Norwegian Ministry of Health and Care services emphasize that immigrants are overrepresented in low-paid jobs and have a higher degree of unemployment than the rest of the population, and that this might have a negative effect on the immigrants' mental health (Helse- og omsorgsdepartementet 2013, 11).

#### *Factors leading to less stress*

It is important to emphasize that the women in this study also mentioned several factors that lead to less stress for them while living in Norway. The most frequent mentioned factors were the feeling of peacefulness, the welfare system, economy and the nice people: *I like the nature and that it is quiet. Not so much traffic and not so much noise. Yes, there is nice people here as well.* Many of the women mentioned that they felt peaceful in Norway: *I like it here. I like that it is quiet. Not so many people.* Some also mentioned that the social welfare system is a good thing about Norway. They feel that the welfare system takes care of people, especially the weak, and they feel safe here: *Yes, I like Norway, because the system here takes care of people. I feel safe here. And the Norwegians are great people.* Other positive aspects were the opportunities to take vacations, and the social service schemes that help them to find employment: *Pros about living in Norway, yes, we have five weeks' vacation. In Thailand you can only take ten days. Here you have NAV (social service schemes) to help you find a job, and studying is for free.*

These findings indicate that Thai immigrant women in Norway also experience factors that lead to less stress. Even though some of the women in this study experienced social isolation and lack of social network, they also appreciated that the Norwegian society is smaller and that it is more quiet, compared with instability and constant striving at home. An important aspect is also the Norwegian welfare system, which makes some of the women feel safer. This study suggests that these factors have a positive effect on the Thai immigrant women's mental

health. The safety aspect and the ability to provide for family may outweigh some of the negative aspects they otherwise experience. The findings are supported by a Swedish study of Thai immigrant women, where the women referred to well-being in ways such as “having harmony in life” and all the women said they felt peaceful in their new country. They also experienced that the welfare system functioned well (Lundberg 1999, 33).

I have now highlighted which factors the participants saw as most influential for their mental health while living in Norway, answering the first research question in this study. These factors concerned their family left behind and their financial responsibilities for them, their relationship with their husbands or ex-husbands, discrimination, social isolation, as well as acculturative challenges in Norway and factors leading to less stress.

WHO (2014b, 9) indicates that there are several factors influencing people’s mental health, both social and economic factors and their physical environments. The social factors include the surroundings in which people live and work, as well as the health systems they can access (Allen et al. 2014, 392). Social arrangements and institutions like education, social care and work have a considerable impact on people’s well-being at different stages in life. Many risk factors for mental health problems are associated with social inequalities, where large inequalities give higher risk for the disadvantaged (WHO 2014b, 9). Studies have shown that poor and disadvantaged people are those who suffer most often from mental health problems and women tend to have more mental health problems than men (Allen et al. 2014, 393). I will continue this investigation by stressing how the women in this study felt about consulting their GP, if they were struggling with mental health problems.

### **10.3. RQ 2: How do Thai women perceive consulting with their GP and how might this affect their willingness to seek help for mental health problems?**

The second research question I will answer is “*How do Thai women perceive consulting with their GP and how might this affect their willingness to seek help for mental health problems?*” Related to this question I will outline how the women feel about the help they receive from their GP and how they feel about consulting their GP for mental health problems.

The majority of the women lacked information about the health services, as it was not available in Thai. This acted as barrier for some to seek help, as they did not know how. When they did seek health care, many of the women in this study experienced that their expectations of the GP were not met. The informants highlighted that their GP was unapproachable and did not take them seriously. Many expected their GP to be an expert. Some had experienced discrimination and felt the GP was too direct in his style of communication. The broad impression is that when they finally seek help, they do not get the help they expect. These unmet expectations seem to act as barriers for consultations with their GP. The women also indicated that long waiting time and availability of appointments, communication problems and cultural differences in labeling diseases acted as barriers for and during consultations.

#### *Health information*

All of the women in this study had visited their GP the last year, but very few for mental health reasons and they were unsure whether the doctor could help them with mental health problems. The informants emphasized that there should be information in Thai about how to navigate through the health care services in Norway. They expressed that some information about how the health system is crucial to know about when you are new in the country, even before you learn the language:

*For instance information in Thai, maybe. In a brochure.. And knowledge about the Norwegian society in your mother tongue. Because here, it is important the first years, I mean. For those who come and get to know the system and what you can do and not do and what the support system is like, so they can live here, easier for them to live in a new country. But now it is not like this anymore, they will cut it, so it is going to be in Norwegian.*

The women stressed that difficulties with finding information about the Norwegian health services in Thai, made the health services less accessible. Some knew Thais that have not used the health care services at all, because they did not know how:

*I know someone who has lived here in 7-8 year, but never contacted. And when I asked “do you know how you do it?” –No. “Do you know that you only can send a message to make an appointment?” –No. Maybe one can make information in Thai.*

These findings tell us that many Thai immigrant women find it hard to navigate through the health services in Norway. This indicates that when you move to a new country, some information about the society and the health services should be available in your mother tongue, to make the integration smoother and access to the appropriate health care easier. Immigrants arriving Norway for family reunification are entitled to participate in 600 hours of Norwegian courses and 50 hours of social studies courses, also containing information regarding the health services. The social studies have been in a language they can understand (VOX 2012). However, from the 1<sup>st</sup> of July 2016, the social studies will be in Norwegian (Justis - og beredsdepartementet 2016). This means that immigrants will not learn about the Norwegian society before they have learned Norwegian, which might be in the last term. For some, fulfilling these hours may take years and this does not guarantee that they will be proficient enough in Norwegian to understand the complex information about their rights and responsibilities. This is an important structural barrier, which may prevent immigrants from seeking health care.

Understanding of the health care services as a barrier to access health care confirms previous international studies. Li and Browne (2000, 153) suggest that “not knowing how” is a central barrier for Asian Canadians to access mental health services, and that there should exist better information of how to access. In the same study, the informants reported that they would have sought mental health care if they got more information about how to access. Scheppers et al (2006, 341) have highlighted that lack of understanding of the availability of health services can hinder immigrants from seeking health care.

### *Unapproachable doctor*

Half of the women in this study felt that their GP was unapproachable and did not take them seriously. The women saw this as a barrier to seek health care, particularly for mental health problems. They found it hard to be open with their doctor when he/she were in a hurry or did not take them seriously. Some had experienced that their GP did not ask them how they were doing, just gave them a note for sick leave:

*The GP saw that I was very sick, but she didn't ask me, just gave me sick leave and good bye and like that. Didn't ask me how I was, even though I didn't look well, right. She should, maybe she understood right away that I had a cold. But I didn't come to get sick leave. I think maybe medicine to make me a bit better and like that. So I had to ask if I could get medicine, that I didn't feel well.*

Others felt that the GP did not take them seriously, which was in huge contrast to the treatment they were used to in Thailand: *I always got the answer "you must not worry, this is common, ordinary. It goes away by itself.* Many of the women also described their GP as unfriendly and too straight forward, and they felt that they did not had the time to express themselves, since the GP were in such a hurry:

*It is the voice she uses, or the type of sentence we don't tend to use: "what can I do for you?". It is too direct. She should rather talk with her patient in a way that the patient tell and gives you information. If you visit the doctor, you would like to have a little time to talk. But the doctor only has a little bit of time.*

The time aspect was highlighted as a barrier, both when it came to making an appointment and during the consultations: *The GP was so stressed with time. It is silly. Even though you have an appointment, you cannot talk to them for long. They almost try to get rid of you. You have a lot of questions, but no. In a hurry.*

Even though many of the women expressed that their GP was unapproachable, a few others had counter experiences. The positive experiences were about the doctor being kind, good, caring and not stressed: *He is nice. He is a very kind man. He is a good doctor.* However, the broad impression was that their GP did not take them seriously.

In addition to lack of information about how to navigate through the health care services; when they do seek help, many feel that their GP is unapproachable. The experience of their GP being in hurry and the feeling that he/she lacks sensitivity and interests in them is suggested as a huge barrier for consultations with the GP. Further, this study suggest that these experiences acts as barriers particularly for consultations for mental health problems as



these consultations often depends on a setting where it is safe to talk. If you feel that the GP does not have time to talk you or is not interested in you, you may choose to avoid talking to your GP about mental health problems. Previous studies have stressed that impersonal patient approach can prevent the establishment of trust between the patient and the provider. A direct style of communication from by provider can cause discomfort for the immigrant patient (Scheppers et al. 2006, 343)

The indications in this study confirms the findings in a study of Thai immigrant women in Australia, where the women felt that the health care providers were unfriendly and direct, and acted as barriers to seek health care (Jirowong and Manderson 2001, 180). Another international study has indicated that some immigrant groups expect a formal, yet friendly approach from health care professionals, and that she/he should exude understanding and recognition. The length of the consultation and the treatment can act as barriers for immigrants to seek health care. Some experience that the consultations are too short and feel that they are not taken seriously. This may weaken the trust between the patient and the provider (Scheppers et al. 2006, 343-344).

