Trauma and mental health - the refugees' experience

Master Thesis

2017 Spring Semester

Aalborg University - Copenhagen Campus

Global Refugee studies

Katalin Keébe 210690-4122

Acknowledgement

I wish to express my gratitude to my supervisors at Aalborg University on the Global Refugee Studies Masters program, Steffen Bo Jensen and Cecilie Lanken Verma.

I sincerely thank Cecilie Lanken Verma for her encouragement of choosing and carrying out my topic and introducing me to the world of anthropology.

I sincerely thank Steffen Bo Jensen for his guidance and endless patience throughout our mutual work.

Abstract

This thesis is about refugees interpretation regarding their trauma experience and inserting that experience into a therapeutic framework. Defining trauma as a form of experience calls for a new angle, providing more space for the refugees to focus on how they attribute meaning to the events surrounding them.

Using four case studies from refugees and one from a mental health care professional the aim of this paper is to capture emerging topics and guidelines during their personal interpretation.

I. Introduction

In this section, the reader is going to be introduced to the motivation of this thesis work that led to the exploration of refugees experience of trauma and therapy in mental health care.

In the problem formulation the main concepts of the thesis are going to be introduced, such as trauma as a form of experience and how therapy is seen in this thesis work. Following the problem formulation, the research questions will be presented.

In the theoretical framework the reader is going to gain an insight into the notion of experience and how humans express these experiences. Following the definition of experience, the concept of trauma will be introduced. Furthermore, the role of culture and society will be presented, in order to position the standpoint of the thesis regarding culture-related phenomena. The last part of the theoretical framework will connect experience, trauma and therapy. At the end of each section questions are going to be presented that later on will give the structure of the analysis.

Based on the experiences' and human psychology's narrative structure in the Methodology chapter the reader will be presented the social constructivist approach of this paper and through what methods the data had been collected. The writer's standpoint of approach, culture and ethics and certain limitations will be introduced under the Positioning sub-section at the end of the Methodology chapter.

The Analysis chapter will be divided by questions, formed on the basis of the Theoretical Framework. Under each topic, the data will be analysed by case studies.

1.1 Motivation:

Since my educational background is in psychology I found it rather fascinating, how it is possible to carry out psychological sessions, when interviewee and interviewer (in this case patients and therapists) possesses different understandings of certain experiences and how can those fit within the frame of therapy. Individual interpretations are influenced by a number of factors, such as cultural background and social context. It is, therefore fascinating how refugees and host country professionals come to terms with these differences.

As an instance from my previous university projects, when asking refugees about their life in the refugee camps within Denmark, a usual term they used was: they become nothing. It refers to several issues in their lives: prolonged stay, stressing about the application, previous traumas. It is a complex socio-psychological situation, what these people describe.

Using the definition from Kublitz (2015) " un-becoming": is a collusion of the marginalized social status within the danish society, a downward class journey, a specific ethnic low-income situation and segmented assimilation (Kublitz, 2015). Through this example, my intention was to illustrate the complexity of the notion and how one definition involves different life experiences in itself.

1.2 Problem Formulation:

The quality and way of providing mental health care are one of the core questions in handling refugees. Numerous studies are prevalent about how the exile situation can negatively influence the refugee's life, well-being and coping methods (Kirmayer et al 2011; Jensen, Norredam, Priebe, Krasnik, 2013).

As Guribye (2008) states in her dissertation, refugees can be referred to mental health care, however, it is often not perceived as adequate help by the patients, who seek other alternative ways to receive the support they need, terminating the therapeutic relationship.
What makes a therapy relevant to refugees? What parts need to collide in order to stay in therapy?

Watters (2001) main critique is, that the Western mental health care system tends to ascribe psychiatric categories to refugees, while their trauma experiences are seen exclusively as investigatory events in their past. Scant pays attention to the refugee's perceptions and interpretation of their own distress (Watters, 2001). Acknowledging, that the presence of trauma itself is not enough to provide adequate help.

Trauma, as an experience, needs to be understood in a way how the patient's consciousness receives it. Through what guidelines it is separated from the flow of stimuli and becomes a core self-regulating event in the individual's life (Brunner, 1986).

Participating in therapy is also a well-localized experience in refugees' life. And as therapy is the platform where therapists facilitate the procession of trauma (Mattingly &Garro, 2000), it has great influencing potential on how refugees attribute meanings to their own distress. As life experiences have self-reflective characteristics, the refugees' trauma does not take a solid place in a therapeutic session.

Therapy can be perceived as a product of interpersonal connections, where therapist and client position themselves in order to create a stable version of expression of the problem (Fruggeri, 1992, Mattingly&Garro, 2000; Bateson, 1972) As Hunt (2000) stated, therapy is a power-structured phenomenon, influenced by the therapist and the surrounding healthcare environment. Therapy thus has the influencing power to provide guidelines which along refugees can build their own narratives. However, if these guidelines perceived not to be in sync with the refugees' interpretations it can lead to inadequate therapy sessions (Al-Krenawi&Graham, 2000). Therefore it is essential to understand how refugees' trauma becomes "an experience" and how can this be inserted into a therapeutic framework.

1.3. Research question:

Based on the above-described problem formulation, this thesis aims to investigate refugees' experience of trauma and participation in therapy in Denmark. To do so, the following questions will be studied:

- Along what guidelines does an experience become traumatic for refugees?
- In what way can refugees translate their trauma experiences into a therapeutic framework?

As human experiences, such as trauma, posses a narrative characteristic, this thesis work is going to approach refugees' trauma experiences through their narratives. Therapy is going to be perceived as an outcome of interpersonal connections between refugee and therapist, where the focus will be put on translations of narratives.

II. Theoretical framework:

In this thesis, trauma is perceived as human experience. Before we turn to the analysis of refugees' interpretation of trauma, first, the notion of human experience is needed to be explored. Following that it will be explained why is it beneficial to study trauma as an experience and what kind of advantages can it give to this thesis work.

Later on mental illness expressions will be discussed, ending the section with the role of culture and social context.

Furthermore, therapy will be discussed as the result of interpersonal connections and how the individual's problems can be placed within this therapeutic frameworks.

2. 1. The notion of experience:

When one studies human behavior, activities, social interactions what researchers seek is the first-hand human experience. In this thesis trauma in refugees' life is perceived as an experience and the way this study gains access to it is also based on the characteristic of an experience. The reason why trauma is handled here as experience will be explained later on, but first it needs to be discussed what is an experience? How can one gain access to it, collect it and interpret it in an academic context? In the following , the notion and characteristics of the "experience" will be unfolded.

Brunner (1986) states that the purpose of the anthropology of experience is to explore how humans experience their culture, namely how these moments are received by their

consciousness. The form of experience can be numerous: a sense of data, cognition, feelings or expectations (Ibid, Rettig, 1990).

Before engaging into a deeper explanation, it is important to specify that experience is not the same as behavior (Brunner, 1986). Behavior can be perceived as a standardized play that is for an audience, where others aim describing the player's routine (Ibid). On the other hand, experience is more personal, since it refers to the individual's active self. By active self, academics mean that individuals not simply engage physically into actions, but during the action, it reflexes itself, therefore through the action, it shapes itself (Brunner, 1986).

2.1.1. Emerging from the flow of stimuli:

Experience as a concept can be divided into "mere experience" and "an experience" (Brunner, 1986:6). A mere experience is when the consciousness receives the temporal flow of events, without any segregation. A mere experience becomes "an experience" when the consciousness segregates it from the flow and attributes a beginning and an ending to it (Brunner, 1986). In the following when experience is mentioned, it refers to "an experience".

Carr (1986) introduces different levels of human experiences, stating that in life-stories one is not able to isolate pure memories or events, narratives result into a layered outcome. Therefore one can make difference between passive, active and self/life experience.

Carr (1986) define passive experiences the ones that occur when the human individual is not consciously aware of the act of encountering. Passive experiences are still charged with the possibility of being significant regarding the individual's future, but it is not connected to a 'story', just perceived in the present (ibid)

On the other hand, according to Carr (1986), active experiences are connecting past, present, and future, creating a configurational dimension, that constantly consult between time and experience. However, looking at the passive and active experiences, those are still not creating 'life stories'. It has to be a fundamental connecting point to make these experiences aligned into a life story. This connecting point, that puts the stories in order, is the self itself. As active-passive experiences create a single-lined timeline of experiences, it is the self that possesses a reflexive characteristic, constantly altering the time/experience apperception (Ibid).

The whole play of human experience involves a third element: reality. Experience is how an event from reality represented by our consciousness and finally experience is the product how the event was framed by the individual (Brunner, 1986.).

It also entails that one is not able to obtain an absolute understanding of reality, as the way of making sense out of experiences will always show the way of thinking of the individual, due to the reflexive characteristic (Rettig, 1990).

That, of course, does not mean an alienation between culture, society and individual. The way experiences fall in their places in the individual's life-narrative is greatly influenced by the surrounding culture, moreover, requires shared expectations and mutual understandings of certain phenomena (Mattingly, Garro, 2000). The linguistic and moral, cultural resources that are required for the construction are provided by and available in the culture in which the individual was raised. „The primary way in which such meanings are transmitted is through […] embeddedness, from the moment of birth, in familial and cultural stories (Crossley, 2000, p.46.)

2.1.2. Expression - the symbolic manifestation of experience:

As Brunner (1986) states, a mere experience becomes an experience when it is shaped into an expression, a symbolic manifestation. What is accessible for others is the expression of the experience, therefore the nature of their relationship also requires a close examination.

These expressions are not objective, granted products, thus their meanings cannot be categorized as true or false (Fassain&Rechtman, 2009; Rettig, 1990). A person can never tell the objective truth, it is the interpretation in the social network that is essential (McNamee&Gergen, 1992).

Experience structures its own expression and vice versa, hence their connection is dialogic (Brunner, 1986). This dialogic nature also appears in the hermeneutic circle of experience and expression: The way how we are able to understand other's expression is based on our personal experience and self-understanding (Ibid). Applying this to human life history: Life as lived, Life as experienced and Life as told (Ibid). Researchers, therapists are only able to access participants' Life as told products.

But as a product, expression does not act as a static object, it always contains a processual activity, an action embedded in a social context, related to those who share that social context in a specific historical period (Brunner, 1986).

Expressions are structured units of experiences and these units are the product of social consensus (Ibid). Humans establish limits to narrow down, therefore construct the flow of experience (Ibid). These limitations do not exclusively concern time and space, but the base of coherence is commonly established (Brunner, 1986). It means that expressions are connected to the individual's cultural background, but also the interpretations are based on the cultural context.

In this sense, every expression is interpretive, putting emphasis on certain parts while discounting others, influenced by the experience self-referential characteristic, namely when during the experience the consciousness becomes aware of itself (Brunner, 1986).

Expression of one's whole life is the consciousness self-reflection moments, arranged by culturally and individually influenced factors. This product is one's narrative about his or her life and self in it (Crossley, 2000). Personal representation of reality call for that life-stories are not ready-made products, but active and constructive processes which require personal and cultural resources as well (Mattingly, Garro, 2000). The narrative structure of experience will be further discussed in details in the Methodology chapter.

The core experience of expressed narratives varies as much as human individuals can perceive the reality around them. Narratives can be produced on various topics and life events. Life events such as suffering, chronic and congenital illness in the individual's life has potential to influence the life narratives, since those problems require altered adaptation from the individuals.

2.1.3. Conclusion:

As above described, an experience becomes central, when the consciousness becomes aware of itself. Regarding refugees, the question is what is that point in their life when they become aware of a certain problem? How did they locate that exact experience and through what meaning attribution do they lift it out from other stimuli?

As an active self shapes itself according to the experience, did the participating refugees perceive any concrete changes about themselves?

2.2. Trauma experience:

As it was mentioned in the introduction this thesis work approaches trauma as an experience. Here the reader is going to be presented with different definitions of the notion and the beneficial reason of seeing trauma as an experience will be explained.
Later in this thesis, after the Methodology part, the genealogy of trauma is included as a stronghold for the analysis.

Humans can adapt to certain stressful challenges in order to survive. A traumatic experience can change an individual's psychological, social and biological balance. But what makes an experience traumatic? In the following two different definition of trauma will be presented. Furthermore the advantages of handling trauma as an experience and not a clinical concept will be discussed

First, the most commonly used definitions is the DSM-V description of trauma: "When a person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to physical integrity of self or others and had a subjective response of intense fear, helplessness or horror (American Psychiatric Association, 2000, p. 467).

This thesis does not question the diagnostic appropriateness of the DSM-V, however relies on another definition of trauma: An event defined as traumatic, when novelty, unpredictability, a decreased sense of control, and a threat to the ego is perceived in the situation (Marin&Lupien, 2011). Furthermore, according to Green (1999) there are additional factors that need to be considered when one talks about trauma: There is an objectively defined event, the person's interpretation of its meaning, and the individual's emotional reaction to it.

Using Carr's idea (1986) again, a parallel can be drawn between the two different definition of trauma and active/passive experience: The DSM-V description states that there is an event, which in itself is traumatic, therefore threatening the individual's physical and psychological integrity, followed by strong emotional reaction of fear. Following this definition, trauma can be seen as a passive experience. It has been perceived by the individual, reacted to it, but the self's reflective characteristic is missing.

On the other hand in Green's (1999) definition the response to the objective event (trauma) depends on the subjective interpretation of the individual. This subjective interpretations brings in the self, as regulating force into the trauma experience. With the self entering into the trauma evaluation, a configurational dimension is created, where the experience and self changes its location according to the reflexive characteristic.

Trauma characteristics are equivalent of those as "an experience": The importance of the traumatic event changes through time and entails self-regulation and fluctuating ego-states (Siesilo, 2014, Brunner, 1986). Thus this study intends to access refugees' trauma as a form of an experience.

Furthermore, this thesis does not aim to investigate trauma experience from a clinical approach, or for a diagnostic purpose. Trauma experience is investigated from an anthropological standpoint, following Good's (2013:744) suggestions: shifting the focus from "categorical comparative universalism" to " cultural and local everyday particularism".

In itself the dimension of trauma is not important (how big the injury is), but how overwhelming the interpretation of the traumatic event to the individual is (Herman, 1992). Thus, we focus on the personal interpretation rather than the severity of the event (Rusch, 1998).

Approaching trauma experience, based on the above stated, gives the possibility to study traumatic experiences outside of the clinical categorization. It is especially useful in the case of refugees as their experiences often ascribed exclusively to their fleeing (Watters, 2011). In this thesis trauma will be understood as any experience of the refugees, that had an impact of their mental well-being, regardless if that psychological problem is trauma related or not in the common classification of mental problems. It allows us to access any event and problems in the refugees' life that can lead to mental health care seeking. Frthermore, the localization of these problems in the therapeutic work is personalised by the participating refugees.

The analytical questions that can be drawn from this section are: what is traumatic to refugees? What life experience do they perceive as a threat to their psychological integrity?

As in this thesis' understanding traumatic experience can involve any kind of problem refugees perceive problematic to their mental well-being, in the following chapter the general expression of illnesses is going to be presented.

2.2.1. Expression of illness:

An experience has a self-regulatory feature, that pushes the self to constantly change and adjust the inner and outer world of the individual. Chronic illness brings permanent changes in one's life, the individual has to adapt to that. Stating Bury (1982, cited by Hunt, 2000) again chronic illness as biographical disruption, "a time in which the normal social structures and roles of reciprocity and support are disrupted" (Hunt, 2000:88). The requirement of constantly altering the self during illnesses possesses the same characteristic of an experience, therefore it can be concluded that illness is a type of experience in one's life.

