



Speaking about social suffering?

Subjective understandings and lived experiences of migrant women and therapists

Mona Lindqvist

Faculty of Arts and Social Sciences

Sociology

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Karlstad, December 2016

This thesis is dedicated to Hanan and her family.

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2. Lindqvist, Mona (2016) Tid och emotioner i psykiatrin. *Arbetsmarknad och Arbetsliv*, årg 22 nr1 våren 2016, 27-41.
3. Lindqvist, Mona and Wettergren, Åsa. Migrant women's negotiation of belonging through therapeutic relationships. Submitted to *International Journal of Migration Health and Social Care*.
4. Lindqvist, Mona and Olsson, Eva. Emotional labor/emotional work and harboring strategies done by health care professionals. Submitted to *Journal of Political Power*.

Abstract

This doctoral dissertation investigates and illuminates lived experiences, cultural representations, and organizational conditions that influence the way therapists in psychiatry receive and treat migrant women in Sweden. Towards this end, two distinct but interlinked part-studies were conducted. The first of these examines migrant women's perceptions of their mental (ill)-health more in general along with their real-life experiences of receiving psychotherapy in Sweden. The second part-study looks at how Swedish therapists, in their organizational working conditions, interpret and experience their professional encounters with migrant women. Qualitative interviews with a total of twelve migrant women and eleven therapists were conducted.

The migrant women in the study viewed (mental) health as something closely connected with a sense of belonging. Non-belonging, isolation and a sense of alienation, for them, meant non-health. Among those in the group, a sense of belonging to the broader society could also be gained through the therapeutic relationship. At the same time, there were also several obstacles associated with this path.

The work of the therapists treating migrants in this study entailed significant amounts of demanding emotion work, making it comparable to physical labour. With increased productivity expectations in their workplace, they were, moreover, faced with demands for accelerated pace of work. The therapists therefore resorted to various strategies to manage their emotion work. Everyday resistance offered one way for them to gain emotional energy and avoid emotional numbing and burnout. It also enabled them ways to increase their work enjoyment, thereby contributing to a more adequate reception of migrants in psychiatry.

Focusing on migrant women's lived experiences of social suffering and therapists' ability to meet migrant patients' needs, the study contributes to a better understanding of a little-researched area in literature.

Keywords: Migrant women, social suffering, belonging, emotions, mental (ill)health, therapist, psychiatry, emotion work, everyday resistance

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1. Introduction

Isabel came in for her weekly therapy session. She was tangled in emotions, mostly negative. All week last week she had stayed at home from her job as a personal care assistant for the elderly and disabled, feeling dizzy and nauseous and, as she described it, like having “snakes in the stomach”. She had had trouble sleeping, suffering from recurrent nightmares and terrible headaches when waking up in the mornings.

The week before her sick leave Isabel had been working with a client, an elderly man insisting that she do some belly dancing for him to provide him with amusement; according to him, “that’s what women from your country are supposed to do.” Being denied his request, the man had become angry, upset, and mean. Immediately afterwards, Isabel had asked her superior to reassign her to another client, but that could not be arranged; she had to continue working with this particular individual or leave her job. Isabel had then become sick, having to stay home from work. It was, moreover, not the first time she was forced deal with this kind of a situation: there had been several incidents of a comparable kind in the past. To me, Isabel stated: “You know me; tell me what to do” with it. She had been attending the therapy sessions for over a year by now, and we had developed a fairly close relationship, but I struggled to come up with any straight-forward advice to offer. Initially, Isabel had come to therapy to deal with her traumatic experiences of having been imprisoned and tortured in her country of origin due to her political activism. Thus, what had happened now with her elderly client might very well have reminded her of her past experiences; yet, as Isabel herself noted, it at the same time about something else, too, about something more than just herself: it was an experience of precariousness of one’s situation, one that she shared with many other migrants in Sweden. With despair in her voice, she stated that it was that very circumstance that made her sick, not really her earlier experiences from somewhere else.