#### *Expectations of the doctor as an expert*

Some of the women in this study were not satisfied with the treatment given by their GP, for different reasons that were mostly connected to expectations of the doctor as an expert. These different expectations of the doctor also caused dissatisfaction. Some did not trust their GP, and rather visited the emergency room: *I have bad stomach, I eat bad food, I have stomach infection. I didn't get anything for it. I go to the emergency room, they help fast. The GP doesn't know, only check "in the book.* Others expected that their GP knew everything and would tell them why they had pain and what they should do. Some were surprised when their GP did not meet their expectations: *I expected that the pain should be gone, but I still have pain. My doctors told me he didn't know why I still had pain. I don't expect such an answer from a doctor.*

These findings suggest that Thai immigrant women in Norway have unmet expectations of their GP. The impression is that they are used to getting fast treatment and precise answers in Thailand, but here the GP are not always able to find out what is wrong with them and they are more reluctant to give them medication. This illustrates different health care approaches in

Thailand and Norway; the traditional approach and the shared decision-making approach. With a shared decision-making approach, the health care providers acknowledge and take into account the patient's perceptions (Ruland 2005, 70). The different approaches may act as a barrier for consultations, as the women feel that their GP in Norway does not tell them what to do. This may affect their willingness to seek help from their GP and talk to her/him about mental health problems. The shared decision-making approach may also cause challenges in the intercultural relation between the GP and an immigrant patient. The GP has to acknowledge the patient's cultural values and ideas, and have this in mind when deciding on appropriate treatment, and the patient must be responsive to the help offered (Suurmond and Seeleman 2006, 258). Regardless, the findings highlight the importance of having available information in Thai, not just about how to navigate through the health care system in Norway, but also about what you can expect when you visit your GP.

#### *Cultural differences in labeling diseases*

Many of the women in this study expressed that different health beliefs led to negative GP experiences. Some of the women had experienced that cultural differences in labelling diseases acted as a barrier during consultations. These barriers were connected to the understanding of diseases; many of the diseases they were familiar with from Thailand were not known in Norway. The women had experienced that their GP had not heard about common diseases in Thailand and did not understand them: *And I think, no I don't want to go to the doctor, she doesn't understand anyway. It is not necessary and just like that. Maybe if she understands Asian type of diseases. Then we can talk about it, right.* The broad impression is that the informants believed that the Norwegian doctors were not able to understand their diseases, and that it would be much better if a Thai doctor came to Norway:

*I think that if you are Norwegian, she is also Norwegian. Maybe they understand better the diseases or what she is telling... There are many diseases in Thailand, in Asia, that they have never heard about and which they don't know. They cannot. It is much better with a Thai doctor. He's Thai himself, he's from Asia himself. When I say that there are many, many diseases which have happened to us, and we tell the doctor, and they don't know. They don't understand.*

These findings indicate that many Thai immigrant women fear that their GP will not understand their problems, which make them less likely to visit their GP. Many of the informants in this study felt that their GP lacked cultural competence and that there was no point in visiting their GP if he/she did not understand “Asian diseases”.

Many barriers for GP consultations are “universal”, which means that they can apply to everyone. Long waiting time is an example of that. Other barriers, like cultural differences, affect only a few (Scheppers et al. 2006, 346). Cultural differences in labelling diseases can be a huge barrier for immigrants to seek health care. The differences are related to different beliefs and different ways of explaining health, illness and treatment methods (Scheppers et al. 2006, 340). The GP may have other cultural perceptions about symptoms than the patient, which make it difficult for the patient to get appropriate health care (Scheppers et al. 2006, 339). For instance, Asian immigrants often have a holistic view of health (the idea that natural systems should be viewed as wholes) and it may not be natural for them to separate mental and physical health (Bäärnhielm and Ekblad 2000, 447-448, Leong and Lau 2001, 208).

The findings in this study highlight the importance of curiosity and cultural sensitivity in medical consultations with Thai immigrant women. In this way the shared decision-making approach may strengthen the health care given and the patient’s engagement in it. This may be particularly important in mental health care, since many Thais hold a holistic view of health, and sees body, mind and soul as one unity, instead of focusing on mental health separately. The typical Western medicine does not seem to include the concept of holism in psychological and sociocultural aspects (Disayavanish and Disayavanish 1998, 334-335, Leong and Lau 2001, 208). This might inhibit some from seeking help from their GP in Norway.

#### *Long waiting time and costs of consultations*

The majority of the women expressed that the waiting time was very long when they sought help from their GP. They found it frustrating to be told that they could come and visit the next week when they called to make an appointment. The broad impression is that the women are used to get the help they want right away in Thailand. The long waiting time in Norway frustrates them and acts as a barrier to seek help from their GP:

*When I'm very ill and call to make an appointment at the doctor's house: "yeah, you can come next Monday, you can come Tuesday". It's difficult, you see. Not as in Thailand. In Thailand, when you get ill, you just go. Not call, you have many, many clinic doctor's, you can go all the time.*

Many of the women also expressed that not only the time to make an appointment were shorter in Thailand, but also the time to get answers and the time to get well were shorter:

*Doctor here you have to wait in line and use time or something, but in Thailand you can just finish right away, in a day or something. You take picture and check everything, everything, everything finish in one day. You know what kind of ill you are, what you have problem with, in one day. But here it may take three months, four months to wait for the answer.*

In addition, many of the women have temporary part-time jobs and find it difficult to take time off from work to consult their GP. Unavailability of appointments and limited clinic hours reinforce this pattern. These barriers can be traced back to their difficulties with finding a predictable job, often a long with childcare responsibilities. Other studies have also highlighted these barriers. According to Scheppers et al (2006, 344), long waiting times and the process of making an appointment can act as barriers for immigrants in seeking primary health care services.

A few of the women were also concerned with the patient fee when visiting their GP. They experienced that the fee was a large proportion of their finances: *Like; look, everything is free, but when you visit the doctor, you have to pay. Like loose change, but is a lot also. And buying medicine, not expensive, but if you need it often, it also costs money.* This shows that even though the Norwegian welfare system are publicly funded and available to all citizens and residents, the patient fee for regular medical consultations is a substantial expense for some, and may act as a barrier to seek health care. Many Thai immigrant women have financial responsibilities for their family left behind, and a fee of approximately 200-300 NOK reduce the proportion of money they can send home.

Long waiting time and costs of consultations seems to be sources of frustration for many of these women. The impression is that the women are used to a different health care system,

where they get help right away. The patient fee seems to hinder some from consulting their GP, especially those with a poor financial situation. As we know, the link between poor economy and poor mental health is unquestionable (Burns 2015, 107). The patient fee may have considerable impact on help seeking for mental health problems among Thai immigrant women, because many are in low socioeconomic positions, along with their role as breadwinners.

Nevertheless, some of the women had counter experiences related to the Norwegian health care system, and were positive to have one doctor to relate to. They emphasized that the GP follows up on you and knows about your problem:

*One thing that is good is that the GP is teaching you. Follows up on you all the time and know about your problem. When I go there in Thailand, and next time I go there, and next time down there. I have to tell everything once again, and they don't know you well. That is an advantage here.*

This study suggests that some structural barriers, like long waiting time and costs of consultations, have a negative effect on Thai immigrant women's willingness to consult their GP. These factors also affect their willingness to seek help for mental health problems, as they have to wait to get an appointment and count the buttons if they can afford to pay the patient fee. This may lead them to cope with their health problems by themselves or seek help elsewhere.

#### *Communication difficulties*

Near half of the women expressed that they had communication problems with their GP, both language difficulties and communication in a broader sense, like the style of the consultation. Some of the women highlighted that language was a huge barrier both when it came to making an appointment and during the consultations: *Many Thai women have never been visiting their doctor before. They say: I cannot speak the language, how can I tell the doctor?, and stuff like that.* Others had experienced that their GP were not interested in them and did not talk as much as they expected, and this was a huge barrier for them to express themselves during the consultations: *The GP doesn't asks so much, doesn't talks so much. Talk short and then finish. I want more some enlightenment.* A few also emphasized that in some cases, the

GP had been unfriendly and discriminating: *I have changed GP twice. I have experienced a little racism, that I'm from abroad and that some doesn't feel like.., it is a little rude the way they talk to me. So I try to find a GP who is nicer and wants to listen why I'm there.* This experience is not in line with the Norwegian Ministry of Health and Service's "National Strategy on immigrants' health 2013-2017", which emphasizes equitable health services (Helse- og omsorgsdepartementet 2013, 4). GPs are in a position of trust and power are supposed to help patients regardless of their background. This affects both the access and the help one gets.