McNamee&Gergen (1992) explains how a single individual functioning in an effective or a malfunction way: In general, the individual has a certain set of skills and knowledge to adapt to the surrounding world. If these challenges and skills meet, the individual functions well. However, if there are inadequacies in the process of adapting, the malfunction can result in disruptions in one's mental well-being.

Chronic illness entails permanent changes in the individual's life, limiting the individual to continue life as before. Bury (1982, cited by Hunt, 2000) denotes chronic illness as biographical disruption, "a time in which the normal social structures and roles of reciprocity and support are disrupted" (Hunt, 2000:88). This kind of permanent loss occurring in roles entails fractures in the self's continuity (Hunt, 2000)

Alteration due to physical injuries is hard, but when it comes to psychological problems, individuals can face it with an even greater challenge. As it was mentioned before members of a society can only have access to an individual's experiences through personal expressions. It is impossible to express an ultimate, objective truth, therefore, without physical evidence, these expressions of mental problems go through a harsher lens of surveillance (Fassin&Rechtman, 2009). In the follow part of the paper, the expressions regarding mental illnesses will be discussed.

As the self tries to cope with the newly occurred problems the self enters into a reorganizing phase in order to make the psychological adjustments to cope with the newly acquired circumstances (Hunt, 2000).

It was previously discussed, that when experiences gain their meanings they turn into symbolic manifestations, that result into narratives, but well established narratives are the

sign of a stabilized self regarding the illness (Kirmayer, 2000). However, prior to that stabilized phase, expressions tend to be undeveloped and illness expressions are limited to metaphors or another type of figures of speech (Kirmayer, 2000). Kirmayer (1993b, cited by Kirmayer, 2000) states that well-established narratives are the end point of the meaning attributing process, not the start. Till that point, individuals tend to use those broken metaphors as stepping-stones to create their narratives (Kirmayer, 2000).

As the above-mentioned shows, creating illness narratives is a process, that jumps in time, space, using building blocks of broken illness metaphors. In the end illness, narratives will serve a purpose to integrate illness into the individual's wider context of life (Hunt, 2000).

2.2.2. Conclusion

Focusing on these stepping stones is one of the analytical points this thesis would like to investigate. What is the procedure refugees use to create a coherent expression of their problems? What are the emphasized building blocks they use to express themselves?

2.3 Role of culture and society in illness representation:

It is not only the individual's private self that has to go under certain changes, but also how the individual connects to society through interpersonal connections. Following Hunt's (2000) ideas: it is not only the individual who organizes an experience, but it is also highly influenced by its audience and the related power structures (Hunt, 2000). Thus it is important to to pay attention to the individual's cultural and social context, when one tries to analyze illness expressions. In this section the influencing features of society and culture is going to be elaborated on. This section does not aim to establish a culture-comparative description, rather to display that interpretation of experiences cannot be abstracted from the individual's background.

Cultural connotation of mental health involve the common sense, commonly shared knowledge that is applied to construct the social and medical experience on mental problems (Marsella, White, 1982). It is the shaping characteristic that influences both the professional and the patient's approach towards mental disorders. Social discourses influence not only the

view on mental disorders but also the expected social behavior towards these issues (Marsella, White, 1982). Cultural background was used as an independent factor, that explains differences in psychiatric phenomena (Marsella, White, 1982).

However, perceiving culture as a single factor can be misleading. Fruggeri (1992) claims, that psychotherapy and mental problems are the results of interpersonal construction processes. Therefore, they cannot be abstracted from the social context but that does not mean that culture has an exclusive role. It is not language or cultural customs itself that generates differences. Individuals gain guiding formulas from relational networks. In these networks language and culture is prevalent and has great influencing power, but their role is not absolute (McNamee&Gergen, 1992).

Nevertheless, looking at the different cultural definitions of mental disorders shows, that the same disorder description is interpreted in different ways, depending on the context that tries to explain it. As a result, different social context entails a different explanation of somatic and behavioral signs. (Marsella, White, 1982). Relying on Marsella and White (1982:3): "Expression of psychiatric illness in thought and behavior are necessarily mediated by the symbolic forms of language and culture". The focus is also on the symbolic structures of social conceptions of mental disorder (Marsella, White, 1982).

2.3.1. Main cultural influences - a highlight

The purpose of this section is to show the most commonly recognizable cultural influences regarding therapy and illness expressions.

The very first influencing factor that can be highlighted is the collectivist versus individualist society in which the individual is raised. As Western societies have individualist features, self-development according to Erikson (1963): The key moment of the development is the psychological separation between the individual and one's parents, which in the end results in an autonomous identity. In contrary, self-development in collectivist societies, like Africa, Asia, South America, Middle-East, lack the psychological separation from the relatives, moreover, the family/group identity remains in focus. The western idea of bearing problems alone, separated, does not occur in most of non-western societies (Kleinman&Kleinman, 1996).

The patient most probably will not decide on his or her own, but it will be up for discussion in the family (Budman et al, 1992; Al-Krenawi&Graham, 2000). This can be seen as an infantilizing and autocratic behaviour from the parents' or the family's side, however, changing the hierarchical structure of the family and forcing the patient to be autonomous most probably will alienate the family, causing more distress to the patient and his or her own family (Al-Krenawi&Graham, 2000).

Revealing personal facts and problems to a psychotherapist is usually a foreign idea for non-western cultural background individuals. The reason lies in the different cultural positioning regarding health-care seeking behavior and the professionals' role (Tribe, 2002).

In western-style psychological therapies, the therapeutic framework is built up as the following: The patient and the therapist have a formal relationship, that is built on trust. However, keeping the framework is important, which means a supportive emotional context, but in the mean timean emotional distance toa certain degree.

Therapists usually function as - facilitators who help- the patients discover themselves and explore their problems and verbalize them. In non-western cultures, professionals have a different type of role, and its origin needs to be explained again, by the family-societal-structure. Professionals are also figures of power, who teach and beyond showing directions, provide a collection of do's and don't's (Al-Krenawi&Graham, 2000). Thus gaining trust also happens in a different way. As Budman et al. (1992) says, gaining trust often happens through informal socializing, what can't be accepted in western-style therapies, therefore would not fit into therapeutical frameworks.

These elements are important to be focused on in order to avoid "doctor shopping", which means the family goes fromtherapist totherapist until they hear what they can accept or eventually get driven away from mental health care seeking. There is a need to find a balance between meanings and behavior which is a solution to the patient, plausible for the therapist and also tolerated by other workers in the facility or by the hospital (Al-Krenawi&Graham, 2000; Budman et al, 1992). The position of mental health care professionals will be discussed in the Genealogy of Trauma chapter, also introducing an interview with a psychologist who works with refugees.

Usage of language during the problem expressions also needs an emphasized focus. It is almost always the case that patients describes their problems using somatic expressions, such as pain in the chest or general pain. Somatization is a usual phenomenon (Tribe, 2002)

as well as attributing the problems to evil spirits (Hecker, Barnewitz, Stenmark, Iversen, 2016). Wide range of metaphors and proverbs needs to be understood in their respective cultural context as a point of reference (Al-Krenawi&Graham, 2000). One specific example from Al-Krenawi (2000): as suicidal thoughts are condemned in middle-eastern cultures to the investigation question: do you have suicidal thoughts" the answer would be a direct no.

However, using indirect, circular questioning style the patients might admit they would like God to take away their lives. The point of this is to show the relativity of positive and negative meanings in a person's life, as it is unknown until we understood the underlying meanings of the experience (Price, Burrell, 2012).

Culture does have a significant role in the attitudes towards mental health problems and in the process of therapy, with even more factors than above was mentioned. However, focusing exclusively on the refugee patient's cultural background results into the alienation of the self from the culture. All individuals have their own subjective disease model. The complex structure of causes, attributions and implications need to be acknowledged here (Budmant et al, 1992; Hecker et al., 2016).

What leads to an effective therapy, if refugees can articulate their preferred interpretations of their problems and those are perceived in their respective cultural and social context (Fernando, 2005).

Based on the above mentioned, when one studies the experience of refugees, culture needs to be involved in the analysis. In this thesis however, the analytical focus will be on the social context in order to avoid cultural comparison.

Thus, the following questions will be elaborated in the analytical chapter: How do refugees define mental health problems and how do they define their own trauma experience? How does the two category resonate with each other?

Bringing back the hermeneutic circle of experience, expression form the notion of experience section, it is important to state again: the way we are able to understand each other's expression is based on our own personal experience and self understanding. Following this definition, the emerging questions are: With whom do refugees share their stories? How does the expression of trauma experience differ based on the listener's identity?

Based on the assumption that knowledge about mental disorders is influenced by culture it is inevitable, that it is prevalent in clinical judgments regarding mental disorders. The mainly used psychological tools and categorization systems are the proof themselves,

that there is a standardized, commonly agreed system to diagnose mental problem symptoms. However, diagnostic categories are not solid phenomenas, regardless culture. They change through social and historical discourses (Hoffman, 1992).

2.4. Therapy as a result interpersonal construction

2.4.1. Before the therapy:

As we see mental health care is a complex, multiple-step process of care, it is necessary to study the starting point of this process, namely, the diagnosis and how therapists can access the core of the problems.

The psychological diagnostic tools and therapy methods are strongly related to culture and language. Each psychological tool is standardized nation by nation in order to adjust it to the citizens, to gain the best possible measuring characteristics.

In psychology, one can seclude two different domains of testing: projective tests and objective tests (Rózsa, Nagybányai Nagy, Oláh, 2006). Objective tests, as questionnaires, captures the self-reported observations of the individual by counting frequencies of certain responses (Mitchell, 1999, Rattray&Jones, 2007). In questionnaire design, item generation is the phase, where the questions are formulated. Item generation requires pilot work regarding content and wording. Different sources are used for the process: associated literature review, pilot interviews, discussion with professionals. (Rattray & Jones, 2007, Rózsa, Nagybányai Nagy, Oláh, 2006). Language, phrasing and order of items can entail the participants' bias response during testing (Rattray & Jones, 2007). Thus, questionnaires have valid and reliable measuring characteristics in the cultural context where they were designed (Cheng & Williams, 1986, Rózsa, Nagybányai Nagy, Oláh, 2006).

The aim of projective psychological testing is to capture the overall operation of the self, exploring internal conflicts, desires, emotions hidden by the consciousness (Rózsa, Kő, Oláh, 2006; Mérei, 2002, Shultz & Shultz, 2011) These tests, like Rorschach, Thematic Apperception Test, drawing tests or word association tests operate with ambiguous stimuli, allowing the respondent to fully express him or herself. The more unstructured the stimuli the more personal answers can be produced (Rózsa, Kő, Oláh, 2006; Mérei, 2002).

The DSM-V (most recent diagnostic manual) provides standardized, public and reliable category system for professionals to categorize symptoms, which will lead to certain disorder diagnoses. Quantitative diagnostic instruments, like the Minnesota Multiphase Personal Inventory (MMPI), also operates with standardized factors and categories (Ibid). But, not only quantitative tools, also, qualitative methods rely on country/culture specific answer schemes, just like the Rorschach Ink test (Mérei, 2002). In Denmark ICD-10 (The International Statistical Classification of Diseases and Related Health Problems 10th Revision) is used for diagnosis (WHO, 2016; Hallas, Hansen, Stæhr, Munk-Andersen, Jorgensen, 2007).

Two main errors can occur if the professionals only focus on the cultural variations in the expression of the clinical problem: First, these out of context expression can suggest pathology, when none exist. Second, neglecting important signs of distress. One specific example from Al-Krenawi&Graham (2000) the experience and expression of depression show ethnocultural differences. It means, that contrary to the western symptoms of depression, in Arabic culture feelings of guilt, self-deprecation, suicidal ideas and feeling of despair are not present. As Budman et al.'s (1992) study shows, these misinterpretations led to inefficient therapy methods, both therapy and medication-wise, what results into prolonged care and additional psychological distress to the patient.

Why is the above presented important? Because questionnaires and mental health care tool's genesis are based on the expression of an experience and how humans attribute meaning to it. Therapists use this information on the analogy what Pilhofer (2011) mentioned: one perceives the others' the interpretation of a notion similar to his/her own.

Mental disorders and psychological problems tend to be stigmatizing both in western and non-western cultural context. The interpretation of the illness, however, is not epiphenomenal to the narrative construction of the problem, it always has an integral feature (D o'Neil, 1997) and professionals need to obtain the fitting symbolics of the illness.

2.4.2. The process

As McNamee&Gergen (1992) claims, self is not a granted, solid object, but an outgrowth of social processes, influenced my conventional norms and beliefs.

The concept of conventional or shared norms is essential when one talks about illness and therapy: Humans generate discourses on certain topics and phenomenas. They agree on what the normative case is. That calls for that individuals have the ability to change the discourses, therefore have the power of alteration (Ibid). Why is this important when one talks about trauma and therapy experiences? Because therapy is based on altering certain personal discourses, thus overcoming problematic issues (Ibid).

As it was stated in the problem formulation, therapy can be perceived as a result of numerous interpersonal connections between therapist and client (Fruggeri, 1994). The way most of the therapies work, is that the therapist and patient aim to built a story-like structure.

The interaction between therapists and patients are navigated by narrative-like interactions. Therapists urge patients to realize themselves as actors in their own stories, entering the therapeutic plots, where patients recount elements from the past (Mattingly, 1998). It is necessary to mention again that detailed and complex narratives are usually the product of coming to terms with a life event, as a solution and sign of the healing process. Especially in the case of chronic, life-altering illnesses and traumatic experiences. These complex, well-built narratives are overbored expectations from the individuals (Crossley, 2000; Kirmayer, 2000).

The way therapists work with illness narratives is that they situate their current work in the patients' stories, facilitating what can be in the next step's untold story. From the patient's side, it requires self-consciousness in order to highlight and analyze life events that will participate in the narratives (Hunt, 2000). This referral to the future's untold story shows that therapy does not aim to create one solid narrative. The aim is to modify the processes of creating narratives, in order to create narratives in a stable way (Fruggeri, 1992). The final version of illness narratives represents not just the patient's experience, but also the beliefs of the therapist and the aftermath prints of audience's (family, hospital staff) interactions (Hunt, 2000). Based on this, Hunt (2000) claims that illness narratives are indisputably influenced by power relationships.

The way people see illnesses, especially long-term illnesses is mainly influenced by health care institutions, treatment settings and the leading approach towards health care. It is pre-constructed how the social world sees long-term health problems, such as psychological problems (Mattingly, Garro, 2000).

2.4.3. Conclusion

In this section the emerging question are: How can the interpretation of certain categories and notions align between therapist and refugee patients when these categories are adjusted to nations? The possibilities depends on how one sees illness categories: objective, solid concepts, or flexible identities formed through discussions.

III. Methodology

3.1. Narrative structure of experience:

As above mentioned, objective human experience in itself is not accessable. What can be observed is its symbolic manifestation. In this thesis, individuals narratives' are perceived as their experience's symbolic manifestation. In this sense, the narrative characteristics are going to be introduced in the followings.

In therapies, the main media how we can study the inner thoughts and processes of an individual is presented with the environment through language and narratives, created by the individuals. Sarbin (1986) argues that human psychology and thinking has an essentially narrative structure , which means humans think, interact, perceive, imagine and make choices according to narratory principles. Studying experiences are mainly based on the constructed narratives. The narrative theory of psychology brings the focus on human existence as it has been lived, experienced, interpreted by the individual (Crossley,2000). Through narratives, individuals frame their experiences and attributing meaning to them (Mattingly&Garro, 2000).