I felt despair as well, both hers and my own. Isabel was caught in general social situation with little prospect of changing anytime soon. She felt sad, bad, and mad (in the sense of both “angry” and “crazy”) about it. She could not do anything to change it, and neither could I. I could only give her advice on where to turn for (legal) help, listen to her, and maybe write a statement about her mental health status to that way help her in her efforts to do something about her situation at work. Right now in the therapy session we could only talk about her feelings of pain and try to help her share them. Afterwards, I tried to find some colleagues with whom to share my own feelings provoked by them. They were all busy, however, with everyone’s doors closed and the red light on; they all seemed occupied with other things. I felt helpless, angry, and fatigued. I became restless. I walked back and forth in the corridor like a caged animal, feeling constrained and powerless and knowing that in just a few

minutes I would already have to see the next patient with yet another story to tell of personal anguish and suffering.¹

This vignette is of my everyday practice as a psychotherapist working at an outpatient psychiatric clinic for refugees in one of the more rural counties of Sweden. It neatly captures much the content of this dissertation in a nutshell, laying bare the two perspectives operationalized in it. On the one hand, this work looks at migrant women's perception of mental (ill) health and their experience of therapy in Swedish psychiatry; on the other hand, it describes and explains how therapists, in their organizational work conditions, interpret and experience their encounters with migrant women in their professional capacity.

The right to health is a human right (e.g., Toebes 2001). At the same time, definitions of health and illness have varied, even quite considerably, over time and across cultural contexts (e.g., Sanner 2009; Weitz 2009; Horwitz 2010; Sheid & Brown 2010; Pescosolido 2011). Mental ill-health has been described variously as either a set of discrete disorders or a continua of affect and (mal)function (see, e.g., Mechanic 2010). Today, the authority to define health and illness and what kind of care is needed for a particular illness appears to have been assumed for itself by (bio)medicine. As a result, broader social determinants such as poverty, stigmatization, and lack of access to health care are often not given sufficient consideration when discussing and addressing ill-health (Mechanic 2010, p. xvii). The same applies to people's own, subjective understandings of their state of (ill) health, even where, as in Sweden, the notion of "patient participation" is frequently referred to in policy documents (Horwitz 2010; The National Board 2016).

How are health and ill-health, especially mental health problems, then understood, experienced, and imagined by migrant women in Sweden? Women, and especially migrant women, appear to be at a greater risk of developing mental health problems (e.g., Patel et al. 1999; Kirmayer et al. 2011), and yet they do not to seek help from psychiatry as often (e.g., Crocks 2009; Koopmans et al. 2013; The National Board 2015). Relevant to this latter finding, and for their part qualifying it, the migrant women in this study recounted recurrent experiences of initiating healthcare encounters but being rejected in them: of on several occasions trying to obtain help from psychiatric services but being turned away or told to seek

¹ All names and identifying details in this dissertation have been changed to protect the privacy of the persons involved. All translations from the original Swedish are by the author.

help from another clinic because their problems were “too physiological”, “too social”, “too religious”, or in some other way too alien to psychiatric definitions of mental ill-health to qualify for services where these were sought. At those other clinics, they were then again either rejected or transferred further. All this made them feel both rebuked and rejected, but did not cause them to give up: they were determined to get what they knew they had a right to get, and, to better enable that outcome, they resorted, instead, to constructing for themselves a fluid multiple being, a coping or communication mechanism that in this dissertation I term their ‘alien habitus’ (Article I).²

While different ways to address migrants’ mental healthcare needs are not infrequently discussed, at least in Sweden, these needs appear to be identified either by healthcare authorities acting alone and from the premises of the pre-existing system, but in any case not by migrants themselves (e.g., Swedish Association 2016). This is rather paradoxical, given that, as mentioned, a user perspective is often emphasized by healthcare organizations in the country, and that there is today an increased focus on healthcare service users’ own experiences as a means to move toward more patient-centred care (e.g., The National Board 2016). One might conjecture, then, that, instead of striving to introduce such a patient-centred perspective in diagnostics and care for the country’s migrant population as well, there seems rather to be a strive to educate migrants in the Swedish healthcare system so as to enable a better understanding of their state of ill-health as viewed through the dominant lenses of biomedicine, and, thereby, to improve the ability to identify the “right” care within the parameters of the already existing healthcare apparatus and organization.