These findings indicate that communication is a central aspect of how Thai immigrant women feel about consulting their GP for mental health problems. Low language proficiency is suggested as a barrier to consult their GP, because it is difficult to explain how you feel if you do not know the language. The consultation with the GP is an interactive meeting which relies on good communication, and consultations for mental health problems may be particularly difficult. The conversation is central in consultations for mental health problems and some may choose to withhold information and explanations when they do not understand. This study also shows that many of those who know the language, express that they find the GP uninterested and unfriendly in his style of communication. This may lead to insecurity and unwillingness to share their problems with their GP, which again can affect their mental health and how they deal with mental health problems.

These indications have also been found in a study of Thai immigrant women in Australia, where the women mentioned language as a barrier for getting sufficient health care (Jirowong and Manderson 2001, 180). The women may feel unable to express their inner feelings and needs and are likely to withhold information to their GP when they do not understand. In addition, some immigrants struggle with communicate their health problems, even though they know the language (Helse- og omsorgsdepartementet 2013, 28). Related to Thai immigrant women, this may be because of common traditional Asian ways of communication, like "respect for authority, being indirect and avoiding conflict", are sometimes misinterpreted in the new culture (Kramer et al. 2002, 230).

Use of an interpreter may help the conversation with the GP for those who have low language proficiency. Half of the women in this study said they had been using an interpreter during

consultations with their GP. The rest said they had spoken English, used a dictionary or spoke well enough Norwegian to understand: *It went well, because I was pretty good in English. So they could understand what I was trying to say.* Some of the women who had not used an interpreter expressed some concern with using an interpreter. They were concerned about the quality of the interpretation, that the interpreter would misunderstand and interpret wrong and that the GP got a wrong impression: *If you cannot [speak the] language. Interpreter, maybe she interprets wrong. She doesn't understand what you mean at all. Interpret what she understands; also the doctor understands other things.* This highlights the complexity of using an interpreter, and that it is crucial that the interpreter is professional and objective. The women, who had been using an interpreter, said they had to use an interpreter to understand what the doctor said and found it very helpful:

*If the doctor talks and asks, I understand that, I don't understand. I must have an interpreter; I have used many, if... I want doctor send a letter to me and ask me a lot. I must use an interpreter, because I cannot understand everything he says. If he says something, if I have an interpreter, I understand. It is better for me.*

Some of those who said they had been using an interpreter explained that they had used family members as interpreters. The others said they were using an authorized interpreter. Some of the women who said they had been using their husband as an interpreter expressed that this was a barrier for them to express themselves. There were things they did not tell their doctor in the presence of their husband: *The first year my husband came with me. But of course I don't get to say what I should, right. When you don't know the language.* Using the husband as an interpreter also potentially contributes to disempowerment of the women and dependency on their husband. Such power imbalances in the relationship may contribute to low self-esteem and mental health problems. In addition; the husband presumably does not know Thai, so how can he interpret? This highlights the importance of using an authorized interpreter.

It is known that use of an interpreter is one way to assist the communication process with the GP. Studies show that an interpreter can support communication difficulties, help a patient in understanding the treatment options and thus improve care (Karliner et al. 2007, 748). However, the health care given depends on the quality of the interpretation. Poor quality can

address negative consequences for people with mental health problems (Flores 2005, 294-295). Communication difficulties can lead to confusions and affect the diagnosis and the treatment given. It can also be unpleasant for the patient if the interpreter belongs to the same social network (Helse- og omsorgsdepartementet 2013, 30). The findings in my study indicate that the interpreter should be authorized to ensure an objective and professional interpretation. “The National Strategy on immigrants' health 2013-2017” emphasises that the integrity of the patient can be improved by using “telephone- and screen interpretation”. The strategy also highlights that training in use of interpreter should be strengthened among health professionals in Norway (Helse- og omsorgsdepartementet 2013, 30-31).

### *Specialist care obstacles*

Some of the women in this study had experienced that even though they consulted their GP with their mental health problems, it was difficult to get appropriate treatment. A few of the women found it difficult to get psychological specialist care in Norway. Even though their GP referred them to psychological specialist care, they were told that they did not need it:

*I need to talk to someone, I think. I'm getting stressed at work, cannot concentrate and worries a lot. My doctor wrote a letter to DPS (district psychiatric centres), but I got the answer right away that I don't need it, so she is trying to send a letter to the psychological service, but I haven't got the answer. But she gives me sleeping pill, because I need it.*

These findings indicate that Thai immigrant women might not only experience difficulties in reaching for help; even when they do, they risk being refused. If it is the case that Thai immigrant women do not get psychological specialist care when they reach for it, we can question the equity in the health care system. Possible reasons may be that their mental health problems are not serious enough, that the specialist care has to prioritize patients or do not have enough capacity. We can only speculate that there exists discrimination of patient groups in the specialist health care services. More research is needed to answer this. Not getting sufficient help when reaching for it, may have serious consequences for one's mental health.

Previous studies from Norway and the UK have identified that immigrants are less likely to visit primary health care services if they struggle with mental health problems, and are less seen in specialist care (Berg 2009, 217, Straiton, Reneflot, and Diaz 2014, 5, Bhui et al. 2003,



112). A recent study in Norway showed that conversational therapy as treatment of mental problems was less common among Thais, compared to Norwegians (Straiton et al. 2015, 12-13). This study suggests that communication difficulties and cultural differences may act as obstacles to conversational therapy.

As we can see, the women in this study described many aspects of the help they receive from their GP. First of all, many lacked information about how to navigate through the health services, and emphasized that it would be beneficial to have some information in Thai. When they did seek health care, some experienced that their GP was unapproachable, their expectations of the doctor as an expert were not met, long waiting time, high costs of consultations, communication difficulties, cultural differences in labelling diseases and/or specialist care obstacles. These aspects may act as barriers for consulting their GP and is likely to affect their willingness to seek help for mental health problems. The same aspects have been found in previous studies, which have suggested language difficulties, lack of understanding of the health system, costs of health care and availability of appointments as barriers preventing immigrant women from seeking health care (Li and Browne 2000, 145-146, O'Mahony and Donnelly 2007, 1177, Scheppers et al. 2006, 329). In Australia, researchers have highlighted language and cultural barriers as factors preventing Thai women from seeking support from non-Thais. Low language proficiency was found to be a barrier for expressing emotions and to use mental health service (Jirowong and Manderson 2001, 179-180).

Over half of the women in this study said they had consulted their GP or were positive to consult their GP for mental health problems if they needed to. Even though many of the women were positive, there was a tendency that the women saw their GP as the last resort, and that they would try other coping strategies first, like this woman puts it:

*I don't know if I would visit my GP if I had emotional distress, I'm not sure. I haven't thought of it. Maybe 50/50. Sometimes if you need help, you just have to talk about it and get some help. But you have to try first if you need it.*

The women who were negative to visit their GP for mental health problems said that they were strong enough to handle their problems themselves: *I would not talk to the doctor if I were sad or had sleeping problems. I am not scared, I am not young, I am not scared.*

The previous mentioned GP- experiences all affects their willingness to consult their GP for mental health problems. But also their view of mental health, stigma attached to mental health problems, the extent of the problem, and available alternative ways of coping were important factors. Many were both positive and negative to consult their GP for mental health problems. I will look further into the women's view of mental health and alternative ways of coping in relation to the third research question.

#### **10.4. RQ 3: Which other factors influence Thai women's willingness to seek help for mental health problems?**

In the first two research questions I have stressed which factors influence Thai women living in Norway's mental health, how they perceive consulting with their GP and how this affect their willingness to seek help for mental health problems. In third and last research question I will call the attention to: *"Which other factors influence Thai women's willingness to seek help for mental health problems?"*. I will outline how the women view mental health and mental health problems, as well as other coping strategies they might use.