Narratives are especially helpful to gain insight into someone's memories and experiences, as Mattingly (2000) states, narratives mediate between an inner world of thought-feeling and an outer world of observable actions and states of affairs.

Personal representation of reality call for that life-narratives are not ready-made products, but active and constructive processes which require personal and cultural resources as well (Mattingly, Garro, 2000).

3.2. Approach

This study follows a social constructivist approach. The reason for choosing social constructivism is that this study works with trauma and therapy experience, which, as above was elaborated, works with socially constructed meanings.

The narrative psychology approaches self through social constructivism, especially the interrelationship between the self and the language (Crossley, 2000). In psychology social constructivist approach is also referred to as 'language-based' approach. The difference between the psychological social constructivist approach and the traditional humanistic psychodynamic approach is that the latter ones take self and identity fir granted, just like an entity that can be studied and measured in itself, just like an object in its environment, while social constructivism requires the individual to construct and communicate their own individuum. What it means is, that psychological social constructivism places the emphasis on language and linguistic practices rather than assuming a self-entity (Ibid). One of the main argument of this approach is that humans are „interpretive creatures" (Crossley, 2000:10). Therefore, all individuals reflect on their own experiences and actions in differen ways, 'making sense of the world'. The main media for this process is language and in order to study this process, narrative techniques offer various analytical tools (like narrative text analysis in this study, see later).

3.3. Qualitative methods

The narratives of people fall into the category of qualitative research, therefore, it was inevitable to apply qualitative research tools to convey this research.

In order to collect data in the most effective way to answer my research question, qualitative methods were used. Corresponding to Alan Bryman's thoughts (2012) the aim is at depicting a holistic picture about the narratives of refugees, how they construct the meaning of these experiences than presenting numbers of incidents and mere examples. Qualitative methods are also suitable since the target group of participants are rather narrow.

3.3.1. Narratives

Text and language do not relate directly to an objective truth, and cannot be handled as an objective identity that can be measured by statistical scientific methods. The qualitative analysis serves to overcome these shortcomings. “Interpretive approaches assume that the meaning of language is subjective - the speaker, listener, and observer may all ascribe different meanings to language” (Lacity & Janson 2008: 139). This clearly corresponds to psychological social constructivism and the importance of interpreting one’s experience and the role of language as media. Done in a thorough way, it holds great explanatory power about the background, the intentions and the biases of the authors (Saarinen 2008; Klüver 2009; Lacity & Janson 2008). Regarding narratives it is important to state that it is not the aim of this study to analyse act of speech. However, it is the branch of narrative psychology in this thesis, the interpretations of refugees and the attributed meanings, are important and the ones in focus.

3.3.2. Semi-structured interviews

Semi-structured interviews fall into the category of qualitative interviews. My research focus is on the narratives and interpretations of the individuals, concerning certain social phenomena and relations which surround the individuals (Bryman 2012).

In order to gain an in-depth look into the individual cases, his interview style operates with open-ended questions which facilitate the interviewees to present their own experiences (Meier 2010; Seidman 2013).

I find semi-structured interviews especially useful during the data collection, as my work also had a self-regulatory principle. First, the study focused on refugees experience participating in therapy in Denmark, however as I got more into the topic, the focus of interest slightly changed. Through this interview style I had the chance to freely move among those points that participants highlighted for me regarding their trauma and therapy experiences.

3.3.3. Contact with the participants

Since my target group of participants consisted of vulnerable persons, I found it important to create a connection with them at the first meeting and conduct the actual data collection.

I recruited refugees mainly using my social network based on previous university projects and tried to find suitable participants through those contact persons. Recruiting mental health care professional was carried out in a more formal way, contacting organizations and psychological associations.

During the first meeting their rights and the way they can participate were introduced to the participating refugees and if they were still interested in participating, we engaged into a less formal discourse.

3.3.3.1. Introducing the participant's ethical rights:

Since my topic investigates a rather difficult and intimate topic, therefore I find it crucial to introduce the participant's rights to them even before we started the first interview.

The steps were as follows:

1. Assure them that their identity will remain anonymous, names, concrete city names, organization-hospital names' (in the case of professionals) will be altered. I will not give their contacts and personal data to any third party and I will not show the original data in any place in my thesis or the appendix.
2. Their right to answer: However in order to do a proper analysis my questions need to be answered. I made it clear to the participants that there is no right or wrong answer (limiting the expected answer-reflex) and if they do not want to answer a question it is their right not to. In the case of the refugees, I did not intend to cause unnecessary distress, making them elaborate on traumatic and uncomfortable memories and experiences, therefore I offered them the chance not to answer those questions they find problematic. In the case of the mental health care professionals I also offered this option if they felt like the answer would undermine the patience-professional privacy.

3. In the case of the refugees I made it clear that I am in no position to help them in any particular ongoing case (housing, work possibilities or medical referrals) and their participation should be voluntary.

3.3.3.2. Participants:

First Interview:

The aim is to create a bond between the interviewer and the interviewee what can progress into a safe environment, where the participants can open up and tell freely about themselves. My goal was to create that environment. Being a refugee is already a vulnerable position, especially when a mental health problem is also prevalent.

The emphasis was on the connection-making, trust-building. As part of the narrative, I found it also important to ask the participants about their motivation to participate in this research. In the following part of the papaer the first meetings with the participants are going to be introduced to the reader:

John:

I received John's (24, from Sudan) contact info through an organization worker. We talked via email and we first met in Aalborg at the university. John came to Denmark as a quota refugee when he was 13 years old. Now he is working with refugees as well, which means he gained a lot of insight into the system and can compare his experiences between then and now. He remembers his first years in Denmark as a hard, but overall good experience. Except going to the therapists. When I ask him why did he get referred to a therapist (if he had any mental care history before) he just laughed. According to him, he was sent to the therapy to deal with integration and cultural differences. But he felt he was better before the therapy than after it. I let John talk about these experiences as much as he wanted but indicated to him that I will also have to ask again for some of this information in the following sessions as well.

He talked a lot about his recent life, work, how he raises awareness of refugee issues and traveling around Denmark as a 'living example'. He didn't talk much about his life

before Denmark. According to John, it was rather chaotic, he couldn't really make an order out of his memories. He thought coming to Denmark alone as an adventure that grown up man can do, so he looked forward to it. Of course, he says, after the first nice experiences he also 'hit the wall' and almost had to start to fit in from scratches.

Steven, Ali, and Adam.

I was able to contact them through John, as he has a developed network among refugees. What I knew about them, is that Steven (28, Afghanistan) had problems with depression back in his country of origin and that Ali and Adam sought mental health care here, after submitting their application (this information was provided by John). I have met them the same palace as I did with John.

Steven already got his asylum in Denmark, however, Ali (31, Syria) and Adam (27, Syria) are still in the middle of the application process. I wanted to slightly lead the conversation towards their memories.

However, when I told them that besides writing my master in refugees studies, I also have a psychology bachelor they got more excited about me and the profession. They directed questions to me about how is the procedure in my home country when it comes to refugees' mental health care and also how much I know about the Danish system. Just like explained in methodology, I started our meetings with the explanation, that I am not able to influence their cases and I have no power, no legitimacy to interact in any of those issues, I felt like they still wanted me to share confidential insights about the system with them. As I tried to balance between giving them honest answers but also not drawing attention to myself I felt they became distant. The way they saw me in the beginning (I suppose the university student) changed into a more „us-them" polarized situation. When I contacted them first they agreed to participate in all of the research parts of this thesis work, however being there changed their mind. They did not want to continue, stating it is time-consuming and they have to go to language school and take care of the refugee camp duties.

As I saw no point of pushing the interview further I asked them if we could meet another time, just to talk about the possibilities, if they could suggest any alteration regarding the research design that is more suitable for them

Steven:

Only Steven came to the next meeting. I explained this with the fact that he already got his asylum granted here in Denmark, as Ali and Adam could have thought their participation in my research can negatively influence their cases.

Steven was really calm, sometimes silent. He fled from his home with his wife, but they got separated on the way. He said they were heading towards Greece, but they heard they can reach north faster through Hungary. However, in Serbia during the night he and his wife got separated. He shared some formal information about how the police tried to find her, but after listing the facts he stopped talking about it and I did not want to push him further.

I tried to ask him about his depression since he mentioned he had issues with it before the fleeing. He said that it started as in adolescence around the age of 13-14, but at that time no one cared about it. He could sometimes miss school, saying he is sick, but never told his parents/doctor/friends that he constantly did not feel well. When he turned 20 (when he met his wife) his depression became more severe (but he still considered himself as well functioning) he talked with his general practitioner, who referred him to a psychiatrist. He got some anti-depressants that, according to him, made him feel lighter. However, when they decided to flee, he did not care about his depression. As he says: In those times that's the least you have the energy to worry about. He has been in Denmark for more than a year now. I asked him if he sought mental health care services. As a reply he told me, he just recently asked to get referred to a specialist. First, he only wanted to get the antidepressant prescribed, but know he is considering to talk about the distress he feels about his missing wife. He still hasn't seen his therapist, as he said: there are a long waiting list and those who don't need immediate medication have to wait a bit longer since they don't need immediate help.

Adam:

Frotunately, Adam also contacted me later via email that he still considers to participate in the interviews. When we met the second time, he explained that change with his curiosity. He said, he had never participated in any studies before and he would like to try it. However, he mentioned that he talked with John again and after that he wrote me. As I asked John not to

push refugees to participate in the interviewing I was concerned about Adam's motives. In the end he seemed truly interested in the topic and what was more important sharing his views.

Adam seemed cheerful and really hopeful regarding his situation in Denmark. He was convinced that seeking mental help care can help him integrating into the Danish society. The time of our second meeting he requested an appointment with a psychologist at Red Cross, but still hasn't gotten any. By the time of our third meeting (second part of the data collecting) he already saw the therapist two times.

Sarah:

Sarah lives in Copenhagen and we got introduced to each other through a mutual acquaintance. During the first meeting she was really friendly and was truly interested in the thesis topic. Later on her attitude changed. She was still friendly with me, but answered only strictly to the questions and did not share more details about her personal life.

Peter:

Peter represents the mental health care professionals in this paper. I received Peter's contact through a mutual acquaintance. He finished his education at Copenhagen University and majored in psychology. He is specialized in cognitive therapy. After university, he started to work for the Kommune and as he claimed, he felt the energy to participate in voluntarily provided mental health care. As he said, it was a longer way to reach till refugees and asylum seekers. He started with homeless people and in youth centers. Besides his job, providing psychological help for refugees, he is volunteering within the Red Cross system. The question if he could explain how he works within the Danish Red Cross he gently refused to answer.

Second meeting with the participants:

The second meeting does not necessarily mean an actual second occasion. I called second meeting the first time when we engaged into the semi-structured interviews.

The beginning of the session started with a few warm up question, referring back to the previous meeting and therefore entail the previously created safety environment. Also consisted of some actual life even questions: What happened in their life since we haven't met? A brief reminded about their rights and ethics of the research

I timed the interviews not to take more than 45 minutes in order to maintain the full range of focus of the participants. After the interview, I gave the participants a few minutes pause before we moved to the next task.

3.3.4. Positioning:

Before engaging in the introduction of the participants and proceeding to the analytical chapters, it is necessary to consider the positioning of the writer in this thesis.
The notion of colonialism, cultural awareness, cultural competency and certain limitations will be discussed in the following section.

3.3.4.1. Colonialism:

Colonialism influences the language and analytical strategies of western research works, therefore it can be a challenge for ethnographic researchers.

Since the topic of this thesis touches the domain of cultural differencies, I would like to start this section with Good's (2012) statement: There is a dichotomy regarding the "subject" that divides "us" from "them". Their "beliefs" and our "knowledge" shows a discounting attitude from "our" side. Subjectivity, in Good's (2012) work is not one rigid item, but a constantly forming material, which returns to the complex interplay of the bodily, linguistic, political and psychological dimension of human experience (Ibid).

In psychiatric anthropology, the ethnographic subjectivity is an essential element. The postcolonial approach towards disorder is problematic and perceived as the primitive and bestial characteristic of the "Others' (Good, 2012). However, this colonialist view is not only prevalent between different cultures. Hoffman (1992) claims, that the result of colonial mentality is that we take psychological categories and research methods for granted, as an objective representatios of truth. In this form, therapists and scientist embodies the ultimate carrier of truth and knowledge, what leads to a form of "practicing down" system (Kearney et al, 1989, McNamee&Gergen, 1992, Hoffman, 1992).

Being aware of this, in this thesis, I did not seek to get access to the participants original diagnosis, nor questioning their knowledge and/or attitude towards mental health care and problems. I payed attention not to view diagnostic categories (if the participants got

any) as ultimate representation of their distress, but if they were satisfied or content with explanation they got from their therapists.

However, there are some concepts this thesis takes for granted. Hence, the purpose of the research is the individual interpretation of traumatic experiences and the way they can fit it into therapeutic sessions, the thesis does not question the competency of the professionals in the Danish mental health care system.

3.3.4.2. Cultural Awareness:

As refugees fleeing from their country due to numerous reasons, both them and the host countries citizens face a certain situation: to interact with people of different cultural backgrounds. Culture acts as a filter, encodes and decodes messages and behavior. It is a commonly shared way of certain group of people, regarding beliefs, values, ideas, norms, customs (Pilhofer, 2011; Papadopoulos, 2006). As Pilhofer (2011) states, these intercultural interactions can turn into a mutual misunderstanding if the participants perceive the other's perspective similar to his/her own (Pilhofer, 2011). Cultural awareness is the realization that different individuals from different cultural backgrounds might value same principles, but interpret those in a different way (Papadopoulos, 2006).

According to Lambert & McKevitt (2002) the notion of rationality is only accurate in its local context and shows socially and culturally specific variations. Nonetheless, in health care, it is not a widely accepted perspective, due to the biomedical approach, which can restrict different cultural rationalities into "their beliefs" and "our knowledge" (Lambert & McKevitt, 2002:211).

3.3.4.3.Cultural competency in health care:

In order to avoid such misunderstandings, a better approach is to apply the knowledge of experts and the knowledge of people as flexible variables that can be used simultaneously for a more appropriate practice (Lambert & McKevitt, 2002).

As Papadopoluos (2006) claims cultural competence is the capacity to provide effective health care, taking into consideration people's cultural beliefs, behavior and needs.

Fernando (2005) emphasizes that in the UK, healthcare professionals can deal better with this problem if they see the refugee patient as a member of his/her ethnic group, rather

than one of the masses of refugees. This approach of providing mental health care to refugees based on their ethnicity is also supported by the common observation, that refugees often seek alternative help among their ethnic group, rather than searching for help in a more homogenous 'refugee' platform or the provided western healthcare (Fernando, 2005; Guribye ,2008).

Knowing the "other's believes", however, is not enough to provide efficient mental health care, claims Bhui et al. (2007). The focus is on how culture alters the illness perceptions, behavior and engagement in different therapies (Bhui et al., 2007).

Cultural awareness in itself is not sufficient, it has to be an active inductive-like process how non-western cultural background patients are handled. In the following, the main aspects of these cultural analyses will be discussed (D O'Neil, 1997).

One last thing should be mentioned before the reader engages into the Analytical chapter. Steven's story, about his wife missing due to human smugglers is not the first time that emerged during my research work at Aalborg University - Copenhagen Campus. A year ago with my group members we interviewed a man from Afghanistan and he shared the exact same story with us, except the locations. Thus, Steven's answers are going to be handled carefully, but won't be eliminated.