Indeed, proceeding in the opposite direction, taking healthcare learning from the patient as the starting point, seems uncommon when it comes to the target group of care-needing and care-seeking migrants (cf. Casement 1985). There are, to be sure, several factors contributing to this state of affairs. One might, for example, ask whether, how, and to what extent the reception of migrants in psychiatry might be improved at all in a situation where there are increasing organizational demands and pressure for greater productivity in accordance with

² The notion refers to (emotionally) performing one’s self in accordance with the prevailing emotional order, yet with a lingering sense of being alien. Derived from Bourdieu (1993), it denotes the bodily and cognitive structures that underlie the actions that humans take, the opinions they have, and the choices they make in their everyday life. For a further elaboration on the concept, see Article 1 below.

the ideas and principles of the New Public Management (NPM).³ How can therapists develop and foster necessary emotions such as empathy for patients in circumstances where there is a constant expectation of increased production numbers, which in the field means more patients treated during a workday regardless of the nature and needs of these patients? Ironically, as a likely reflection of this dilemma, mental health problems among healthcare workers themselves have increased (e.g., Olsson 2008; Maslach & Leiter 2012). Burnout among healthcare workers and in the closely related profession of social workers is a long-known phenomenon by now (Prosser et al. 1999; Hannigan et al. 2000; Lloyd et al. 2002; Glasberg et al. 2007). Maslach and collaborators (2001) have defined it as the on-going reaction to emotional and interpersonal strains at work, emphasizing the complexity of the notion that covers a larger organizational context, not only individual experiences and responses to work. Yet, very often it is the weary worker who is singled out as the sole responsible instance for her fatigue, with the work overload explained as an inability or a psychopathology in the individual professional (e.g., Tennant 2001; Tillet 2003). In any case, such burnout and emotional fatigue among healthcare workers may also negatively affect patient satisfaction, leaving workers drained of emotional energy and yet held responsible for the problem (Garman et al. 2002; Vahey et al. 2004).

This somewhat inconsistent view concerning the reception of migrants in psychiatry means that we need to learn more about women migrants and their own understanding of their pain and suffering. It, furthermore, suggests that we need to examine how psychiatry functions for those who succeed in securing treatment services for themselves. At the same time, however, we must also more systematically investigate and consider the difficulties (but also possibilities) that therapists face in working with individuals from this group, given the organizational frames surrounding their work as well as the various strategies for coping and resistance resorted to by therapists to influence their working environment and make it more conducive for their purposes.

³ The New Public Management (NPM) model suggests new techniques and practices, drawn mainly from the private sector, to manage and control activities in the public sector, with the aim of enabling more efficient and rational resource utilization (see, e.g., Lane 2000). While the concept has become increasingly important and more and more widely applied in also healthcare contexts, both in Sweden and internationally, it remains only indirectly engaged in in this dissertation and will not be specifically discussed. For such a discussion elsewhere in the literature, see, e.g., Gruening (2001) and Blomqvist (2016).

To my own professional understanding, migrants often talk about and reflect on health and illness from a holistic perspective, one in which the body, social relationships, and religious or spiritual matters all are intertwined and interact. This understanding of health and ill-health is, in fact, in line with how the World Health Organization (WHO) defines health, providing also the point of departure for my own approach to health in this dissertation. As the WHO defines it, health is “one of the fundamental human rights of every human being” and “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.” While mental health thus forms an inseparable part of people’s overall health in this description, the WHO at the same time also has a more particular view of mental health, one that is, just as its understanding of health overall, both broad and all-inclusive. As the organization states in its fact sheet:

Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. Individuals with mental health problems are often shunned discriminated against and denied basic rights, including access to essential care. (World Health Organization 2016)

In general, health care as practiced in the West (including Sweden) nevertheless appears to rely upon a post-Cartesian approach to human beings, one that divides them into two distinct substances, body and mind. In this division, all social aspects then become issues for social services while the soul remains purely a religious concern. Yet, there are also therapists working in psychiatry who take the whole human being as their starting point, attempting to keep a more comprehensive perspective on individual suffering. Succeeding in that, however, is busy becoming more and more difficult under increasing organizational pressures to achieve higher production rates. Due to consequent time constraints, one is very often forced to narrow down treatment to consideration of one part of the human being only, their psyche, with the aim of curing afflictions as fast as possible. Individual therapists, even those most committed to a holistic approach, become overwhelmed by organizational noise about “hard facts” – mostly financial and economic details – that seem difficult to reconcile with the requirements of human encounters. For these reasons, this study also took it upon itself to look at the resources and constraints that shape therapists’ working conditions, influencing their ability to receive and treat migrant patients in their psychiatric organizations.