##### *Views on mental health and mental health problems*

Nearly all the women in this study were unfamiliar with the terms "mental health" and "depression", but after the interviewer explained the terms, many of the women described what mental health and mental health problems meant to them. They mentioned several reasons why you can become depressed, like for instance because of your genes or because of money problems: *There are many reasons why you can get depressed. Maybe it is because of economy or your genes you get sad. Chemical substance in your head that puts you in imbalance. But I think the main cause is money.* Others mentioned longing for your family in Thailand, overthinking and problems at work, as reasons for mental health problems: *I think you get depressed because you think of your family. In Thailand and here. Then work and money. Thinking so much. Only think, think, think, think.* Many were not familiar with expression like anxiety and depression before they moved to Norway, and said they did not use these terms in Thailand: *Actually, I didn't think of the word before I had lived here for a*

*while. I'm not used to these words; anxiety and depression.* Some also indicated that mental health problems were a bigger problem in Norway than in Thailand, because the society in Norway was much smaller and you had fewer people to socialize with:

*Depression is a big problem in Norway, I think. In Thailand there is a lot of people, a lot of places, sunshine and you can be happy and eat with people. The culture and the society there are totally different. But here you don't know people and you don't know the language. You don't have a job or you have little work there. Everything is smaller. Less to do and fewer people to meet.*

These findings tell us that many of the women were unfamiliar with the concept of mental health before they came to Norway, but adapted to the concept after they had been living in Norway for a while. This may be grounded in different health views. In Asian cultures, religious, spiritual and supernatural aspects are natural sources of health care, while the Western world is typically more concerned with psychosocial and biomedical explanations and treatments (Weerasinghe and Mitchell 2007, 310). In the Thai culture, the concept of holism is central, a health view which includes spirituality and do not separate mental and physical health, but views them as wholes (Lundberg and Kerdonfag 2010, 1121-1122, Weerasinghe and Mitchell 2007, 310). In contrast to this holistic perspective of health we have the biomedical perspective, which have been significant in the Western medicine for decades. The biomedical model indicates that mental health problems are “biologically-based brain diseases”, which need “biologically treatment” (Deacon 2013, 847). Most Western physicians are trained in the biomedical model. Another model has also been in force the last decades, and that is the biopsychosocial model, which is an extension of the biomedical model. The biopsychosocial model also considers the emotional and social aspect of illness and disease (Klimenko et al. 2006, 258, Henningsen 2015, 362). The biopsychosocial model is closer to the holistic model, but the biomedical model holds a great deal of impact on the Western medicine. In many non-Western societies is physical and mental health integrated, so talking about these health problems separately is not common (Lauber and Rössler 2007, 159, Kramer et al. 2002, 228). The contrast between the holistic and the biomedical approach may explain why many of the informants found it difficult to frame their problems to their GP, and were not familiar with the mental aspect of health. This study suggests that Thai women's view of health does not necessarily harmonize with the mental health care system in Norway.

The health services in Thailand seem to exist of both “modern” and “traditional” treatment (Burnard, Naiyapatana, and Lloyd 2006, 744-748). In the same way, many immigrant patients operate with parallel sets of beliefs and health practices, sometimes Western health practices and other times non-Western practices (Scheppers et al. 2006, 343). This may explain why the women in this study described many reasons for mental health problems, but did not consider these problems in relation to their cultural belief patterns. Their perception of mental health problems seems to be something they have adapted while living in Norway. The findings concerning different and parallel sets of health beliefs, emphasizes the importance of cultural competence in health care. It also indicates that non-Western immigrants might be responsive to both the Western and the non-Western practices.

### *Stigma*

Nearly half of the women expressed that mental health problems are strongly associated with stigma in Thailand and that it might be a barrier for them to visit their GP for mental problems. The stigmatization of mental health problems was considered to be closely linked to shame, embarrassment and fear of being perceived as crazy. Some of the women were afraid that they would be perceived as crazy if they went to their GP with their thoughts, and it was a barrier for them to seek help:

*When I feel bad in my head, I sometimes think I want to talk to a doctor. I had pain inside and sometimes I cannot talk with my husband or my friends. I think that if I talk like that, they might think I'm crazy. And the doctor also may think I'm crazy or stupid.*

The women explained that in Thailand many do not understand what depression is and people tend to distance themselves from it: *We lack knowledge about it in Thailand. Many doesn't understand what depression really is. So they think that depressed people are crazy persons. The one who visit psychologist and psychiatric doctor is a crazy person.* The women explained that in their culture they are used to hiding it if they struggle with their mental health. The impression is that many Thai women feel that mental health problems are not accepted and if you are open about it, people will avoid you and not talk to you. The women emphasized that if someone in a family becomes mentally ill, it is embarrassing for the whole family, because it indicates bad genes: *Psychological diseases in Thailand.. we don't show*

*that much that we are mentally ill... If someone in the family is mentally ill, it is a bit embarrassing.* Even though many of the women told that mental health problems were stigmatized in their culture, a few women also mentioned that mental health problems are more accepted in Thailand nowadays:

*If someone in the family is sent to the mental hospital, the family will be ashamed. Maybe now it is a bit better than before. Because people get more information and some examples of when you visit the psychologist, it means that you... everyone is crazy, but you need help. Not physically ill, but maybe sick and not crazy and stuff like that. People understand a bit more, I think. They are a bit more modern than before.*

Some also highlighted that the number of psychologists in Thailand have increased, and that more people seek help for their mental health problems: *In Thailand earlier, we didn't have that many psychologists or mental doctors. But now mental doctors are increasing. And there are many patients that have depression or other mental illnesses.*

These findings indicate that many Thai immigrant women are afraid to be stigmatized if they have mental health problems. Many will try to ignore it if they have feelings of distress, rather than seek help. This study suggests that stigmatization leads to difficulties in dealing with mental health problems for the women, because it hinders them in seeking help. Other studies highlight that mentally ill persons in Thailand are likely to be stigmatized (Burnard, Naiyapatana, and Lloyd 2006, 742-745). For most Asian groups, saving face is extremely important. The fear of social stigma may lead the patients to avoid discussing their mental health. In many Asian cultures, mental health problems reflects poor family lineage and lower the chance of future marriages. It is more accepted to have physical symptoms of illness (Kramer et al. 2002, 228).

#### *Other coping strategies*

The women in this study mentioned several coping strategies related to mental health problems, besides from visiting their GP. Many of these were active coping strategies. The findings indicate that religion and talking to friends are the most common strategies. Other typical strategies are talking to their family in Thailand, participating in activities and keeping busy, meditation and avoiding thinking. In this section I will highlight the women's use of

religion and friends as coping strategies for mental health problems, as well as the role of their family.

## Religion

Nearly all the women mentioned religion as a strategy to cope with mental health problems and it was the most frequently mentioned strategy. The majority of the women who mentioned religion as a coping strategy are Buddhists. They said that they were likely to visit the temple and pray and some also preferred to talk with the monk if they felt sad. The monk would say comforting things to get them back on track: *For me, if I have a problem, big problem in my head, many problems in the family. Sometimes I go to the temple and talk with the monk. He says nice words and makes me awake in my head. If it is wrong or if it is right, the monk can tell you.* It was also common for the women to visit the temple for their well-being. The women told that it is common to become a temporary nun if you have problems; dress in white and stay in the temple for one week or more: *We come together and become nun together... It is where I become calm.* Visiting a Buddhist temple was less stigmatizing for them than visiting a mental doctor:

*Many that have problems want to be a temporary female monk and be at the temple for a week just to calm down. Many try that instead of going to a mental doctor. Because if you go to the doctor, you are called "crazy" and it is embarrassing if someone gets to know.*

The analysis also revealed that visiting the temple and donating money to the monks helped them in their life, and contributed to good karma: *We believe that if we do something good, support religion or like that, give donation or food to the monk or give money and support some places that have problems, it helps you in your life.* Although many of the women found good support in their religion, some experienced a cultural conflict with their husband, who did not understand why they had to visit the temple and donate money:

*Yes, many of us relate to... Buddha's teaching.... But it is hard because of the cultural difference, right. The women who want to go to the temple, and yes and pray for a better life also do good, give food to the monk and a little money for... that we feel that it is good karma, right, we as Buddhists. But the men, they think that why do we have to give money? So there is a conflict there.*

The women in this study mentioned that visiting the temple and donate money would help them in their life and lead to good karma. This reflects the Buddhist belief of rebirth; that human beings are constantly reborn as humans or animals. The form of rebirth depends on their karma from previous life. Karma can be described as “the law of cause and effect”, like those who are kind and caring will achieve happiness (Choowattanapakorn 1999, 97, Chamratrithirong et al. 2010, 1856, Kramer et al. 2002, 228).

These findings indicate that Thai immigrant women are likely to use religion as a coping strategy for mental health problems. It is common to visit the Buddhist temple and talk to the monk or become a nun to de-stress, relax and get back on track. This study highlights the importance of religion as an alternative coping strategy and the temple as a place where the women feel safe. The temple is a place where they can relax and get the chance to remove themselves from the stress of daily life.

These findings confirm a previous study from Sweden, which have indicated that Thai immigrants commonly visit the temple and practice Buddhist teaching and meditation to cope with mental health problems. Visiting the temple made them feel peaceful (Soonthornchaiya and Dancy 2006, 691-692). Even though Western medicine characterises public health services most places in the world, it often function in combination with more traditional medical systems. Spirituality and religion means a lot in many regions and affects people’s perceptions of health (Helse- og omsorgsdepartementet 2013, 28).