IV. Analysis:

The Analysis chapter is divided into two main section:

First a historical introduction of trauma is included. The evolution of trauma definition and the changing social discourses around it are needed to be explained in order to understand the participating psychologist' interview, which shows great overlapping between approaches towards trauma and refugee's mental health care.

The second section will analyse the participating refugee's interviews. In the Theorethical framework at the end of each section the reader was introduced to the leading questions. These questions are grouped into four groups, that give the four main point of the analysis. The grouping principles can be found at the beginning of the second analytical chapter.

4.1. The genealogy of trauma:

Introducing the genealogy of trauma has an important role in this thesis. Its aim is to present, how a taken for granted notion changes according to different clinical and social discourse effects. It is also important to emphasize these influencing processes, as in this thesis it is not in the focus of investigation whether the participants' have any kind of diagnosis, nor if their diagnosis fits with their symptoms.

In this section the evolution of trauma will be discussed both in clinical diagnosis and social phenomena. First, the diagnostic route will be introduced and later on its place in socal discourses. The third part of this section is going to introduce a critical view of the recent approach towards trauma and trauma related disorders, mostly following the work of Summerfield (2000). Finally, in the last part a Danish mental health care professional's interview will be analysed in order to show how social and clinical concepts and ideas overlap in actual practice providing refugees mental health care.

4.2. Trauma through history:

4.2.1. Trauma in psychology:

Trauma first was perceived as nervous system attack, due to micro lesions of the spinal cord. The symptoms and the term later was used by Charcot in order to pull out hysteria from the realm of gynecology and extend the usage to male patients as well (Fassin&Rechtmanm 2009).

However, it was Sigmund Freud and Pierre Janet who introduced the term 'trauma' into psychology, with Janet stating that hysteria is a consequence of a psychic trauma (Fassin&Rechtman, 2009; Herman, 1992).

In his dissociation theory he claimed the role disturbing factors and their effects on the self integrity, however Janet did not attempt to explain trauma in detail (van der Hart&Horst, 1989, Fassin&Rechtman, 1992).

Freud took a different approach (altered several times from seduction theory till the development of fantasy theory) on trauma: He claimed that sexuality is a trauma in infancy

that gets triggered in adulthood, evolving into hysteria and other psychological problems (Herman, 1992)

However Janet's theory was the first attempt to bring trauma into psychological field, it was Freud who assigned psychological content to the notion of trauma, shifting the focus also on the emergence of trauma (Fassin&Rechtman, 2009; Herman, 1992). Deserting the sexual as original trauma theory, he claimed that trauma is caused by an external agent and it shows up in the individual's psyche. By external agent, he meant any event that expose the psyche to unbearable, intolerable conditions, which results into repression mechanism in order to protect the consciousness. This is the first time trauma as an organizing force appears in human psychology, emphasising that it is not entirely the external cause that is important, but the internal one, which alters and regulates the unconscious to deal with the problem (Fassain&Rechtman, 2009).

However, in the 1960's psychological terms it wasn't Freud's but Janet's theory that influenced academics and professionals, leading to the creation of PTSD, based on Janet's theory of dissociation (van der Hart & Horst, 1989, Fassain&Rechtman, 2009).

But before the reader gets introduced to the 1960's and 1980's events that led to the classification of PTSD, war psychiatry and its theories needs to be discussed.

War psychiatry, meant to deal with the soldiers' psych-problems during and after the World War I. had a harsh approach towards soldiers exposed by traumatic events. As during the war deserters faced death penalty and in times where suicidal behavior on the battlefield seen as heroic, trauma related mental health problems were grouped into two categories: The first one, referred as "Combat madness" was a pathologic manifestation of anxiety, panic and exhaustion, resulted into murderous insanity was seen as the highest form of patriotism (Fassin&Rechtman, 2009:42). The other one "trauma insanity" included other symptoms: unable to move forward and carry on the fights, seen as a coward act (Fassin&Rechtman, 2009:42). The diagnosis of trauma insanity hold soldiers as a born to be weak individuals, seen war as an option that brought our their weak side. Psychiatrists claimed that it was a pathological response to the sutiation, neglecting and refusing the idea that war itself is a traumatic event, that puts soldiers under unbearable conditions (Fassin&Rechtman, 2009).

The shift in this paradigm was brought by the survivors of the World War II. concentration camps. Holocaust therefore become an unavoidable point of trauma and its effect on human beings (Fassin&Rechtman, 2009; Herman, 1992). Based on the papers by

Bettelheim (1978), the diagnosis of trauma insanity or trauma neurosis was replaced by survivor syndrome (FassinRechtman, 2009). The symptoms were identical as those of trauma neurosis, but the suffering individuals mental weakness (or patriotic heroism) was no longer the question in focus. The main shift in paradigm was, that these symptoms were an outcome of a pathological event effects any kind of individual, and developing these symptoms were seen as a normal reaction to abnormal conditions (Ibid).

PTSD as a disorder was first mentioned in DSM-3. Due to several societal processes and push factors (elaborated later in this chapter) demanded psychologists and psychiatrists to re-new the diagnostic manual. Trauma neurosis was deleted from the manual and PTSD gained its own place among the diagnostic categories (Figley, 2012; Fassin&Recthman, 2009).

4.2.2. Trauma in social discourse:

The end of the 19th and the early 20th century the insurance industry started to rise, traumatic symptoms, and/or disorders, gave place for financial compensation (Herman, 1992; Fassin&Rechtman, 2009).

Therefore, outside of mental health domain, the social discourse was influenced by insurance interests that approached the sufferers with suspicion. Even a new illness category was introduced: sinistrosis - that claimed individuals heal slower from work related accidents if they are insured than those who doesn't. The insurance interests hold such a strong statement in evaluating these problems, that even the DSM-1 and DSM-2 was in favour of them, when it came to diagnose trauma neurosis (Fassin&Rechtman, 2009).

During the World War I the question of heroism and patriotism versus cowardice were in focus. As in the previous diagnostic chapter the reader could see, soldiers mental disorders were seen through two different lenses: the heroic suicidal, murderous insanity and the coward, unable to move one. As combat madness give emotional support and motivational powers to the fellow soldiers, trauma insanity decreased the moral of the troops, therefore by authorities it was seen as an unwelcome feature of the weak in mind individuals. Thus, healing these problems were not so much in the interests of professionals and authorities, but more to use psychological and medical tools to select out frauds (Ibid).

The events of the Holocaust changed the diagnostic features of trauma related disorders and gave credit to the survivors and started to change the social discourse around trauma exposed people (Herman, 1992). Following the survivor syndromes emergence the 1960's feminists movements attempted to give voice and credit of abused children and women were raped in childhood or in adulthood (Fassin&Rechtman, 2009).

The work of Florence Rush in raising awareness of abused children and rape against women and the anti-psychiatric movement pushed the American Psychiatric Association to re-new their stands on diagnostic criterias (Alcoff, 2006; Fassin&Rechtman, 2009). Therefore, in 1980 in the DSM-3 PTSD appeared without any negative connotation regarding the one who is suffering from it, expanding the possible subjects from the mentally weak to any human being (Fassin&Rechtman, 2009).

4.3. Trauma and PTSD nowadays in refugees' life

PTSD can affect any age group and it is usually the following disorder of traumatic event. (Figley, 2012, DSM-V). It appeares after the individual experiences a traumatic event and causes disturbances in the individuals day-to-day life (Figley, 2012; Maxwell, 2012). The cause and why traumatic events result into PTSD is unknown. It changes how the body and mind react to stress, thus negatively influence day-to-day tasks (Ibid).

Several studies pointed out how PTSD can influence the refugee's integration and their life in the new host countries. However, in contrary, Yehuda & McFarlane (1995) argues that PTSD is a rather rare response to trauma and even those who went under horrible conditions not necessarily develop this syndrome. And as Taylor (2006) claims, forced migration can, but not necessarily causes mental illness. Supporting this, Guribye (2008) states that the prevalent rate of PTSD among refugees is around 9%, far less than the previous studies claimed.

Stating Watters (2011) again, the generalization of psychological problems and handling refugees as a homogenous mass of people exclude the possibility to explore how refugees express their distress and exclude possible emerging categories. Neglecting the importance of their interpretation might disable their treatment engagement as they don't find it as an adequate solution to their problems .

As Guribye (2008) emphasizes, even in the same socio-cultural background there is a great variety how people think about these matters and when it comes to a different cultural background this gap between the interpretations is growing.

4.3.1. Trauma in recent dialogues:

Trauma is a sudden, potentially deadly experience with the potential of leaving long lasting physical and mental damages (Figley, 2012). It can cause by natural or human-induced disasters, loss of a beloved one, social and psychological deprivation (Maxwell, 2012). The "word" trauma bears two different meanings: one is rooted in the domain of mental health as "traces in the psyche". Other, more broad meaning is a damage on the society's collective memory (Fassin, Rechtman, 2007, p. 2.). As a social phenomenon, trauma is constructed and interpreted through a conventional societal filter (Maxwell, 2012). However, Fassin&Rechtman (2007) argues that the two usages of the word are often used interchangeably, without indicating the difference. In this way "trauma" became a shared truth of the contemporary world (Ibid). Contemporary Society accepts physical and psychological damages the same way. Today trauma is a legitimate status, furthermore a new condition of victimhood. This recent view has been evolved through the above presented historical discourses, from a state of suspicion and perceived weakness to an unquestionable proof (Fassin, Rechtman, 2007).

This universality or communion in trauma is created through two different approaches in recent days: humanist and radical angel.

The humanist approach emphasizes the ability to understand other humans and their experiences through our own, which creates a degree of sensitivity towards the victims (Fassin, Rechtman, 2007). The radical or critical approach assumes an identical traumatic core in all society. It might take different shapes (events, violence), it always comes from the same root (Fassin, Rechtman, 2007). Taking either approaches Fassin&Rechtman (2007, p.19.) says that the universalization of trauma results in its trivialization. Degree, history, and context of the trauma vanishes, no difference between the form what reached to the individual (Fassin, Rechtman, 2007).

4.3.2. Critical view:

This supreme and unquestionable prevalence of trauma has been criticised by Summerfield (2001) stating that PTSD had not been discovery, but had been invented. Thanks to societal and political impacts the focus has been shifted from the individuals' psychological history to the traumatogenic nature of war (Ibid). As Fassin&Rechtman (2007) says during the univerzalisation of trauma it losts its characteristic such as degree, context.

Summerfield (2001) also argues that the usage of PTSD encouraged only by the impact of the traumatic event, excluding psychological history, older and recent conditions and cultural background of the patients. Summerfield (2001) goes further in his argument, claiming that the notion of distress and trauma became interchangeable, thereby broadening the application to commonplace events. Therefore the boundaries between the individuals' experience of reasonable risk and traumatic impact has been vanished (Ibid). The promotion of the category also leds to a self-fulfilling prophecy: in order to fit into a pre existing category patients will realize what they feel and what they have to say (Summerfield, 2001). This challenges the nature of the victims' experience, what is normal and what is psychopatological (Summerfield, 2001).

Summerfield (2001, p. 97.) also questions the objectivity of PTSD, claiming the unlikely assessment of the disorder that assumes "time and casualty move from the traumatic event towards the criteria and the event is specifically expressed in the content of the symptoms". As other disorder categories has a multficatorial pool of causes, PTSD excludes factores and enchances only one cause. Thus the diagnosis does not work with the patients' psychological history, behavioral and responding variations and tendencies. One peculiar characteristic of the PTSD diagnosis could be the procedure how survivors process detrimental experiences and what meanings they attribute to them. Notwtihstanding no psychiatric category captures that (Summerfield, 2001). Rather trivialize the cause into a single universalized phenomena and show no interest in the patients' experience and its expression.

4.3.3. Narratives of professionals:

As this theoretical framework started with the notion of human experience, it has to be stated that intervention, providing therapy is also an experience , the experience of the professionals, that also seeks to be narrated.

The feature that distinguishes the professional narratives that in some way they have to be emergent from commonplace narratives in order to be worthy to tell (Pollock, 2000). They possess two main characteristics: first, they are narratives, therefore all those principles can be applied to them as well. Second, however, they are acting according to the narrative principles, these narratives "are social acts of representation that are part of the public construction of the domain of medicine (Pollock, 2000:109).

4.3.3.1. A professional's view:

Peter represents the mental health care professionals in this paper. As a therapist he needs to position himself in the interplay of socio-political processes and health care approaches. The interpretation of psychological trauma is influenced by political, human rights movements and as part of the health care, economic decisions as well (Herman, 1992). In this multilayered scene therapists need to find their way to provide adequate mental health care.

<u>Basic problems of refugees' mental health care:</u>

Peter stated the language barrier first. Not speaking fluent English is a big concern for him and the problem is even more detailed when the patient can't speak English at all. The possibility of using translators often limited.

It is also problematic if they have the same idea about the goal of the therapy or the same definition of notions. "*Their understanding of mental health and furthermore therapy is different". " It happens that they get a diagnose here and they claim they got something else back in their country*, *However, we can't check the previous diagnose, Without precise documentation, we can't do anything*".

The question of time is also a complicating factor. Asylum seekers and refugees have already experienced prolonged time -issues throughout their application process. Facing the situation that mental health care is also a time consuming phenomenon can cause distress, which results in the abrupt ending of the therapy sessions. *"Most of the time I can see they are not so thrilled if we need another session."*

The way how patients look at psychologist is also an influencing factor for the effectiveness of the therapy: *" They think I'm a doctor and I am not. [...] I try to tell them the difference between psychiatrist and psychologist. It usually helps. [...] But it can happen, that because of this they stop coming to the sessions, seeing it as not useful.* "

Refugee status or ethnicity:

As it unfolds from Peter's interview there is not a certain separation between the two categories, that would define different approaches. Taking culture into consideration is the basis of the therapy, any additional request depends on the patient.

If the patient indicates he or she would prefer the therapist to focus on certain aspects of the experience of fleeing, being a refugee. As Peter states *" I focus on the person. I try not to hold pre-conceptions. [...] But I think it is the same generalized category, ethnicity vs. refugee*". In this sense, the therapy's dynamics will determine the approach and the focus, not a pre-constructed transcultural approach.

Continuing therapy:

In order to continue a certain therapy, mental health care professionals need the previously recorded medical, treatment history of the patients. It is also the case when they are about to establish a new support session.Using one of the quotes from earlier: "*However, we can't check the previous diagnose. Without documentation, we can't do anything"*.

Choosing a certain type of therapy is based on detailed medical and mental history and categorization of symptoms. Therefore every individual seeking psychological help in Denmark has to go through the formal ICD-10 recording. After being referred to the mental health professional it is the therapist and the patient mutual decision what diagnostic tools they will use.

According to Peter, cases regarding medications are quite prevalent. Patients claim they were prescribed a certain type of medications (in his interview the mentioned one was antidepressants) and they would like to continue with that treatment. In Peter's case, he is a psychologist who can't prescribe medicine and as he stated earlier, based only the patient's claim they cannot use psychopharmacological substances nor therapeutic methods.

Therefore there is no distinctive approach between the treatment of problems caused by the fleeing or already existed psychological problems.

The conclusion here is that therapists need to follow certain institutional guidlines, such as diagnostic materials and classification of symptoms, but within the therapy's framework they can provide a more personal approach. But, as it reveals from Peter's interview, refugees attitude towards therapists sometimes not favorable for therapeutic processes. Peter claims he is seen as a doctor, attributed with different skills and different scope of expertise.