As the need for mental health care for migrants arriving in Europe and thereby Sweden is estimated to only increase with time (e.g., Carballo & Nerukar 2001; Fazel et al. 2016), there

is a clear imperative to find out what the needs of this group of people are, exactly, and how they can be met in their suffering in a manner that is not just effective from the point of the view of the care-giving organization but also dignified for the care receivers (cf. Bäärnhielm & Mösko 2012; Giacco et al. 2014). For therapists in psychiatry to be able to provide appropriate reception and treatment for migrants, it is vital that they understand not only the wider implications of the migrants' subjective needs, their experiences in the new society, and how these experiences affect their daily life in the new country, but also the context in which they themselves interact with and relate to the migrants – that is, in the case of this study, the psychiatric system in Sweden. Accordingly, this study explores both migrants' subjective experiences of their mental health and their therapy providers' (in)ability to meet the expectations arising from these experiences within the psychiatric organizations employing them. The study thus explores an issue of obvious relevance to policy-makers with an interest in egalitarian, patient-centred care.

Migrants' Healthcare Needs

According to a 2016 report by the Swedish Association of Local Authorities and Regions (Swedish Association 2016), 160,000 individuals applied for asylum in Sweden in 2015. The year before, in 2014, the same number was 80,000, with 50,000 of the applicants eventually allowed to stay. Of these latter, the report estimated approximately 20 to 30 per cent to currently suffer from mental ill-health. Some form of mental illness among asylum seekers and newcomers was thus more common and, according to the report, often also more severe than in the general population, with women in particular appearing to be vulnerable in this regard. At the same time, however, the report fails to provide any clear definition of mental ill-health, of what it consists of, even if ill-health is in general discussed using diagnostic terms such as post-traumatic stress disorder, anxiety, and depression. The main causes of stress and trauma are attributed to war and conflict in the asylum seekers' and migrants' countries of origin, the experience of the migration itself, and the stress and strain associated with the establishment phase in the new country. Somewhat against this characterization, however, it has elsewhere been argued that the most significant factor here, one with a greater negative impact on migrants' health than their previous experiences elsewhere, is actually the waiting period for one's asylum decision in the new country (Kemp & Rasbridge 2004; Mansouri et al. 2009; Andersson et al. 2010).

Another important aspect influencing migrants' healthcare needs is the fact that while in the past migrant patients in psychiatry were predominantly war-traumatized men, in recent years there has been a notable increase in the number of migrant women seeking or receiving psychiatric care (e.g., Watts & Zimmerman 2002; Carta et al. 2005; Office for the Coordination of Humanitarian Affairs 2007; Hjern 2012). My own impression as a practicing therapist confirms these observations. At the same time, it is also my experience that migrant women, at least in Sweden, address mental health problems somewhat differently, especially compared to those in the country's general population. Owing to this seemingly significant difference, the reception and treatment of migrant women in Swedish psychiatry suggested itself as an important focus for this dissertation work.

In Sweden, asylum seekers and clandestine migrants (cf. Sager 2011) are not entitled to publicly provided care and treatment other than that categorized as urgently required. The participants in this study all had permanent residence in the country at the time it was carried out, but were likely to have been affected by this rule earlier on during the stay in Sweden. Such provision of only immediate care to asylum seekers is somewhat paradoxical, since, according to the Swedish Health and Medical Service Act (Hälso- och sjukvårdslagen 1982:763), the goal is to be good health and care offered *equally to all*. As a later government report describes it, egalitarian health care means that the care and treatment are to be offered on equal terms, with equal treatment to all irrespective of the person's place of residence, age, gender, disability status, education, social status, place of birth, ethnic or religious affiliation, and sexual orientation, and that the care system is to strive to achieve good health and care on equal terms by prioritizing those most in need (Swedish Government 2011).⁴

To only have access to immediate care can, from this perspective, hardly be considered a sign of such egalitarianism; in actual reality, the equal right to health care referred to in the legislation and government documents is only applied to those in the country with a residence permit. In this study, there were indications that at least some of its participants had been subjected to this discrimination earlier on, having been able to only receive immediate care⁵ in response to their psychiatric needs and being thus victimized by what indeed can be called

⁴ The report cites Article 25 of the Universal Declaration of Human Rights, which states health, well-being, and medical care to be a right for everyone (www.un.org/en/universal-declaration-human-rights/).