### Friends

The second most frequently mentioned coping strategy was talking to and hanging out with friends, most commonly other Thais. Half of the women expressed that their Thai network helped them through hard times. It was important for them to talk to their friends and to help each other. Friends were also emphasized as important activators to divert their attention from their problems and to avoid loneliness: *If you feel a bit depressed, then maybe you talk to friends...so that you will not be home alone as often.* Many of the women would rather talk to a friend than their GP, since their GP were from another culture and would not understand them anyway: *I think a person can talk to a person instead of sending to doctor, so I think we*

*can just talk and... We have another culture...so some who visit the doctor, they are not satisfied with.. Things they get, because they think they only get pills, like sleeping pills.* The women in this study also emphasized that their Thai network was important for assistance with practical issues, for instance regarding the health services, knowledge about the Norwegian society or legal services.

These findings indicate that socializing and confiding in to friends are important coping strategies for Thai immigrant women. Many prefer to talk to their friends than their GP, because their GP does not have the cultural competence to understand their problems. The impression is also that many Thai immigrant women participate in Thai networks in Norway, where they share information, support each other and help each other with practical issues. However, as I have pointed out earlier in this study; some also experience gossip in these networks.

The importance of friends has also been found in a Swedish study, which indicated that Thai immigrant women often describe their health in relation to having social support (Lundberg 1999, 33). Other studies have indicated that family and social network play a great role in Asian cultures (Kramer et al. 2002, 231).

#### *The role of the family*

Many of the women highlighted that the role of the family was different in Norway, compared to Thailand. They were used to an extended family that took care of each other and were someone to turn to if they struggled physically, mentally or financially. If they became ill, someone in their family would support and care for them. In Norway they did not feel that they could turn to their new family, because the family unit was not as strong here: *Many here in Norway do not have an extended family. If you have problems or if you get problems, maybe you think a lot and cry. Who do you turn to? Where can you talk? It is not right.* In addition, some of the women felt that they lacked support from their family back home, because they were so far away and they could only talk on the phone. Many of the women expressed that they would nevertheless not concern their family back home if they had problems: *I mean that most of us will not tell that we have problems here. We want to protect them, right; they must not worry about me.* Even if they experience problems with their husband or even a divorce, some would not have told their family back home:



*Because in Thailand, Thai people have much respect for Europe. They think that Europe is kind and nice, you see. If Thai a girl gets problems with her husband and he behaves badly, she doesn't want to tell her family. She thinks she has a problem, not her family. She has to stay strong, live in Norway.*

The women were concerned with saving face and not expressing failure. This again shows the vulnerable and dependent situation they might be in while living abroad, since many also wants to live up expectations from their family back home.

This study indicates that family would be a natural coping strategy for the informants in this study, but many lack support from their relatives in Norway as well as their relatives back home in Thailand. The importance of the family for Thais has also been identified in other studies. Traditionally, Asians look at the family as a unit. Age and gender define your role in the family hierarchy, and how you are expected to behave within that role. The family shares responsibility for resolving and managing serious problems experienced by family members (Kramer et al. 2002, 228, Lundberg 2000, 277). Lacking support from their families may put these women in a vulnerable situation, as some attempt to deal with their problems on their own. The study shows that many Thai women do not want to involve their family back home if they have problems, since they do not want to concern them, nor lose face.

The findings related to the last research question reveals that many Thai women are unfamiliar with the term “mental health” before they move to Norway, which might be because many hold a holistic view of health. Different health beliefs may be a barrier to seeking health care and receiving appropriate treatment. The analysis of the study also shows that religion and friends are common alternative coping strategies to deal with mental health problems. Family would be a natural source of support for the women, but the majority of the women lack such support in Norway.

I have now outlined the findings in this study. In the next chapter I will review the study limitations and strengths, before I proceed with the discussion, structural implications and the conclusion.

## **11. Study limitations and strengths**

I am studying Thai immigrant women within a postcolonial feminist perspective. One important question is whether, I, as a Western researcher, can speak for the informants without misrepresenting them. The fact that I come from a social and cultural location cannot be avoided and it has been important to reflect on the impact of my cultural and academic background. I have attempted to emphasize the informants' experiences and focus on representing the data without "othering" their knowledge. In this way I believe that I am contributing in making Thai immigrant women's position, challenges and experiences of power imbalances visible.

One possible limitation is that I have not conducted the interviews I am analysing, and the data collection is therefore a product of someone else's predilections. Alan Bryman (2012, 405) notes that informants most likely will be affected by the characteristics of the interviewer. The interviewer in this study is Melanie Straiton and she is from UK and has a PhD in psychology. She was 30 years when she conducted the interviews. Her position to the informants was close in terms of being a woman and an immigrant. Shared experiences of migration and being a woman may have made the women more open. Yet, her position was also distant, in terms of cultural and linguistic differences and her position as a researcher. A positive aspect of using someone else's data material is that data-collecting is time-consuming. With limited time and resources for my master thesis to design and conduct large-scale data, it has been very useful to analyse other data material. In addition, the fact that I did not conduct the interviews may have contributed to an objective understanding of what has been said, since I have not met the women and are not influenced by their appearance. It has also been helpful to have discussions with my supervisor, who was also the interviewer, about the data material. According to Andrew Shento (2004, 67), debriefings and discussions with someone who knows the data material is helpful in avoiding tunnel vision. In this way you can test your own interpretations and become aware of other perceptions, as well as recognise biases.

An important issue that must be considered is how representative the sample in this research is for Thai women living in Norway. One third of the women in this study are educated and

resourceful. Statistics show that less than one out of ten Thai women who live in Norway have higher education (Lie 2003, 47). As we know, education, work and socioeconomic position are important determinants of health, and this may indicate that a number of the Thai women in this research have better health, better language skills, better resources to cope with difficulties and easier access to services than the average Thai woman living in Norway. This may act as a limitation of the research. However, women who have only primary education are also included in the research, so several educational backgrounds are considered. In addition, the women in this study expressed that they face many challenges in Norway, even though many are more educated and resourceful than the average Thai woman. Their experienced challenges might therefore be applicable to a large proportion of Thai immigrant women in Norway.

Another possible limitation is that the interpretation are to some extent influenced by my leanings, which makes it impossible to replicate the study (Bryman 2012, 405). External validity, which means “the degree to which findings can be generalized across social settings”, seems to be problematic for qualitative interview, because of small samples (Bryman 2012, 390, Shento 2004, 70). However, the goal of most qualitative studies, is “not to generalize, but to provide a rich, contextual understanding of some aspects of human experience, through intensive study of particular cases” (Polit and Beck 2010, 1451). Further, I have considered previous research in my study. According to Shento (2004, 69), considerations of previous research and relations to existing knowledge increases the credibility of the data. Relative to transparency; I have also provided a clear description of the sample, the interviewer and the analysis. With a clear description of what is being studied, it will be easier for the reader to understand the context, and thereby the opportunity to compare it with what they see in other situations (Shento 2004, 69-70).

One important aspect of this study is that the available literature in this field is scarce and some of the previous studies are old. Even though I have searched for updated literature, some of the literature used in this study, is out of date. However, it indicates that this study is an important contribution to the field.

During data analysis, I have been dependent on the quality of the interviews, as well as my own analytical abilities. It is the first time I am analysing qualitative interviews, and it has

been a challenge to constantly question whether my personal beliefs and perceptions bias the research. I have therefore had good discussions with my supervisor to avoid tunnel vision.

## **12. Discussion**

This study shows that Thai immigrant women in Norway face many challenges. All the informants reported some level of stress or distress, illustrated by their reported experiences of sadness, guilt, low self-esteem, loneliness and sleeping problems. Despite this, very few had talked to their GP about their mental health and even fewer had received specialist mental health care. Identifying barriers to health care can give an indication of what can be done to make mental health care more accessible and more appropriate for this group of women. I will start to summarize the factors influencing Thai immigrant women's mental health, before I discuss their perceptions about GP-consultations and how it affects their willingness to seek help for mental health problems. Then I will discuss other factors influencing Thai women's willingness to seek help for mental health problems.

### **Factors influencing Thai women living in Norway's mental health**

Several factors influence Thai immigrant women in Norway's mental health. Many of the women struggle to fulfill their roles as a wife/partner, daughter and mother. They try to live up to expectations from their family in Norway and their family left behind in Thailand, and many experience that the cultural differences act as a challenge to meet these expectations. Lack of support from their new family in Norway as well as being far away from their family members in Thailand affects their confidence and well-being. Most of the women also have financial responsibilities for their family left behind and feel that they are unable to support them well enough. Feelings of guilt affect their mental health. The Buddhist belief system emphasizes reincarnation and the Law of Karma, which indicates that those who are kind and caring will achieve happiness (Choowattanapakorn 1999, 97, Chamratrithirong et al. 2010, 1856, Kramer et al. 2002, 228). Because of this, the tradition of repayment to their parents brings merit and is of great value for the women (Limanonda 1995, 77). Daughters are normally seen as more dependable, better caregivers and emotionally closer to the parents (Knodel, Saengtienchal, and Sittitrai 1995, 89).