4.4. Refugees' trauma experiences:

The next analytical section will elaborate on the participating refugees trauma and therapy experiences. At the end of each Theoretical section a number of questions were indicated. Those questions are going to lead the structure of this section.

First the participating refugees definition of trauma and their traumatic experience will be presented, following by how that traumatic event can become a meaningful, life altering life-event. The role of social context will follow and last, the ways of inserting those expereinces into therapy will be investigated. Under these topics the paticipants' case studies will be analysed one by one.

1. Emerging trauma - the self become aware of itself
- What is perceived trauma in general/threatening to their psychological integrity?
- When and what is the point in the refugee's life when they became aware of the problem?
2. Constructing the problem and the expression
- How do the participants separate this experience form the rest of the stimuli?
- What is the procedure refugees use to create a coherent expression of their problems?
- What are the building blocks in their trauma expressions?
3. Social context - altering the story based on the audience
- How does refugees' narratives changes according to their audience?
- With whom do they share their experiences?
4. Different interpretations - inserting experience into therapy
- How do refugees' see their therapist's position?

- How can they fit ther interprtation of certain categories with the therapist's interpretation? If it doesn't fit, why not?

4.4.1. The emerging trauma - realizing and vocalizing the problem

John:

John as an orphan from Sudan faces a lot of assumptions about his traumatic childhood. *"Being a kid in my hometown is quite traumatic. I am an orphan. So being an institutionalized foster child, life is not easy. No, but you know, it wasn't traumatic. At least i don't think so. I know everyone whom I tell my childhood story think, oh John, it must have been horrible and terrifying. No. It was hard, but as i told you. I wasn't abused in anyway.*
It shows that for John living through hard times in itself is not a traumatic event. However, he has a hard time with semantic separation. He calls it traumatic, but also negate that it would be a trauma for him, emphasizing the lack of physical abuse.

As he answered to the question What is trauma?: "*Trauma is an event that influences your life negatively. Either by physical means, or mentally*".

According to John hard life circumstances are not enough reason to be traumatized. As we proceed in the interview he shares his traumatic event: *[...]"Can i say that therapy was traumatic? [...]Yeah, I hated therapy*". This is not the first time he indicates his negative feelings regarding the therapeutic sessions he had to attend as a teenager. During the second meeting he elaborated in details how much he thinks the therapist tried to put him into a certain "refugee" category.

He claims that those therapeutic sessions were only proof that he cannot be understood. He felt a constant pressure to answer to a question he was not aware of.

Sarah:

Sarah's problem was clearly articulated from the beginning of the first interview. The topic of motherhood was prevalent in her speech and narratives. The second interview was

the same. She referred back to the first occasion, saying, for her it is still the main concept she organizes her life around.

According to her trauma "*is when something bad happens to a person. A serious accident, death..[...]"* She made a difference between trauma that is happening to the individual itself and the one that happens to a loved ones: *"If you have an accident and you have injuries and if something bad happens to someone close to you* [...] *It hurts more if bad things happen with someone you love"*. In her understanding evaluation of the trauma depends on who is the receiver, as she is not that concerned experiencing trauma, as long as her core role as a mother can be fulfilled: "*If it happens to someone else, you can tell them to be calm, you can tell them it will go away, but you can't make it go away"*.

However as a personal trauma she states that she is scared not being able to take care of her family. Shifting from negative physical characteristics of trauma (serious accident, death) she indicated a loss of control in her motherhood: *"I told you before that I was depressed because I was scared I can't be able to take care of my kids"*.

Steven:

Steven's definition of trauma was the following. *"Bad thing happening to you. Something huge that..[...]makes you weak or sad or do bad things with your body and mind. If it's the body, it hurts. If it's the mind, then you become not right. Weak."*

As a personal traumatic experience Steven brought up to topics: *"In Afghanistan life is not easy sometimes. You feel hopeless. And when we came to Europe, the road was hard. And I was really sad when my wife went missing"*.

Steven is the first participants, who does not perceive his mental health problems problematic. He seemingly does not mind to talk about his psychological problems, regardless he claimed it is seen rather negatively in his home country.

What is hard for him is talking about his journey from Afghanistan to Europe and the loss of his wife. As he seemed upset during these questions, I decided not to focus on directly. This avoiding behavior can be seen as a symptom of a trauma-related problems.

Adam:

Adam explained trauma as a negative event that changes people and their lives. As he states : "You can't be with your friends and family. Because you are not yourself, you can't be with those people. And you can't meet with new ones [...]Because you are not yourself [...] If you are not yourself, than you made mistakes. You are rude, or not patient, or you talk too much about yourself". As A traumatic event Adam mentioned the time period when he left Syria and came to Denmark. He refused to elaborate on the details of how he came here, but he shared his feelings of being anxious.

4.4.2. Constructing the problem - trauma becoming an experience

As John says the interview, he had physical symptoms before he was referred to therapy. Sleeping and eating problems, however, he did not seem these problematic. He talked about it to his caregiver, but did not think it had a huge impact on him. The problems started when he entered therapy. He felt he is under surveillance, and he had to solve something he didn't know the answer: *" When you are a kid, you want to answer adults. You have been brought in a way, that you have to tell adults what they want. And if you can't do it, you feel you have failed [...] Talking to someone who doesn't seem to understand you".*

Sarah:

Sarah's explanation of her experience is dense. She is afraid she will not be able to take care of her children at some point. Her story started with problems at her workplace. An emerging fear of not being a good mother: " *I had depression episodes [...] I was heavy in my head. [...]I had no pain, no problems to sleep, to eat, nothing".*

In her understanding, being a good mother means she is there in every aspects of her family's life. As her narratives display, her fear is that she and her problems (let those be physically or mentally) will raise into a priority place in her family's life.

What is interesting in Sarah's narrative, is that according to her, she was never unable to act as a good mother in her understanding. She was afraid, her physical problems (perceived depression) will lead to that traumatic experience. Thus she seeked help before she had to face a trauma, both in Syria and Denmark.

This preventive behavior calls for a quite clear understanding of what kind of experience is traumatic to her. It does not mean this is the only experience (not taking care of

her family) that can be traumatic to her, but it shows an active self working for the stability of the individual.

Adam:

For Adam leaving his home and coming to Denmark was the experience he labelled as trauma. He also mentioned that when he was on the road to Europe, he did not think that much about the future and why did he have to leave his home. According to him because he had to be on the move constantly, he did not have the energy nor the mental capacity to think about his problems in details. He also explained that when he reached Denmark, his problems did not disappear at once: "It is not easy here either. But you know it is not the same. Here you have to learn about the people, the language, how they do things. But back home is crazy. Here you can do things. There no."

Steven:

Steven is the only participant, who verbalized his traumatic experience only on the third meeting. Before he did talk about his depression, but it didn't seem as a life altering experience. Furthermore, on our previous meetings he refused to talk about the reasons why they left Afghanistan. Mentioning his missing wife also happened the first time during our last interview.

It was rather hard to do the interviews with Steven. He replied in really simply sentences, shortly. However this thesis did not analyse the act of speech, comparing Steven to Adam showes great differences: Adam had problems with english, most of the time lack of words or grammatic sturcture. Still, Adam had the intention to share his story. Steven showed a kind of resignation.

4.4.3. Social context - altering the story based on the audience

John:

John said he never told his feelings about not being understood because of therapy to anyone else. Not to his friends, nor to his care giver. When I asked him, if he told the therapist that he has these certain problems, he claimed again that as a child, you never question an adult. *"Every week you just want those days to pass, just to get it over with"*. When I asked what

did he tell to the therapist, he answered: *"I told her what happened with me in the last week. That was what we did all the time She asked, what did i do and i replied. It was a waste of time. Always with big pauses after I said something. Don't get me wrong, it's not like it was scary. It was annoying and frustrating [..]It is frustrating when you talk, but the other does not seem to understand you. Especially, when you get repeated questions all the time*."

At the time of the therapy, John did not share his feelings to anyone else. When I asked him, if he shares it nowadays, he replied: *"Not with many people. Of course I tell them how I came here, I was in therapy, It was bad [altered by the author], I hated it, but not much"*. (But you work with refugees, do you explain mental health possibilities to them?) Yes of course. I tell them, if they feel bad, they should see a doctor or talk with their friends, but don't keep it in themselves (Would you suggest this to your old self?) [...] no need to. If I would have parents that time, most probably I would have shared my problems with them. I don't see the purpose of thinking about if's and what would have happened.

Sarah:

Sarah shared her story and fear with numerous people. In this sense Sarah' relied on her social network at its finest. She first relied on her mother, then female friends and before seeing a therapist, shared her concerns with her husband. We can find an explanation for this order in a later part of her interview: She asked for a female therapist. However, Sarah denies that she explicitly asked for a female therapist, as she articulates, she had been offered with that option. *"Because a woman understands better when it's about children. What can I talk about them with a man?"* In her mind having kid as woman was not even important, as she sees other females as individuals, who shares the same value system and can relate to her problem: *"I think I can talk with you (the writer) more about kids and giving birth than with a man therapist. He will never give birth, so I think it is a big difference."*

Her search for audition started with the person who was the closest to her and who could rely to her experience: her mother. Then she went on to female friends. Her husband was only before she went to therapy.

Adam:

Adam is keen to share his story with people. It was one of the reasons why he agreed on to participate in this interviewing. Similar to Sarah, he seems to use his recent social network as

much as possible, considering his roommates advices: “How did your environment (firends, family) react when you seeked mental health care in Denmark? - *I did not tell everyone. Just the ones know who suggested it to me*”.

With his therapist, Adam is focusing on his recent life here: “*I told you last time. So he can help me to be in the Danish society [...] He helps you to understand the culture*”. Adam’s core interest lies in how he will carry on with his new life in Denmark.

His conversations with his roommates are slightly different in topic: *“We share our stories. You know, there are a lot of ways to come to Denmark. Different Stories*”.

Steven:

When I first met with Steven, he applied for therapeutic counselling, but had not participated any. By the last time, he was an in an ongoing therapy. As it was mentioned previously, it was rather hard to do the interview with Steven. Based on his answers, his approach towards both therapy and therapist is really formal, furthermore he did not indicate any difference in style when he talked about his problems with his family.

Steven showes how the broken narratives of illness and trauma needs time to get organized into a life-story. It seems his fleeing is a bigger trauma him than his depression,even tho he emphasize how important to him to get better. He only talks about his wife’s disappearance in a few, short words. As Crossley (2000) stated, well structured narratives regarding traumatic events and experience is the sign oof healing, not the beginning of the process. According to this, Steven is still in the merging phase of traumatic experience, and Steven’s self hasn’t started it’s self-regulatory work yet.

4.4.4. Different interpretations - inserting experience into therapy

John:

When I asked John if he feel he could fit his problems with the therapist’s, his answer was a straight no. As he said above, the interpretations and understanding were so different, that actually started to frustrate him, giving him a constantly emerging problem from week to week, when he had to go to the therapy. He did not tell these problems to the therapist, nor did she explain the situation or the reasons to him. This lack of colliding interpretations caused him more trouble than his sleeping and eating problems. “*What happened to the*

physical symptoms? Those are disappeared, by themselves. After a fee weeks. How long were you in therapy? Few months." Even though he was referred to a therapist because of signs of psychological distress, he lived and perceived therapy as a more disturbing experience.

Sarah:

Sarah is the only participant who seeked help at two therapists with her problems. The first occasion took place in her hometown.

During our first meetings she called the first professional as therapist, however the last time she called him a doctor and claimed she has never seen a mental health care professional in her hometown, only in Denmark.

In the followings I will call the first professional doctor, as she did. She told her doctor her physical symptoms and her fear that due to these symptomy she cannot take care of her family. Her doctor told her, that she has depression. If her depression is treated, than her fears will disappear.

Her second occasion with a therapist happened in Denmark. Sarah had clear intentions what she wants: To act before anything traumatic can happen to her. She explained it as: "*In Denmark you have to wait a lot. Who knows… Weeks. What if I get really sick? What will happen with my kids?"*

What the reader can see from Sarah's case is that she did not aim to make her understanding of trauma meet the therapist/doctor's definition. She separated her narratives: the ones she tells to her family/closed ones and the official version. It has to be mentioned, that unlike John, Sarah did not participate in an ongoing therapy session, nor gained the traumatic experience.

What is interesting though that her expression of the perceived traumatic event has changed. Her memories show her less accurate and demanding during her first meeting with the doctor in Syria, than going to the therapeutic session in Denmark. As in Syria her position seemed more subordinate: *"we agreed on that if it gets harder for me, I can go back and I can be referred to helping groups"*.In Denmark her intentions were clear and rather demanding: *"When we were in the center, you had to wait to get to the Red Cross. And i thought it is better to do soon. [...] She (the therapist in Denmark) was a bit confused, what I want. But it was fine in the end. [...] But I explained and she gave me ideas where to go if i need support."*

Adam:

Adam is keen on to share his story of journey with others. He personally asked for a professional, with whom he can talk, and as he claimed they exchange their stories all the time with his roommates. However, it seems he does not try to fit his trauma or illness experience within the therapeutic framework. He does mention once, that he talked about his way to Denmark to his therapist, but he mostly highlights future-perspective topics, such as integrating into the Danish society, or learning about the new culture.

Steven:

Based on Steven's emotional reaction, my expectations were that with his therapist the main topic they discuss is his wife's disappearance and their fleeing from Afghanistan, On the contrary, not even his severe depression is mentioned during the therapy sessions: "*We talk a lot. [...](about)How I'm doing. [...] What did I do, how is it with my new job and flat*":

Out of all the participating refugees Steven seems the only one who does not have any future perspective or goal to aim for.

4.4.5. Discussion:

In this last section of the Analysis chapter the research questions are going to be answered based on the above described findings.

This paper focused on traumatic events in refugees life as a form of experience and how it can be inserted into therapeutic sessions in the host country. In order to understand these issues the following questions had been investigated:

- Along what guidelines does an experience become traumatic for refugees?
- In what way can refugees translate their trauma experiences into a therapeutic framework?

In this paper two kind of guidelines emerged: A general definition of the participants, when all of them stated that trauma is something negative and painful. Elaborating on their personal experiences however, showed a more precise picture. In two cases (John and Sarah)

participants did not even had to be exposed to the traumatic event, the possibility of the trauma related outcome indicated traumatic experiences.

Following the construction of the problem section's findings, one can talk about the emerging self-defending functions. In case of Sarah, it is an active engagement into preventive behavior, contacting a professional right before anything could happen. Also a future aiming approach can be seen in the case of Adam. Adam seemingly does not have any trauma, at least not according to this paper's interpretation.

John jumps back into the past, claiming that the way he was raised as a kid (assuming the absolute authority of an adult) made him unable to break the traumatic therapy sessions.

Steven's case is unique. He could be the individual who has been exposed trauma and most probably has some kind of trauma-related problems

Translating trauma experiences into therapy:

Examining the participants answers one can say, that the translation of refugees' trauma experience is influenced by their original motivation of why they are in therapy. Sarah and Adam are satisfied with the way they interacted with the therapists, and their explanation and expectation of their problems have been handled adequately. It is also important, that their connection with their therapists seems satisfactory, adjusted well to the task, perceived by Sarah and Adam.

John, who was sent to therapy, can not say similar positive things. Through his case one can conclude that missing mutual interpretation of notions can entail serious consequences, as in John's case therapy itself became the stressor.