The study indicates that many Thai women feel that their expectations of their transnational marriage and their life in Norway are not met. Many experience that they have a low

socioeconomic status and are dependent on their husband. Power imbalances affect them as women and immigrants and lead the women in vulnerable positions. The residence permit conditioned by marriage contributes to reinforcing these power imbalances, as the women may be “forced” to stay in the relationship, since the husband can decide if she gets to stay in Norway or not. Feelings of dependency has a strong impact on the women`s mental health. This confirms previous suggestions that immigrant policy contribute to place these women in a disadvantaged position (Belleau 2003, 599).

Today we are witnessing an increase in transnational marriages between Western men and non-Western women, which is made possible by growing technology networks and increased travel. A closer look at the scenario reveals several dimensions that may contribute to imbalances in the relationship (Belleau 2003, 595-596). The transnational marriages can potentially contribute to unrealistic and contrasting expectations about the relationships. Put somewhere extreme, the Western husband may look for a wife whom he can control and dominate; a dutiful and passive wife. He rejects women of his own nationality, because they are too ambitious and demanding. Contrasting to these expectations, Thai women desires a kind and respectful husband (Belleau 2003, 596). Some women feel obliged to stay in the relationship, because their family in Thailand expects them to fulfil their daughter duty and nor do they want to lose face. Many of the women migrate to make sure that their family back home is able to keep their values and social standing. Money remittances from migrants are a growing phenomenon. In this way the Thai women who marry foreign men, still keep a sense of belonging rooted in their family and their ethnic group (Angeles and Sunanta 2009, 549-554, Plambech 2009, 37). Their financial support helps their parents, and in some cases their children left behind or other relatives, as well as maintains the family`s properties (Angeles and Sunanta 2009, 569).

The findings in this study show that many Thai women experience social isolation in Norway, in terms of having few close friends. This is a huge contrast to their often large social network in Thailand and may affect their mental health and how they cope with difficulties.

International studies also indicate that social isolation and low social trust are strongly related to mental health difficulties among Thai immigrant women (Fernbrant et al. 2014, 163, Srirangson et al. 2013). A study of Thai immigrant women in Australia indicates that many Thai women experience that the family members of their spouses are not as supportive as they

have thought, along with lacking support from their own family in Thailand. Another study has also indicated that Thai women is likely to experience conflicting expectations from their husband, their family members in Thailand and the members of their spouses' family (Jirowong and Manderson 2001, 179-182). Moving to a new country calls for social support, but some Thai women may instead find themselves socially isolated. Loneliness is a known influencing factor of mental health and social well-being and can potentially lead to mental health problems (Mushtaq et al. 2014, 3, Pedersen, Andersen, and Curtis 2012, 42 and 43).

The study also shows that many Thai immigrant women in Norway are affected by acculturation challenges, which seem to influence their self-confidence and hence their mental health. Adjustments related to language, employment and culture requires a lot of effort. Low language proficiency may lead to low self-esteem in social settings and contribute to power imbalances between the women and their husband, as their husband becomes the link between them and the society. Some Thai women are also victims of discrimination, which affects their opportunities to obtain a professional job, their self-esteem and maintains their low social position. Many of the informants struggled to find a permanent and suitable job, and experienced that their qualifications were not recognized in Norway. This may lead to disempowerment and feelings of inadequacy. Unpredictable jobs and income leads to instability and stress for the women. These worries are often reinforced by their role as a mother, daughter and breadwinner and the expectations that come along with these roles.

The findings in this study confirm previous research suggesting that immigrants often deal with economic struggle and marginalization, regardless of reasons for migration. Some struggle with low socioeconomic status, immigration status, stigma and limited language proficiency, and many try to meet their basics needs with little knowledge of the resources and shortcuts (Im and Yang 2006, 666, Kim, Worley, et al. 2011, 1250-1252).

### **Perceptions about GP-consultations and how this affects their willingness to seek help for mental health problems**

All the informants in this study had visited their GP the last year, but very few had ever visited their GP for mental health problems. Most of the women were unsure whether their GP could help them with mental health problems. Many of the women emphasized that it should exist information in Thai about how to navigate through the health system in Norway

and what you can expect of the health services. Such information is especially important when you arrive in a new country, even before you learning the language, as this can take years. Information in Thai will make the health services more accessible, as well as empower the women, as they will not need assistance from their husband or others about how to seek health care for their problems.

When Thai immigrant women seek health care, there are many factors that influence how they feel about the help they receive, which in turn affects their willingness to seek help for mental health problems. The study indicates that many Thai immigrant women feel that their GP is unapproachable. The feeling of the GP being in hurry or not being interested in them can increase reluctance to seek help consultations for mental health problems. An impersonal patient approach and limited time also inhibits the establishment of trust between the patient and the provider (Scheppers et al. 2006, 343-344). Many are not familiar with the shared decision-making approach regarding diagnosis and treatment, which can present communication challenges and increase patient dissatisfaction.

Many of the informants had experienced that their GP did not understand them or their diseases. Cultural differences are related to different believes and different ways of explaining health (Scheppers et al. 2006, 340). Immigrant groups may have other cultural perceptions about health problems and their needs may be expressed in a different way (Scheppers et al. 2006, 339). Wrong assessments can occur when a clinician from one ethnic group uses his/her system to evaluate an individual from another ethnic group. A clinician should be flexible and open when defining disorders among the immigrant population (Leong and Lau 2001, 206). Cultural competence may be particularly important in mental health care, as some immigrants are not familiar with the term “mental health”.

These findings confirm previous studies suggesting that cultural background influence peoples view of mental health in terms of several factors. Mental health problems are understood in different ways in all over the world, and the value of developing an international psychiatric terminology can therefore be questioned. Some symptoms and characteristics of mental health problems can be shared across cultures, while others are indeed culture- specific (Burnard, Naiyapatana, and Lloyd 2006, 743, Kleinman 1977, 4). Ethnic minorities often express their health problems in a different way, because of “cultural

behaviour patterns” and “communication styles” (Leong and Lau 2001, 206). It is important to remember that many immigrant patients operate with parallel sets of beliefs and health practices, sometimes western health practices and other times non-western practices. If health care services ignore this, people with another cultural background than the Norwegian may end up ruling out health care services as a source of help. Studies show that believes in traditional practices does not hinder the perception that western health care can work as well (Scheppers et al. 2006, 343). Their experiences in both their home country and their host country should be considered when detecting and managing mental health problems among immigrants. Successful assessment of mental health problems among Asian patients should be based cultural understandings, and conversations about acceptable diagnosis and treatment (Kramer et al. 2002, 231). The Norwegian Ministry of Health and Care Services highlights that the health services in Norway have become more focused on the patient perceptions the last years, considering the shared decision-making approach, but there is room for improvements. Shared decision-making should involve active communication with patients about their diagnosis and treatment options. To achieve this, there is need for practical instructions for health providers, related to ethics, language, and communication, use of interpreters, and migration health (Helse- og omsorgsdepartementet 2013, 29 and 38).

Long waiting time and costs of consultations is also a barrier for many Thai immigrant women to seek help for mental health problems. The patient fee of medical consultations may hinder those who already struggle financially. In addition, those who struggle financially are more likely to have mental health problems (Burns 2015, 107). Many of the women in this study had such difficulties, along with their role as breadwinners. If they do not use money on medical consultations for their own well-being, they can send more money back home to their family in Thailand. Together with long waiting time, this may lead to delays in help-seeking.

Low language proficiency is a prominent barrier for the women in help-seeking for mental health problems, as it is difficult to articulate feelings in another language. The consultation with the GP is an interactive meeting which relies on communication. Additionally, typical traditional Asian ways of communication, like “respect for authority, being indirect and avoiding conflicts”, are often misinterpreted in the new culture (Kramer et al. 2002, 230). This, together with an uninterested and unfriendly GP, may lead to insecurity and withholding of information. This study suggests that an interpreter can be helpful to aid communication



during consultations with the GP, which confirms previous research (Karliner et al. 2007, 748). However, poor quality can cause misunderstandings and withholding of information. Even when the quality is good, the patients ask fewer questions and discuss their mental health less than patients with no language barriers (Flores 2005, 294-295, Green et al. 2005, 1053-1054). The study also shows that the use of family members as interpreters makes it difficult for patients to express themselves truthfully. Using the husband as an interpreter potentially maintains power imbalances in their relationship and should be avoided.