5. Conclusion

In this paper the reader got introduced the notion of human experience and in what way can those experiences gain meaningful positions in an individual's life.

A new interpretation and approach of trauma was also presented, handling trauma as an experience. The basic standpoint why trauma was seen as an expereince, because they

posesses similar characteristic. But the main reason for this semblance was to broaden the definition of trauma, enrich it with the refugees own interpretation.

Here, I would like to reflect on Summerfield's (2001) critical view on the omnipresent characteristic of trauma. As Summerfield (2001) argues, that trauma gained an uneven significance, I would like to mark a line between this paper's effort to expand the notion of trauma and what Summerfield (2001) criticizes. This paper does not state that every life-changing experience falls in the category of traumatic event and refugees experience traumatic events in very segment of their lives. The reasoning behind this definition expansion is, that in that way trauma can be interpreted freely from the established diagnostic criterias, allowing social constructionist processes to shape it.

This thesis' findings shows how one can gain more specific and layered definition of trauma, if we give space to the individual for interpretation. Also, therapeutic progress and mutual understanding with the therapist can be influencing regarding therapy experience, however, motives and goals of the participants also requires attention in order to understand the whole scene.

6. Bibliography

1. Alcoff, L. M. (2006): Visible identities: Race, Gender and the Self, Oxford University Press
2. Al-Krenawi, A., Graham, J.R. (2000): Culturally Sensitive Social work practice with arab clients in mental health settings, in: Health & Social work, Feb 2000; 25, 1.
3. Bhui, K., Warfa, N., Edonya, P., McKenzie, K., Bhugra, D. (2007): BMC Health Services Research, 7:15
4. Bruner, E.M. (1986): Experience and Its Expression, in: Turner, V.W., Bruner, E.M. The anthropology of experience (1986), University of Illinois Press, Urbana and Chicago
5. Bettelheim, B. (1978): The Holocaust,in: Encounterm Dec, pp. 7-18.
6. Bryman, A. (2012): Social Research Method, Oxford University Press
7. Budman, C.L., Lipson, J., Meleis, A.I. (1992): The cultural consultant in mental health care: the case of an arab adolescent, in: American Journal of Orthopsychiatry 62(3), July, 1992
8. Carr, D. (1986): Time, Narrative, and History. Bloomington: Indiana University Press
9. Charmaz, K. (1995): Grounded Theory, in : Smith, J., Hare, R., Van Lagenhove, L. (eds) Rethinking Methods in Psychology, pp. 9-27, London: Sage
10. Cheng, F-A., Williams, P. (1986): The design and development of a screening questionnaire (CHQ) for use in community studies of mental disorders, in: Psychological Medicine, 16(2), pp.415-422
11. Crossley, M.L., (2000): Introducing Narrative psychology: self, trauma and the construction of meaning, Open University Press, Buckingham
12. D O'Neil, T. (1997): Psychiatric Anthropology and Psychiatry, in: Anthropology Newsletter, Vol. 38., Issue 2., p:17.
13. DSM-V: Diagnostic and Statistical Manual of Mental Disorders 5th edition, APA
14. Erikson, E.H. (1993): Childhood and Society, W.W. Norton & Company
15. Fassin, D.; Reichman, R. (2007): The Empire of Trauma: An Inquiry into the Condition of Victimhood, Princeton University Press
16. Fernando, S. (2005): Multicultural Mental Health Services: Projects for Minority Ethnic Communities in England, in: *Transcultural Psychiatry* September 2005 42:420-436,

17. Figley, C.R. (2012): Posttraumatic Stress Disorder, in : Figley, C.R. (2012): Encyclopedia of Trauma: An Interdisciplinary Guide, SAGE Publications
18. Good, B.J. (2012): Theorizing the 'subject' of medical and psychiatric anthropology, in: Journal of the Royal Anthropological Institute, Vol. 18(3), p:515-535.
19. Good, M-J D. (2013): Perspectives on trauma and healing from anthropology and social affective neurosience, in : Transcultural Psychiatry, 50(5), pp. 744-752.
20. Green, B. L. (1999): Defining Trauma: Terminology and generic stressor dimension, in: Journal of applied social psychology, 20: 1632-1642.
21. Guribye, E. (2008): Refugees and mental health interventions , Dissertation for the degree PhD at the University of Bergen
22. Hallas, P., Hansen, A.R., Stæhr, M.A., Munk-Andersen, E., Jorgensen, H.L. (2007): Length of stay in asylum centers and mental health in asylum seekers: a retrospective study from Denmark, in: BMC Public Health, 7:288
23. Hecker, T., Barnewitz, E., Stenmark, H., Iversen. V. (2016): Pathological Spirit Possession as a Cultural Interpretation of trauma-related symptoms, in: Psychological Trauma: Theory, Research, Practice and Policy, Vol.8, No.4, 468-476.
24. Herman, J. L. (1992): Trauma and Recovery - The aftermath of violence from domestic violence to political terror, Basic Books Press
25. Hunt, L.M., (2000): Strategic Suffering: Illness Narratives as Social Empowerment among Mexican Cancer Patients, in: Mattingly, C., Garro, L.C.(200): Narrative and the cultural construction of illness and healing, University of California Press
26. Jensen, N. K, Norredam, M., Priebe, S., Krasnik, A. (2013): How do general practitioners experience providing care to refugees with mental health problems?, in: BMC Family Practice, Vol. 14., 2013, p. 17.
27. Kirmayer, L.J. (2000): Broken Narratives: Clinical Encounters and the Poetics of Illness Experience, in: Mattingly, C., Garro, L.C.(200): Narrative and the cultural construction of illness and healing, University of California Press
28. Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K. (2011): Common mental health problems in immigrants and refugees: general approach in primary care, in: CMAJ, vol. 183 (12), 2011, Sep.6.
29. Kleinman, A., Kleinman, J. (1996): The appeal of experience: The dismay of Images: cultural Appropriations of suffering in our times, in: Daedalus, Vol. 125., No. 1., Social Suffering, p. 1-23.
30. Lacity, M.C., Janson, M.A. (1994): Understanding Qualitative Data: A framework of text analysis methods, in: Journal of Management Information System, Vol. 11., No.2., pp: 137-155.
31. Lambert, H. ; McKevitt, C. (2002): Anthropology in health research: from qualitative methods to multidisciplinarity, in: BMJ, 2002, 325:210
32. Marin, M.F., Lupien, S. J. (2011): Stress and glucocorticoid effects on learning and memory, in: Conrad, C.D., : The handbook of stress: Neuropsychological effetcs on the brain (pp. 248-265), Malden, Ma. Blackwell.

33. Marsella, A.J., White, G.M. (1982): Cultural Conceptions of mental health and therapy, D. Reidel Publishing Company
34. Mattingly, C. (1998): Healing dramas and clinical plots: The narrative structure of experience, Cambridge University Press
35. Mattingly, C., Garro, L.C. (2000): Narrative as Construct and Construction, in: Mattingly, C., Garro, L.C.(200): Narrative and the cultural construction of illness and healing, University of California Press
36. Meier, L. 2010: *Qualitative Methods*, in Barney Warf (2010): Encyclopedia of Geography.
37. Mérei, F. (2002): A Rorschach-próba, Medicina Könyvkiado Zrt.
38. Mitchell, J. (1999): Ideas in Context: Measurement in Psychology: A critical history of a methodological concept, Cambridge University Press
39. Papadopoluos, I. (2006): The Papadopoluos, Tilki and Taylor model of developing cultural competence, in: Papadopoluos, I. (2006): Transcultural Health and Social Care - development of culturally competent practitioner, Churchill Livingstone, Elsevier
40. Pilhofer, K. (2011): Cultural Knowledge - A critical perspective on the concept as a Foundation for Respect for cultural differences, Diplomica Verlag
41. Pollock, D. (2000): Physician Autobiogrpahy: Narrative and the Social History of Medicine, in:Mattingly, C., Garro, L.C.(200): Narrative and the cultural construction of illness and healing, University of California Press
42. Rattray, J., Jones, M.C. (2007): Essential elements of questionnaire design and development
43. Rettig, S. (1990): The Discursive Social Psychology of Evidence: Symbolic Construction of Reality, Plenum Press
44. Rózsa, S., Kő, N., Oláh, A. (2006): A személyiségmérés projektív technikái, Bölcsész Konzorcium
45. Rózsa, S., Nagybányai Nagy, O., Oláh, A. (2006): A pszichológiai mérés alapjai, Bölcsész Konzorcium
46. Rusch, M.D. (1998): Psychological response to trauma, in: Plastic Surgical Nursing, 18:3, pp. 147-153.
47. Sarbin, T.R. (1986): Narrative psychology: The storied nature of human conduct, Westport, CT, US: Praeger Publishers/Greenwood Publishing Group Narrative psychology: The storied nature of human conduct.(1986). xviii 303 pp.
48. Seidman, I. 2013: *Interviewing as Qualitative research: A guide for researchers in education and the social sciences*. Teachers college press.
49. Shultz, D.P., Shultz, S. E. (2011): A History of Modern Psychology, Wadsworth, Cengage Learning
50. Smith, J. (1995): Semi-structured interview and qualitative analysis, in : Smith, J., Hare, R., Van Lagenhove, L. (eds) Rethinking Methods in Psychology, pp. 9-27, London: Sage

51. Soesilo, A. (2014): Trauma Experience, Identity, and Narratives, in: Buletin Psikologi, Vol. 22., No.1, Juni 2014: 1-17.
52. Summerfield, D. (1999): A critique of seven assumptions behind psychological trauma programmes in war-aected areas, in: Social Science & Medicine 48 (1999) 1449±1462
53. Summerfield, D. (2001): The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category, in: BMJ, Vol. 322, jan. 13.
54. Taylor, G. (2006): Migrants and Refugees, in : Papadopoluos, I. (2006): Transcultural Health and Social Care - development of culturally competent practitioner, Churchill Livingstone, Elsevier
55. Tribe, R. (2002): Mental health of refugees and asylum seekers, in: Advances in Psychiatric treatment, Vol 8(4), 240-247.
56. Van der Hart, Horst, R. (1989): The dissociation theory of Pierre Janet, in: Journal of Traumatic Stress, Oct, 2:397
57. Watters, C. (2001): Emerging paradigms in the mental health care of refugees, in: Social Science & Medicine 52 (2001) 1709–1718
58. Yehuda, R.; McFarlane, A.C.(1995): Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis, in: The journal of American psychiatry, 152.12(1995): 1705:13.

7. Appendix

7.1.Data collection:

I asked the participants to create a 10-word association list and write down the 10 first word when it comes to their mind about ’refugees’ and in the case of the other group ’psychologists/therapists’. The aim of this activity is to create a guide for coding for the narrative texts what I also asked later from the participants. However my sample is not enough to run a valid statistical analysis, the association list gives the opportunity to contrast the participant's view on a more quantitative basis between and inside the participations’ groups.

Since qualitative inquiries give better results if the phenomena are tested with several different tools, in my thesis I did not want to rely only on the usage of qualitative interviews. Therefore I also intended to do the narrative analysis. The data for this was the participant's self-created texts. The writing of these texts did not require my presence and I asked the participants to send me by email. I asked the participants to write these texts alone and send me via email. The reason why I do not want to make a third meeting session with them for this activity is that the first responses for the participating were slightly negative according to the meetings time-consuming features (First and actual interviews take minimum 40-45 mins each). However, two of the participants were concerned about that they can be tracked by their emails, therefore we came up the solution that they will type their stories on my computer, granting full anonymity. The aim was to make the participants create a coherent,

well-through think narration what I can compare to the interviews and also gain data from a different angle, but on the same studied phenomena.

From the refugee group I asked the 3 following question:

Please write down a, your first experience when you went to a therapeutic session in Denmark. b, an ideal therapeutic session you would like to participate and you think you could benefit the more. c, a possible bad therapeutic session you would feel inadequate.

From the professionals:

Please write me down a, a process of an average therapeutic session b, a session with difficulties that you perceived the hardest to solve c, a session when you feel the work reached a breakthrough and it was effective

7.2. Interviews

7.2.1. Adam

Adam

Adam in the end agreed to meet with me again and answer my questions

- what does it mean to you to be healthy?
  You feel good. No problems. (Problems like?) Pain, in your leg, head, arm.
- in your opinion what is the difference between mental and physical health?
  Don't really know. One is biology and the other is in the head? One is the body's sickness the other is i the head.
- what does mental health means to you?
  I don't have problem in the head. (what do do mean by that?) that i am not sic kin the head.
- what is the general view of mental well-being in your country?
- *laughs* not good. It means you are weak. You cannot work, or you are not good to your kids. (Not good in what way?) you cannot teach them, because you are sick in your brain.
- have you received any kind of therapy in your home country?
  no. just medicine when i was sick (sick in what way?) stomach pain, fever.
- how do you feel about that therapy?
  -

- have you seek alternative methods as well? social support, talking group, „empowering group”?
- How did your environment reacted when you seek mental health care?
- how do you feel about those alternative methods?
- when did you decide to seek mental health care in Denmark? What led to this decision?
  After my application. (What made you do that?) . I have nothing to do. I cannot work until my application accepted. I can clean and study english and danish. (How does it make you feel?) You do nothing. YOu just wait and wait all day. (who suggested you to go to a psychologist?) The others who have their application. They said it is good. Helps to understand things. (Can you get it until your application haven't been processed?). I need to go to the doctor. He will tell me what to do.
- How did your environment (friends, family) react when you seeked mental health care in Denmark?
  I did not tell everyone. Just the ones know who suggested it to me.
- How would you describe your experiences about it? Admission, therapeutic sessions, outcomes

- What were the most difficult aspects for you regarding the therapy? (language, cultural differencies, etc.) What do you think what is going to be the difficulties:

  Language. My english is not so good. And I do not speak danish. (other than that, like if you have experienced any difficulties during your application, do you think something can happen?
  If they do not listen to you, that is hard. (listen in what way?) when they dont understand what are you saying (you mean the language?) nono. You are coming from one place. it is a different country. Things are different. And it is important that they hear what you say, who you are.
- (if received therapy in both places): how would you describe the two different methods? What were the main differenceis for you?
- How did it help to you? What kind of outcomes did you get from the therapy sessions in Denmark?
- What are your thoughts about the future? How do you see yourself within the therapeutic framework?
  I hope it will help. (Help in what way?) To understand the danish people. (Can you make an example?) To understand how they think. It is good to know how people think

1. Association list: 10 first word that comes to your mind about psychologists/therapists
   a. doctor

b. help
c. head
d. thinking
e. refugees
f. camp
g. application
h. problems
i. sickness
j. sadness

2. Please write down a, your first experience when you went to a therapeutic session in denmark. b, an ideal therapeutic session you would like to participate and you think you could benefit the more. c, a possible bad therapeutic session you would feel inadequate

how do you imagine a first meeting with the psychologist?
He is like a doctor. He check me if I sick or not. And we talk. He can show me how to talk with the danish people.

3. drawing test: draw me a man draw me a mental patient draw me a therapist, draw me a refugee

Adam – 3nd occasion

Adam first cancelled the participation in the interviewing. However, later he agreed to answer the questions.

1. Can you tell me what trauma is?
A bad thing. It hurts and it is not good for you (Why is it not good?) Because you can't do certain things (Certain things like?) Working, sleeping. (can you tell me why it is bad if someone can't work or sleep?) This is not a good question (Do you want me to rephrase it?) Nono. But what can I say? Of course it is bad for you. YOu don't have money, you don' sleept. It is like not living your life. (Can you tell me other things that can go bad if you have trauma?) You can't be with your friends and family. Because you are not yourself, you can't be with those people. And you can't meet with new ones (Why not?) Because you are not yourself. (And if you are not yourself, how does it influences meeting with new people?) If you are not yourself, than you made mistakes. You are rude, or not patient, or you talk too much about yourself. these things.
2. Could you please share me a traumatic event/memory from your life?
Traumatic? (When something happened to you and you become not yourself. As you said earlier). Leaving Syria was hard. Really hard. You leave your home and family. And you don't know what is going to happen. (When did you decide to leave?) When the bombing got closer to the town. You can't leave there (Were your town hit by a bomb?) No. But who waits until the bombes come. No one. (Can you tell me how did you do it?) You ask around. I came alone. It is easier. You pack your things and go talk with the right people. (How was the journey?) I don't want to answer that question. (Sure, no need. ok, but could you tell me what did you feel when you left? what were your thoughts?) You are.. what is the word… not scared…not annoyed. Something with a and n (anxious?) yes! You ae really anxious. (What about the journey?) I didn't think much. You need to move all the time. Move and move. And

when you don' t move you are too tired to think. Sometimes you think what will happen, but when you move, oyu have osmething to do. So your mind is not that ffree to think. (And when you arrived?) I was excited. You have hopes, you know you are safe no bombs. (How was it when you arrived?) I was calm. Excited, but calm. (How do you think about your home situation now that you are here?) The same. It is still really bad there. it is not easy here either. But you know it is not the same. Here you have to learn about the people, the language, how they do things. But back home, is crazy. Here you can do things. There no. (So how did the journey changed you?) I don't understand. (You said that coming here was not easy, it was something you would call traumatic. And earlier you said trauma is something that changes you in a not nice way). Ahh, yeah. It didn't change me in a bad way. I have to be interested in the new things here.

3. When was the first time you talked about these feelings and with whom?
   I wanted to talk with a professional. About my experience coming here and how i'M doing here. (What was your reason to do so?) I told you last time. So he can help me to be in the danish society (What do you think a psychologist does?) A psychologist? (A mental health care professional) A doctor? (It can be a doctor). He helps you to understand the culture (Do you know how?) If i know I won't go. (And you already have been one session, righ?) Yes. (How was it?) I talked a lot. How i get there how i feel here and what i want to do. (What did the professionaliist said?) That I can tell him everythign i want. (what was the topic you talked about the most?) How i want to learn about danish things.

4. when you went to see a professional here in denmark, when was the first this tomic come up?
5. Was there anthing else you talked about with your therapist?
   no
   (Do you talk about your journey here with others?) Yes, with the guys I share the room. (And what do you talk about with them?) We share our stories. You know there are a lot of ways to come to Denmark. Different stories. (What are the differencies?) Someone came through italy, someone greece, osmeone hungary. Lot of places. (Any more differencies?) How long it is. (What about being here in denmark?) We all ant to work and learn. (And what doyou want?) I want to live in peace. I want to work and I want to learn danish.

7.2.2. Sarah

Sarah (29) married, two kids : girl (6) boy (3)
1st occasion: - general introduction. who they are? what are their stories? everything they would like to share with me (both past and present happenings)

- what are their expectations from the participating? Motivation (for the sake of setting up boundaries)
- explaining their rights, ethics etc. from my side and the brief purpose of my research

2nd occasion:

- Warm up: what happend to them since we met last time
- actual interviewing:

○ what does it meant to you to be healthy?

I have good health, i don't have pain, i can take care of my kids

○ in your opinion what is the difference between mental and physical health?

Hmm. I think mental health is that you don't have psychological problems, like me *laughs*
(And you experienced this?) I had depression episodes back home.
(How didi t happened?) I had my second kid, my son. And I think i was under a lot of pressure. I wanted to work -she was a receptionist- but i also wanted to take care of my kids.
(What were the certain circumstances that made it difficult?). I wanted both and i couldn't do. It was simple. So i started to be really, hmm how would you say in english. I was heavy in my head. I thought a lot about solutions how can i do both but i couldn't fins a solution.
(and how was it different than being physically sick?) I was healthy, I had no pain, no problems to sleep, eat, nothing. But i was always thinking. my head was always full.

○ what does mental health means to you?

That i can think clear. I can focus on the important things and not on useless ones
(Can you explain me what do you mean by useless)? If you have two kids and want to keep your job you should not think about how to balance. Cause you need your energy and focus to do it.

○ what is the general view of mental well-being in your country?

Not good. But it's not good anywhere, right? My family was and is suppoortive, so I had it good. But it can be seen that you are not a good mother to you kids. Or to your wife. Buta s i talked about women here, it is kinda the same here. You have to be there for them.

○ have you received any kind of therapy in your home country?

I went to a psychologist once
(As therapy?) Nono. We talked about possibilities.
(Possibilities of ?) Like, if these thoughts get worse, what can i do. If i should take medicine
(Did you take?) No, I was still breastfeeding, so I didn't want to do that at all.
(So what was the conclusion?) We agreed on the doctor, that if it gets harder for me, I can go back and I can be reffered to a helping group
(Whatk ind of group?) Mothers, who need some help. Not help like money, or with the kids. I mean, it is with the kids somehow, but I was completely able to take care of them. I just thought I might not be one day. And that frightneed me.
(Did you get any diagnosis?) No.
(And you didn't go back?) No. It didn't get worse. I still have it
(How do you cope with?) I talked with my mother and my sisters that this is ok, to have these thoughts. As long as it won't effect your real life.

○ how do you feel about that therapy?

It was nice I had that option to go back and now that there is actually another way than medicine. (How would you felt if you would have to take the medicine?) While i was breastfeeding, no. I don't even take painkillers. It efffects your kid.
(And if you don't breastfeed?) hmmm. that's another case. Depends. If it is so bad I can't do my daily life, yes. I don't think it is bad to take medicines. JUst during pregnancy or when you still have a hungry kid.

- have you seek alternative mrthods as well? social support, talking group, „empowering group”?

I have never went to that group. but i talked with women with kids, does it count? It is always nice to talk with somebody who is in your situation.

- How did your environment reacted when you seek mental health care?

It wasn't a problem. I think they would be concerned if i would take the medicine. It means that things are serious.

- how do you feel about those alternative mrthods?

I think it is a better way to deal it with your own and family

(Better than with doctors?) no, doctors are needed. But, if you can solve it with the help of people you are close to you, it is better.

- when did you decidet o seek mental health care in Denmark? What led to this decision?

I thought it is better to consult the psychologist beforehand

(beforehand?)

Yes. I don't have problems right now. I mean, it is not like i have those heavy thoughts like before back to my *hometown*.

(then whad did you make to get an appointment?) I wanted to know my options it it happens again (And this happened during your application or after you got the asylum?) before. So many thing happens when you come here, so many things to pay attention to. It is nice to know where to go. And as an asylumseeker, sometimes you have to wait a lot until they answer you. When we were the center, you had to wait to get to the red cross doctor. And i thought it is better to do it soon.

- How did your environment (friends, family) react when you seeked mental health care in Denmark?

My husband thought it is a good idea. Because of the waiting list . Of course i didn't tell my kids. They are too small to understand this. They knew i go to a doctor. That's all. no need to know more.

- How would you describe your experiences about it? Admission, therapeutic sessions, outcomes

It was a lot of waiting. I had to wait a few days to see the doctor at the center. Than, i think it was 2 weeks I got the appointment with the psychologist

(and how was the meeting with him/her?) It was a woman. A nice woman

(Did you ask for a female pychologist?) No, not by myself. The red cross doctor asked me if i would prefer a woman or not. I said I would like a woman if it is possible. It is easier to talk with a woman.

- What were the most difficult aspects for you regarding the therapy? (languange, cultural differencies, etc.)

It wasn't a therapy. She was confused a bit what i want from her. But i explained and she gave me some ideas where to go if i need support. Women's group mostly.

(how was your feelings with the session?) It was really new. But I was happy that i have somewhere to go, if i need help. My biggest problem was the waiting. It was more than 2 weeks. What if oyu have a big problem? You have to wait that much as well?

- (if received therapy in both places): how would you describe the two different methods? What were the main differenceis for you?

It was different. it is so easy to get the appointment in *hometown*. You can just go there and get the appointment. Here you have to go to the GP/Red Cross, convince him to reffer you to the psychologist. (And during the „talk”?) Language of course.

- How did it help to you? What kind of outcomes did you get from the therapy sessions in Denmark?
  It is nice to know you are not alone. There are people in your situation with whom you can talk. (Also from you country?) No, they are other refugees. But women. They have kids. It is difficult when you have kids.
  (Can you tell me in what way?) ahahaha, being a mother. You are not alone. You can't be selfish. I can't be lazy doing something, or wait, cause I can cause harm to my kids with it. If i get sick, who's gonna take care fo them?
- What are your thoughts about the future? How do you see yourself withing the therapeutic framework?
  I know these groups. I would ask for help there
  (Not going to psychologist?) No
  (can you tell me why?) Going to the groups is easier. So much easier. I don't have time to wait.

1. Association list: 10 first word that comes to your mind about psychologists/therapists
   a. doctor
   b. medicine
   c. lot of time
   d. problems
   e. therapy
   f. understanding

2. Please write down a, your first experience when you went to a therapeutic session in denmark.
   She was a nice woman. First was hard to make her understand why I wanted to see her. But she sai she understands. She asked if i worry a lot about my kids or taking care of them. I said I have no problem with that, I just want to know how things go here. What can I do if something happens.
3. b, an ideal therapeutic session you would like to participate and you think you could benefit the more.
   She could tell me more information. She asked a lot of questions, if i feel ok to take care of my kids. That was not my question.
4. c, a possile bad therapeutic session you would feel inadequate
   It would be bad if they don't understand me. Or if they can't help me.

Second interview session:
Sarah – 2nd meeting

1. Can you tell me what is trauma?

Trauma is when something bad happens to a person. A serious accident, death, things like this.
How can people react when such thing happens?
I think it is different what happens. (What do you mean exactly 'different'?). If you have an accident and you have injuries and if something bad happens to someone close to you. (Why is it different if it happens to someone else?) It hurts more if bad things happen with osmeone you love. Hahahah, i know i always come with my kids, but: if i hurt myself, it will go away. hurts, that's it. But if one of my kids fall off from their bikes and hurt themselves, it hurts me in my heart. (Can you describe me that feeling?) Hmm, it is.. you can't make them not hurt. Is it understandable? If it happens to someone else, you can tell them to be calm, you can tell them it will go away, but you can't make it go away. I think that is the difference.

2. Could you please share a traumatic event/memory from your life?
   Hmm, not that easy question. I told you before that i was depressed because i was scared i can't be able to take care of my kids.
   (Can you tell me any other?). Not really. I have never had accidents. So i wasn't in big pain. My gradfather died when I was a teenager, but that is life. So, no.
3. when was the first time you talked about this feeling and with who?
   I talked with my mother. I asked her advice, what to do. (What did she said?) That everything is going to be fine, i'm just tired. and the more i worry, the more tired i become.
   (Any others you shared the story with?)
   when it was really bad, before i went to see the therapist, i told itt o my husband. (And his reaction?). He said I'm a good mother and our kids are happy.
4. when you went to see a professional here in denmark, when was the first time this topic come up ?
   I started with it. The first time i explained to her, that i was seeing a therapist because I was depressed. and i was afraid that i can't take care of my kids (What was the professionalist's reaction?) I think i told you this. She was a bit confused, what i want. But it was fine int he end. (Last time ou told me you asked for a female therapist, can you tell me why?). Because a woman understands better when it1s about children. What can i talk about them with a man? (do you know if your therapist had/has kids?) No i dont. We never talked about it. (What if she didn't have kids?) Ahahahahahah. I don't know. (Sorry if this question made you uncomfortable). Nono, but what if what if..hahaha. I think i can talk with you more about kids and giving birth than with a man therapist. He will never give birth, so i think it is a big difference.
5. was there anything else you talked about with your therapist?
   Official things. Like where to go what to do. (What did she said about your problem?) What do you mean by that? (Like, what did she tell you about this situation. You afraid not to be able to take care fo your kids.) ohh. Nothing, really. She asked me what diagnosis i got before, if i took medicine. But she just refferred me to those empowerment groups.
   (Can you remember how was it with your therapist in *hometown*) I told you, we talked about taking medicine. (Yeah, but did you tell him the fear of not taking care of your kids?) Of course. (What did he said?) That i feel like this because of my depression. And once depression is treated, i'm going to be fine again. (Was there any differences how you talked about this fear to the two professionalist?) What do you mean? (Ok, i'll try to rephrase it: you

told me you went to see a theraoist here in denmark, with a concrete question – to tell you poossibilities) yes. (was it similar the first time with your doctor in your hometown?) no, he was a doctor. (You said he was a psychologist). No, he was a doctor, who said i can go to a psychologist if i need it. (So when you went there, what did you tell him?) That i'm tired, I cry a lot, i feel weird, My head is not right. (Nothing about your kids?) No, i toold him, that i'm worried that i can't take care of them, because i'm ill.

7.2.3. Steven

Steven: (28, Afghanistan)

Second meeting:

- Warm up: what happened to you since we met last time

Actual interview:

- *What does it mean to you to be healthy?*

I don't have pain. I can wake up and go to sleep with no pain in my body.

- Can you tell me what is pain for you? When you hurt in your body.

- *In your opinion what is the difference between mental and physical health?*

One is pain in the body and one is pain in the head.
- In the head? pain in your thinking
- Can you please explain this?
You don't think in te right way. You have problems to think the right things.
- What are the right things for you? To do your job, take care of family.

- *What does mental health means to you?*

To think in a good way. No sickness in the head.
- Can you tell me what is sickness in the head? I told you. When you don't think right.
- Can you please give me more example? You have dark thoughts, or your brain is slow. You think about different things than you should.
- Can you give me a specific example? You think about something useless and not about your job.

- *What is the general view of mental well-being in your country?*

People think you have a bad brain and you do bad things. And they ask: why do you do that? why don't you do it in the right way?
- Have you experienced something like this? Yes, when i was a kid. My parents told me my head is somewhere else.

○ *Have you received any kind of therapy in your home country?*

Yes, I went to the doctor and to therapy. Got medicine. It was better, but not gone. The medicine made it better, but it was still in my head.

- Have you received anything else than medicine? We talked with the therapist. How am i doing in my life, with my family.

○ *How do you feel about that therapy?*

Don't know. I had to go to the doctor, because something was not good with me, depression. But I have never healed.

- How do you imagine to be healed? You have so many questions about that. I do my things in the right way and my family is happy with that.
- Do i ask too much about these things? Should we stop? No, but i told you.

○ Have you seek alternative methods as well? Like social support, group meetings?

No. I talked with about it with my family and with my wife. More with my wife. She said I should go to the doctor more often

- Can you be a bit more detailed about this? She told me i should go to the doctor more often, or go to more doctors
- More doctors? Yes, different doctors. So they will see my depression more.
- I am not sure that I really understand that. You go to a doctor and he gives you medicine or treatment. If it won't heal you completely, you go to another one,, maybe that one can help.
- Did you go to different doctors? No. Just my doctor (GP) and the psychologist.

○ *How did your environment reacted when you seek mental health care?*

When I was a kid we didn't pay attention to it. My mother gave me soup and tea when I didn't want to eat.