This study also stresses the specialist care obstacles some Thai immigrant women experience. Not getting sufficient specialist care when you reach for it, may lead to serious consequences for your mental health. A few of the informants were told that they did not need professional help when their doctor referred them to psychiatric specialist care. Specialist care requires good communication, since talking therapies are usually involved. We could speculate that Thai women are less likely to get specialist care when referred, due to expected communication difficulties. Previous studies have also questioned if women with language difficulties may be underrepresented in certain treatment options (Sentell, Shumway, and Snowden 2007, 343, Jirowong and Manderson 2001, 180, Scheppers et al. 2006, 339). Cultural perceptions of mental health problems can also affect treatments like conversational therapy. When clinicians do not share the same language as their patients, the explanation of symptoms and cultural expression and meanings becomes problematic. This two-way communication difficulty may lead to misunderstanding of symptoms, which potentially contribute to diagnostic and treatment errors (Anand and Cochrane 2005, 201). A recent study in Norway has showed that Thai women more seldom receive conversational therapy, compared to native Norwegians. The same study indicated that the use of interpreter do not appear to hinder the odds of conversational therapy. Thai women who used an interpreter had higher odds of conversational therapy, psychiatric referrals and disability applications compared to Thai women who did not use an interpreter (Straiton et al. 2015, 14). There is reason to believe that the interpreter contribute to less misunderstandings.

Although many of the women in this study were positive to visit their GP for mental health problems, they saw it as the last resort, and would try other coping strategies first. This study suggest that all the mentioned GP-experiences above affect their willingness to consult their

GP, but also their view of mental health, stigma attached to it and available alternative coping strategies, which I will soon deliberate.

An important aspect emphasized in this study is concerns about not getting sufficient care when reached for it. Are the doctors well enough equipped to help patients with low language proficiency with mental health problems? Alternative methods or cooperation's may be a further step that should be investigated to make the health care more accessible and appropriate for this patient group. Immigrants will also benefit from better information regarding the Norwegian health care system and the shared decision-making approach. This study suggests that the social studies courses for immigrants should be in a language they can understand. This is one route to make health services more accessible and to empower Thai immigrant women.

### **Other factors influencing Thai women`s willingness to seek help for mental health problems**

This study indicates that many Thai immigrant women are unfamiliar with the term “mental health” before they move to Norway. Different health understandings are suggested as a reason for this, as many Thais hold a holistic view of health. Spirituality is a central part, and is said to give the life a meaning and purpose (Lundberg and Kerdonfag 2010, 1121-1122). This is likely to be in disagreement with the typical health view in the Western medicine, where the biomedical approach has been significant for decades (Deacon 2013, 847). As such, Thai women`s experience of their own health may not necessarily harmonize with the mental health care system in Norway. Many may have a spiritual understanding of health and view their mental health as integrated with their soul and their physical health.

This study suggests that stigma may inhibit professional help-seeking among Thai women. Many Thai women are afraid to be stigmatized for mental health problems, and it leads them to cope with difficulties on their own. The stigmatization is closely linked to shame, embarrassment and fear of being perceived as crazy. These findings confirm previous research suggesting that mentally ill persons in Thailand are likely to be stigmatized (Burnard, Naiyapatana, and Lloyd 2006, 742-745). In many Asian communities, saving face is extremely important and the fear of social stigma may lead the patients to avoid discussing their mental health. Stigma, together with viewing the body, mind and spirit as one, may

explain why studies with Asian immigrants often indicate a tendency to somaticize mental problems. In the traditional Thai belief system, mental health problems are also described as an obsession by evil spirits (Kramer et al. 2002, 228, Lauber and Rössler 2007, 159 and 170). However, none of the women in this study indicated that they believed in this.

This study also indicates that Thai immigrant women are likely to use their religion as a coping strategy for mental health problems. The temple provides them with an environment where they feel safe and relaxed. Another coping strategy many of the women in this study found helpful was socializing with, or confiding in friends. They indicated that they would rather turn to friends in their social network than their GP, because the GP would not understand their problems anyway. However, the question is, is this this help enough and what happens if they do not trust their friends? Thai women are also used to turning to their family in times of difficulties, but the women in this study lacked close family ties in Norway, in addition to being far away from their own family. Nor do they want to concern their family back home if they have problems in Norway. Lacking support from their family unit and maybe lacking friends they can trust, makes these coping strategies less helpful. The women may benefit from having additional tools to cope with difficulties in life.

### **13. Structural implications**

This study suggests that learning the native language is a crucial factor for the integration of immigrants. Norwegian courses are especially important for immigrant women, who may face a disadvantaged position because of their immigrant status, low language proficiency, low socioeconomic status and their gender. Learning the language is a suggested key to independence. With improved language skills, the women may not have to be dependent on their husband as a translator, and they will potentially gain self-esteem in social settings and in their work life. This study also suggests financial support for the women to take further education to customize their qualification from Thailand to the Norwegian system.

Unrecognizable qualifications clearly show how structural barriers maintain immigrant women in subordinated positions. Many immigrants hold useful knowledge and qualifications; available resources the Norwegian society can benefit from.

The study further suggests cultural sensitivity and curiosity as important components of the health care given to Thai immigrant women. Increased cultural competence by the health

professionals is likely to strengthen the shared decision-making process and the patients' engagement in it. The experiences of long waiting time and costs of consultations show barriers on a structural level, which may lead to untreated mental health problems amongst the most vulnerable patients. This study suggests that financial support for medical consultations will increase the accessibility for people with an income below a certain level. Immigrants will also benefit from improved Norwegian language skills in order to communicate with their GP. If an interpreter is needed, he or she should be authorized. Using an interpreter is complex, especially in small communities, where the interpreter often knows the one he/she is interpreting for. This leads us back to the importance of language, which has been identified as the key to independency for the Thai immigrant women in Norway. With language proficiency the women will get easier access to employment, social network and health care.

Different health views, like the holistic and the biomedical, may influence Thai women willingness to seek help for mental health problems. Again, it illustrates the importance of cultural competence in mental health care. It does not mean that practitioners should fully let go of their own health view, but have in mind that the patient may have another view. A shared decision-making approach with cultural sensitivity may strengthen the health care given and the patient's engagement in it.

Fear of being stigmatized seems to be another important factor, which influences the women's willingness to seek help for mental health problems. A cultural sensitive and gentle approach from the doctor may also make mental health problems less stigmatizing for the women. However, the doctor may not be well enough equipped to help. Therefore, this study also suggests that the health services may benefit from working together with the Buddhist temples to make mental health care more accessible for the Asian immigrant population. The women in this study emphasized that the temple is a place where they get the chance to remove themselves from the stresses of daily life. The Buddhist temples may be a route to better detect and treat mental health problems among the Asian immigrant population, since it is a place many visits. Knowledge exchange between the temple and the health services may strengthen the cultural competence in both directions, and may contribute to more appropriate health care for the Buddhist population. It can potentially help many, and in addition relieve the health care system. Further research is needed to see if knowledge exchange between the

mental health services and the Buddhists temples can be a route to gain more cultural competence.

A number of the participants in this study were resourceful and educated, which may indicate greater opportunities for personal, social and economic adaptation in a new country. They showed that they worked hard to fulfil their own expectations of life and expectations from their family in Thailand. Some of the women in this study showed a great deal of awareness of how to cope with expectations from their family in Thailand, loneliness and stressors of employment and finances. Support from family and friends played a great role in dealing with mental health problems, which has also been found in other studies. Many Thai immigrant women consider their health in relation to their social support and their surroundings (Lundberg 1999, 33, Kramer et al. 2002, 231). However, many of the women in this study experience that they do not have this support from either their family in Norway or their family in Thailand, and in addition they do not have many close friends. This may lead to social isolation and low social trust, which previous studies also have suggested as factors contributing to poor health amongst Thai immigrant women (Fernbrant et al. 2014, 2, Srirangson et al. 2013, 163). This reinforces the importance for Thai women to have additional tools to deal with mental health problems.

## **14. Conclusion**

This study indicates that even resourceful and educated Thai immigrant women in Norway face many challenges, which affect their mental health. Being an immigrant and a woman may place them in a doubly disadvantaged social position, in addition to difficulties connected to power imbalances between them and their husband. Many feel dependent on their husband; socially, economically, linguistically and to obtain permanent residence permit. Adopting the theoretical perspective of postcolonial feminism has helped me to make these power imbalances visible, by stressing how structural and social factors potentially maintain these women in subordinate positions. The study reveals that gender, ethnicity, culture and socioeconomic status influences Thai immigrant women's mental health and their coping strategies. Immigrant policies possibly maintain these power imbalances, since their residence permit is conditioned by marriage for five years. The women try to live up to expectations of them being a wife/partner, daughter and mother and/or a breadwinner for their family. The barriers for consulting their GP for mental health problems are many. Information about the

Norwegian health system in Thai is suggested as an important factor which can help them navigate through the health system. Information in Thai will potentially make the health services more accessible, as well as empower the women. In this way, they might not have to ask for assistance from their husband or others about how to seek health care for their health problems. The study also indicates that most Thai women try alternative strategies to cope with their problems, as many feel that their expectations of the GP are not met. Religion and friends were emphasized as the most obvious strategies. However, in many cases, these coping strategies do not seem to be sufficient and some of the women struggle with untreated mental health difficulties. All of the women reported some level of stress or distress, which might suggest that their coping strategies are not sufficient and that they may benefit from more accessible and appropriate health care. Very few of the women had talked to their GP about their mental health problems or gotten specialist mental health care. Many Thai women feel that their GP does not have cultural competence to understand their problems. This study suggests that the GPs should gain cultural competence and talk to their Thai patient about acceptable diagnosis and treatments. Efforts regarding cultural education for the GPs are suggested as beneficial. Further research should consider how cultural competence amongst the GPs can be conveyed.

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## **Appendix 1: Request for participation in a research project**

### *Background and purpose*

This is a request for you to participate in a research study that investigates how Thai and Filipina immigrant women experience using primary health care services in Norway. Better understanding the needs of immigrant women can lead to an improved health service. You are being contacted following recommendation from another member of the Thai community in Norway who has also been involved in this study. Please complete the form on the last page and send it back to the project leader, Melanie Straiton (tel: 2107 8364; [Melanie.Straiton@fhi.no](mailto:Melanie.Straiton@fhi.no)) to indicate whether or not you are willing to participate.

### *What does the study entail?*

Participating in this study involves you being interviewed about your experiences with your General Practitioner (GP) in Norway. The interview will also cover themes such as living in Norway, and perceptions of physical and mental health. It is likely to last between 1-2 hours and can take place in a location and at a time point which is suitable for you. Prior to the interview, you will also be asked to complete a short form with some background information such as your marital status, length of time in Norway and employment status as well as a few questions about your feelings and emotions. You can choose if you would like to be interviewed in English or Norwegian. However, if this is not suitable for you and you would still like to participate, we can also arrange for an interpreter to be present during the interview.

### *Potential advantages and disadvantages*

By participating in this study, you will be providing valuable information that will be used to better understand difficulties in accessing or using the Norwegian health service, and in particular, for mental health problems. This can increase awareness of how and when immigrant women use available health services which can ultimately lead to an improved service.

Due to the interactive dynamics of an interview, it is not always possible to know in advance all the topics that may arise during discussion about your health care experiences. It may be that you find some of the topics sensitive or uncomfortable to talk about. You do not have to answer all the questions. The researcher has been trained in qualitative interviewing and will listen in an open and empathetic manner. After the interview you will have an opportunity to discuss how you felt about the interview and will also receive information about places to seek help, should you feel this is appropriate.

### *What will happen to the information about you?*

The interview will be audio recorded and subsequently transcribed (written out in full). In the transcripts, we will recode all information that is personally identifiable, such as your or your family members names, your hometown etc. in order to protect your anonymity. Your interview transcript (data) will then be analysed together with other interviews, without names or other personal information. A code will tie your data through a list of names that will be securely and separately stored. Additionally, only authorised project personnel will have access to the list of names and other data you provide in the study.

The data will be used for research purposes as described above. The interview will be analysed together with information from other participants and be used to inform national and international research. In resulting publications, we may use quotations from your interview,

but in order to protect your anonymity, this will be done in such a way that your identity is disguised. When the study is complete, all personal identifiable information about you will be deleted.

*Voluntary participation*

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. You do not have to answer any questions that make you feel uncomfortable. If you agree to participate at this time, you can still withdraw from the study. If you have questions concerning the study, you may contact the project leader, Melanie Straiton.

## **Appendix 2: Interview Guide**

### **1. Can you tell me about yourself and how you came to live in Norway?**

Probes: where were you born, when did you move, why? Have you lived in other countries?

Situation now - Marriage / family / children – in Norway and at home. Responsibility for family at home?

Employment history – before and after moving.

Long term plans – staying in Norway?

### **2. How do you feel about living in Norway?**

Probes: How well do you feel adjusted? Role of husband and other family members / friends / social network / work.

Good / bad aspects of living in Norway (e.g. being away from family, climate, food, language, work, people, social network, racism, responsibility for family etc). How have you overcome these problems? What helped?

### **3. How do you manage to balance different responsibilities at work and at home and responsibilities for your family in your home country?**

Probes: Have you ever experienced a tension between your family's expectations and what you are able to help with? Did you find it stressful? Have you been able to resolve this?

### **4. Have you ever felt sad or low while in Norway?**

Probes: can you give me an example of when? How did you feel, how did it affect you? For how long? What happened? Did it influence your daily life?

### **5. What helped you get through it?**

Probes: Family/friends/work/understanding the culture/language/time? Hobbies or other activities? Did you talk to anyone about the way you felt? Friend, family, husband, professional help? Did you look for practical help? What changed about the situation?

### **6. I am wondering a little about cultural health practices in your home country compared with Norway**

Probes:

What are the normal practices when someone is ill at home? E.g. cold/flu. How is it treated? When would you consult a doctor? Use of home remedies/herbal medicine / other medicine? What about more serious or chronic illnesses? Experience of quack doctors? Do you think people are healthier at home compared with in Norway? Is there much focus on staying healthy at home? How does someone stay healthy? Role of diet, exercise etc.

### **7. What about perceptions of mental health?**

Probes: What does depression mean to you? Do you have a word for depression in your language? How might someone with depression act? What sort of symptoms might they experience? Why might one become depressed? What are the causes of depression? How might these symptoms be perceived in your home country? How would someone cope with their problems? What kind of help might someone get? What might prevent mental health problems? What about anxiety? What sort of symptoms might someone have? What about suicide? Self-harm?

Do you think it is different here? In what ways? E.g. Stigma/ treatment / concern/time off work/family help / medicine. Coping strategies? Expressions of stress or depression – somatic problems – headaches, pain, stomach ulcers. Sleep, tiredness, appetite etc.

- 8. (If indications of stress or feeling low) Do you think you have ever experienced a mental health problem? Or have you ever had a diagnosed mental health problem?**  
Probes: if so, was this while in Norway? Can you tell me a little more about it... when did it start, how did you feel, what symptoms did you have? (e.g. sleep, appetite, tiredness, headaches, pain, suicidal etc.) Did it affect your daily life? How did you cope with it? What kind of help did you get if any? Did your family know about it? How did you family / friends react when they heard? Did you visit a doctor?
- 9. Have you ever had physical symptoms such as headaches, stomach aches, muscular pain that have not had a physical explanation for?**  
Probes: can you tell me more about it? Did you experience changes in sleep patterns, appetite, tiredness levels too? Could these be signs of emotional problems too?
- 10. Moving on to talk a bit about your experiences with the health care system in Norway. How easy do you think it is to visit the doctor here?**  
Probes: difficulties making an appointment, getting to the doctors, other barriers such as cost, time, travel, work etc. Waiting for appointment, prioritising problems. Have you used any health care other services in Norway? E.g. out of hours (legevakt), hospital, community health centre (helsestasjon)?
- 11. How easy was it to understand how the health system in Norway works?**  
Did you get help from anyone? E.g. spouse, friend, boss, colleague, Norwegian class? How did you get a GP? Have you had more than one GP since you've been here? Navigating the health system – gatekeeper role versus direct entry to secondary services. What might make it easier for immigrants?
- 12. How do you find it actually being at the doctors during a consultation? Do you get the help you expect?**  
Probes: How often do you visit the doctor? Does he/she listen to your problems? Are you pleased with the way the problems are resolved? Example – good and bad? Do you feel the doctor understands your needs? Do you ever experience communication problems? Example? Have you ever needed an interpreter when you've been at the doctors? Does this help your communication with the doctor? Do you think your doctor's cultural background affects your communication?
- 13. How do your experiences compare with visiting the doctor back at home?**  
Probes: Is the process very different for making an appointment? How is it when you are at the doctors there? Is it easier to get the help you want? Does the doctor understand your needs more? What are the main differences in visiting the doctor at home? Have you visited the doctor or other health care services at home since moving to Norway?
- 14. Have you or do you think you could visit your doctor here in Norway if you were having emotional problems, or were feeling stressed or depressed?**  
Probes: Why/why not?

How do you think the doctor might be able to help?/What did the doctor do to help?  
Prescription medicine, sickness absence, conversational therapy, referrals to psychologist, telephone contacts.

Alternative: What about if a friend was experiencing problems? For instance, if they were depressed / very sad and low? What might you encourage them to do? Do you know anyone who might have experienced depression?

**15. Where else might you look for help if you were having emotional problems, or were feeling stressed or depressed?**

Probes: Would you discuss it with your spouse? Family or friends in Norway? Family/friends at home? Others in social network – school/work e.g. manager? Professionals? Helpline? A religious leader or group? Other social groups? Alternative medicine? Take up hobbies /other activities? Internet resources? In what ways do you think these people might be able to help / offer support? Practical support to change the situation causing stress?

**16. Is there anything else you want to add about health care or mental health that you've not had chance to say yet?**

**17. Can I ask how you felt about being interviewed today?**