- What made you think you need to go to the doctor with your depression? My mother and my wife was worried for me. That I am quiet, don't sleep well and eat less.
- Have you experienced any negativity? Nono. Never. I worked, there was no problem at home.

○ *How do you feel about those alternative methods? Like talking with someone who is not a doctor.*

It is good to talk. But you need to see a doctor.

○ *When did you decided to seek mental health care in Denmark? What led to this decision?*

It wasn't my idea. I talked with my consultant a lot, when I applied for asylum. I told him abotu my life. He said, I should go to therapy here as well, if I had depression back in Afghanistan. -

- The previous meeting you said you asked for it. Yes, I asked for it, but my consultant said I should do it.
-What made you agree with him? I don't feel right. I know depression is still in my head
- What would you like to do with it? The medicine, the antidepressant was good. I hope they can give it to me. It helps when you feel bad.
- How do you feel bad? You can't think right.
-What kind of treatment would you prefer? I don't understand you. they decide.

-I meant you are expecting something similar like the one you received before? Yes, the medicine was good.

- *How did your environment (friends, family) react when you seeked mental health care in Denmark?*

They said it is good to see a doctor when you are sick.

- *How would you describe your experiences about it? Admission, therapeutic sessions, outcomes*

I did not go yet.

- *What were the most difficult aspects for you regarding the therapy? (languange, cultural differencies, etc.)* Language. I am not so good in english.

- Have you experienced problems with it? It is hard all the time. You are in a different country.

- (if received therapy in both places): how would you describe the two different methods? What were the main differenceis for you?
- *How did it help to you? What kind of outcomes did you get from the therapy sessions in Denmark?*

I hope I can get better. So I can work and be part of the society

- Now it is not possible? Yes it is. But I know how my family was worried. I don't want anyone to be worried. I hope it will make it easier

- How do you think it can help you? To make me think right.

- In what way? I won't be said.

- Is it a problem now? No. It is not easy ot be a refugee. Good to have help.

- How do you think would it help you? To understand people here. So i won't be so different. That helps to have a job and study.

- *What are your thoughts about the future? How do you see yourself within the therapeutic framework? (altering due to problems with english: Would you like to continue with the therapy?)*

I hope i won't be sad. But it is a long way to get to the therapy.

- Long waiting list you mean? Yes. it is like going to the doctor at the center. if it is not an emergency, you have to wait a lot. It is the same with the therapy. If you are not that sick, you have to wait. (

-How do you imagine this therapy? Everything is different here, I think this is also.

1. Association list: 10 first word that comes to your mind about psychologists/therapists

    1. medicine
    2. bad thoughts
    3. appointment
    4. bad appetite
    5. sickness

6. hospital
7. doctor
8. the place where wait to get to the doctor
9. medicine

Please write down a, your first experience when you went to a therapeutic session in denmark. b, an ideal therapeutic session you

1. –
2. It is fast. Do not take much time. I tell them what is wrong and they know what medicine I can take. It help to stop the sickness int he head. You can go back to work soon and do things at home.
3. inadequate:

They do not know what is wrong with you. You have to go there a lot and it takes time and talk. Or you have to go to other doctors and they still do not know what is in your head. That is bed. When they need lot of time to find out what is wrong with your head.

Third meeting:

1. Can you tell me what is trauma?

Bad things happening to you.

- Bad things like? Something huge that .. how do you say..makes you weak or sad, do bad things with your body and mind.
- What things does it to body and mind? If it's the body, it hurts. If it's the mind, then you become not right. weak. Buti t can happen at the same time. It is not so easy.

2. Could you pls share a traumatic memory of yours?

You mean when I was hurt?

- Yes. You described what is trauma. Have you experienced it? I never had accident.
- Can you describe an event when you were really sad? In afghanistan life is not easy sometimes. Yu feel hopeless. And when we came to europe, the road was hard. And I was really sad when my wife went missing. I haven't seen her since..
- Can you tell me what happened? I lost her. They told me we have to go in different ways, so it will be easier. But i haven't seen her since.
- Who told you that you have to go separately from your wife? Those people who helped us getting through the border.
- What did they say about your wife's disappearance? They said she will come later. And in this way it is easier.
- What do you think, what happened to her? I hope she is alright. Mayvbe she got into a different country. And it is not so easy to find each other. different country, how could she find me?
- But there's still an investigation about her? I told the police. But i don't know what is happening.

3.Anything else made you sad? No. Not like this.

4. Have you got into therapy since our last meeting?

yes.

- How is it? It is good. We talk a lot.
- What do you talk about? My life, how I do with my danish classes, job finding.
- How often you go? Every second Wednesday.
- What do you tell him? How i'm doing.
- Last time you said you want to get medicine prescription, did you get it? No. He said i don't need it.

7.2.4. John

- what does it meant to you to be healthy?

  I'm happy, have no pain and I can do whatever I can, reaching my limit and bending them
- in your opinion what is the difference between mental and physical health?
  Physical health is based on biology while mental health can be due to environmental conditions (fx bad family, struggling with problems). But they both influence each other. I remember I didn't eat or sleep when I had to go to the therapy. (Didi t start before the therapy? yes, but got worse). And i can totally imagine that an extreme illness, cancer, disfigurment can cause psychological problems. (Can you give an example how? Well, as i said earlier being health is to be able to live your life fully. If something comes int he way, you suddenly can't do the thing you like anymore. Like, i love to swim. what If i have an accident and whoossh, no arms or no whatsoever? A part of my life disappears.) (Have you experienced something similar? Yes, during the therapy , i mean not because fo the therapy, buta t that time I felt like i can't talk. Like, i'm talking of course, but hey, no one fucking understands, you know what i mean right? You are also living in a different country. And of course you are from Europe, so guess it is not that huge difference, but I'm pretty sure you had such dificulties. Wellm imagine it, but like way worse. Because I also look different (don't get me wrong i won't start to preech about racesizm here *laughing*.) different and they took really good care of me. (What do you mean). Ok, so i was a quota refugee, an underage boy alone. And I do got good care. They payed attention to me. A lot. But i guess in a bit wrong way? I felt they really want to prove that oh, it is gonna be so hard for tou to fit in. And you must experienced such terrible things, you have a trauma. I mean sure, I came from great poverty, true that. But I wasn't raped, or tortured or anything like this. And i felt they really want to give me a category. Now i know they wanted to diagnose me with either PTSD

or other shit. Sorry, for swearing *no problem*. So, that time I just felt they want a certain answer me and i had no clue what was that.

- what does mental health means to you?
  Hmmm, good one. I don't think I can totally separate the two. Like what i said before. It is a mixture of ability. Ok, I think it means to me that i'm happy with who i am? I don't feel shame, guilt like i'm no under pressure to be someone else.
- what is the general view of mental well-being in your country?
  Hmm, guess weakness? Ok, not really weakness, but something that not physical is more related to religion. Spirits more likely. Bad spirits. (And how would people react if someone in their family would develope such problems). Oh, i think they would say to ignore it. be strong. (Be strong in what way?) physical of course. Like, don't let it effect your work.
- have you received any kind of therapy in your home country?
  No, just here.
- how do you feel about that therapy?
  -
- have you seek alternative mrthods as well? social support, talking group, „empowering group"?
  -
- How did your environment reacted when you seek mental health care?
  technically i didn't seek it *laughs*. I was reffered to the psychologist. and since I was alone here, it wasn't like your family have an opinion about it. my social consuler was overall worried about me, for the same reason i mentioned. But like being at therapy. I think it made people who worked on my case more relaxed. Like, ok, he got the care, with capitals.
- how do you feel about those alternative mrthods?
  Well, never had those. (can you tell me about it in general? what is your opinion about those?).
  I think it is good that you can choose. And you can be with people with similar problems. Don't get me wrong, I don't say that psychological therapy is not necessary sometimes, or just because i didn't like it. All i'm saying that maybe it fits someone a bit more. Less formal, maybe they more familiar. There could be many reasons. (what do you think about the idea that some people only seek these alternative methods?) well, what is alternative? Where i came form, it is totally normal to go to a witch doctor and get the bad spirits away. Here, for just the fact that you did this, would send you to therpay. Aren't they? *laughs*. Don't misundersand please, of course when it comes to a serious problem I don't think you should avoid proper psychological help. But i think it is ok to try other things as well.

- when did you decidet o seek mental health care in Denmark? What led to this decision?
  -
- How did your environment (friends, family) react when you seeked mental health care in Denmark?
- How would you describe your experiences about it? Admission, therapeutic sessions, outcomes
  the beginning it was just another doctor visit (how old were you exctly? – 16). Then i was a bit like, wait what, I need to talk about me? Like how? I really didn't see the point of talking about myself. Like, in general? me? there's nothing to talk about it. there are things i like and there are things i don't like. And she just pushed this think. talk about your self. freely. don't hold back. no right or wrong answers. Ok, but don't you understand i have nothing to say?*laughs*. I don't know if she was more frustrated or I was.. Now i know she thought i have some major personality issues, and i really didn't get this waste of time. Like, seriously? (have you ever mentioned to her these feelings?). yes, i told here that there is nothing to talk about me. I like these tihngs i don't like these things, and in general this and that. (what was her response?) that if i open up, i'll have an easier time to get usedd to denmark.
- What were the most difficult aspects for you regarding the therapy?
- (languange, cultural differencies, etc.)
  Language was ok. I learnt english pretty fast and then danish. I guess i'm good with languages. So, i would say it was the cultural differencies nad the time. For me at that time it was totally waste of time that 1h per week. Hated it. You know why? Cause that one hour was the higlight of me not to be understood here (what do you mean by that?) of course there were cultural clashes, at school, at the training (football) or with friends or like in general with living in denmark. But with the psychologists it was a pure essence. If i hink back now, it was really she wanted me to put me in a box. Maybe i had some problems. Maybe i still have psychologically. Don't know. What i know is that she didn't help. not like she was a bad person, she just didn't pay attention to me.
- (if received therapy in both places): how would you describe the two different methods? What were the main differenceis for you?
- How did it help to you? What kind of outcomes did you get from the therapy sessions in Denmark?
  the outcome was that i started to hate therapy *laughs*. And for quite a time i was against it. But oyu grow up and you realize these are just isolated instances. I have friends got therapy and it helped a lot to them (And theyare from?) denmark. Ethnic danes.
- What are your thoughts about the future? How do you see yourself withing the therapeutic framework?

Now i don’t go to therapist. (if there would be circumstances, what do you think, would you consider it as a possibility?) Definitely. Like, definitely wouldn’t be against it. But you never know

Association list:

1. doctor
2. time consuming
3. talking
4. mental problems
5. to be lost
6. difficulties
7. lot of scheduling
8. hidden meanings
9. Hannibal (the tv series)
10. care

Texts:

1. first experience: I was 16 and I had some problems. I had difficulties with sleep, drop some weight. In general I looked a bit sick. Skinny little guy. So my social contact person asked me if everything is alright. I told him yes of course. I feel tired a bit. He arranged an appointment with the GP. He made some tests, blood pressure etc. He said I should see a psychologist. So after a few weeks my first appointment was scheduled. The psychologist was really welcoming, she seemed a nice person. She explained how the whole therapy will go on. Took some tests and we agreed on a certain day, when i can come back. It was more formality, frames, ethics, rights and such things.
2. I know professionals need to lay down the formal parts of the therapy, but I could also use more informal connection with her. As I said, she seemed a nice person, but I felt a distance what she tried to keep, but at the same time she expected me to open up. I think, especially with a teenager like I was, it could be better if they also pay attention to create some kind of bond.
3. I think it would be the exeggarated version of my negative experiences. To be pushed too much, to be diagnosed with something i am not. Now I would say, if the therapist would like to diagnose me because of my refugee past: You have PTSD, or you have problem to fit into the culture, or you have a language barrier. I speak fluen english/danish. I don’t have problem with that. But sometimes this is all what people can see. You were a refugee, you stay a refugee. You came from Africa, you are traumatized. I likethe expression of Africa a

lot. It is such a huuge place. It is a fucking continent. I came from Sudan. It is a country that different from the other. I have experienced this. My therapist didn't say it out loud of course, but I always felt there is something she is looking for, a certain kind of answer. Today I know, she was lookking for typical refugee problems.

John 2nd occasion

1, can you tell me what is trauma?

Trauma is an event that influences your life negatively. Either by physical means, or mentally. (What iis the diffference between the two?) Physical trauma can be an accident. car crash injury, etc. Psychological trauma comes from a distress situation. Like your life was in danger. (But a car accident can also be life-threathening). Yes. Then it is psychological trauma as well. Psychological trauma is worse. Injuries can be treated. painkillers, bandaid hahaha. Psychological trauma is a bitch. YOu can't e it. it is not so evident, not so easy to access. Maybe you don't knowyou have trauma.

2, Could you please share a traumatic memory of yours?

no, not really. I don't think i have one. Ok, now i'm pretty sure i have one, I just opress it, right? You know this better than me. hahahaha. Being a kid in *hometown* is quite traumatic. I am an orphan. So being an institutionalized foster child, life is not easy. No, but you know, It wasn't traumatic. At least i don't think so. I know everyone whom o tell my childhood story think, ohh John, it must have been horrible and terrifying. No. It was hard, buta s i told you. I wasn't abused in anyway.

(How do you responde these reactions?) No, they don't tell me. Of course no one will tell you hey dude, you have been traumatized. I don't have to responde.

(What about your life in denamrk?) No, it wasn't traumatic. I was in good care. Yeah, i hated the therapy. hahaha. Can i say that therapy was traumatic? (you can say everything you feel to share with me). Yeah, I hated therapy. (Can you please tell me why?) Cause the therapist didn't understand me. I did quite well adjusting here. and that one occasion every week was just, uhh. It was so.. not normal? (not normal?) I had to talk about something i don't even feel. (what do you mean?). I always felt there is something she wants me to say out loud and i couldn' find out what. (did you tell her this?) no. i was a kid. she was a 'doctor'. actually i don't remember if she was a psychologist or a psychiater. (Was there anyone you shared this feelingwith?) No. (why not?) Ahahaha, i don't know. I was a kid. I just did what adults wanted me to do. Of course it would be different today. (how so?) I would emphasise my feelings more.

Can you please tell me again how did you end u pin therapy back then?

One day my consuellor told me I have to go to see the therapist woman. Basic psychological evaluation. And that time i had some sleeping ad eating problems. I think that's why they sent me. (What did you talk about with her?) What i do in general, how i do in school and in activites. (Did you get any diagnosis?) Not that i know of. They didn't tell me. (For how long you went there?) Few mmonths? 6 months i think. (and what were you talk about during those months?) just discuss what happened the previous days. (can you recall any certain topics?) nah. the sleeping and eating problems were really prevalent. (those symptoms were there for 6 months?) no. int he end we just talked. I talked, she listened. and wanted me to talk.

- what was your general feeling aobut the therapy?

I told you last time. I hated it. Ok, Hte is a strong word, buti t was uncomfortable. Taking to someone who doesn't seem to understand you. Funny, telling these things about a psychologiist to a psychologist. (what made you think she didn't understand you?)
It was just a feeling. Have you had this feeling youtalking to someone and the two of ou don't seem to be on the same page? it is the same feeling. But when it's about you, as an individual, it is really fruustrating that you can't make yourself understood. (so how the eating/sleeping problems solved?) they just disappeared after a while. (did the psychologist said something about it?) No. (What did she said to you? Like what can you recall discussing). Discussiing? Nothing. she asked questions and i answered. (Questions like?) what did i do in school, about friends. pretty normal annpying questions.

-

8. Table of contents