⁵ The degree of urgency is evaluated by the healthcare professionals in charge of the case.

structural violence (cf. Farmer 1996; Farmer et al. 2004).⁶ Furthermore, as demonstrated, among other things, by the above 2016 report by the Swedish Association of Local Authorities and Regions, migrants' perspective on their ill-health and healthcare needs is only seldom, if at all, taken into larger consideration.⁷ On the whole, that report can then be said to reflect efforts, not to attend to migrants' needs and situation, but to manage their mental ill-health on an administrative level, in consequence, probably, of the recent increase in the number of asylum seekers and refugees in the country.⁸

Caring for vulnerable strangers is an urgent challenge of our time marked by displacement and mobility of people fleeing from wars, disasters, political executions, and economic decline (see, e.g., Kirmayer et al. 2011). Healthcare professionals, including therapists, in refugee-receiving countries face the challenge of having to provide people from diverse migration and cultural backgrounds with treatment they really need (Ruiz-Casares et al. 2016). While this is not a new phenomenon in the multicultural societies of the global north, the recent exodus of communities will make these challenges more visible than they have been before. We therefore need to begin earnestly rethinking how health care, medical institutions, and medical practices can be improved in meaningful ways and made more responsive to socially, economically, and culturally heterogeneous communities (Östlin et al. 2011). The diversity of patients poses new ethical questions about how to respond to the vulnerability and social suffering of people who often have different care needs and expectations. It also helps us to see the contours, limits, and dilemmas of our existing care

⁶ As defined by, e.g., Farmer et al. (2006, p. 1686), for whom, similarly to Galtung (1969), structural violence is about “social structures – economic, political, legal, religious and cultural – that stop individuals, groups and societies from reaching their full potential.”

⁷ In general, it seems that patients in Sweden tend not to be asked about what they believe to be the cause of their health troubles and what they think might perhaps help to heal their suffering. In psychiatry, there is an appendix to the diagnostic and statistical manual DSM-5, a cultural formulation interview manual, which provides a tool for use as an aid in assessment and treatment (www.psychiatry.org/.../APA_DSM5_Cultural-Formulation-Interview). In reality, however, the manual is only rarely if ever used in Sweden. This in direct contravention of the instructions provided by Kirmayer, one of the authors of the original cultural formulation manual for DSM, who has stressed that the manual should be used for *all* patients in psychiatry, not just migrants, since everyone of them comes with or from “a culture” (unpublished talk, Stockholm, Sweden, 7 November 2013).

⁸ On 21 July 2016 the Swedish Parliament adopted a new law that limits the ability of asylum seekers to obtain a residence permit and be reunited with their families (<http://www.migrationsverket.se/English/About-the-Migration-Agency/New-laws-in-2016.html>). Severely limiting the rights of asylum seekers and newly arrived migrants in the country, the law has been said to signal its transformation from being in “the humanitarian major league” to representing the “humanitarian bottom league” (Alexander 2010).

institutions. In this situation, qualitative in-depth studies of healthcare encounters between professionals and suffering individuals may pave the way for a better understanding of our challenges and abilities in responding to human suffering through psychiatry (cf. Grønseth 2006; Bergold & Thomas 2012; Grønseth 2013).

Aim and Research Questions

Against the background outlined above, this dissertation aims to *investigate and illuminate lived experiences, cultural representations, and organizational conditions that influence the way therapists in Swedish psychiatry receive and treat migrant women*. This overall aim is pursued through two distinct but interlinked part-studies, each with its own particular aim and set of research questions.

The aim of the first of these, presented in Part 1, is to *examine migrant women's perceptions of mental (ill) health along with their actual experiences of therapy in Swedish psychiatry*. This part-study is guided by the following research questions, with the relevant article making up this dissertation indicated:

- How do migrant women define and understand mental health? (Article I)
- What links, if any, are there between migrant women's ill-health and the psychosocial circumstances they find themselves in? (Articles I and III)
- How can migrant women benefit from psychiatry in managing their social suffering brought by forced displacement and changes in social status in the new country? (Article III)

The aim of the second part-study, presented in Part 2, is to *describe and explain how therapists, in their organizational working conditions, interpret and experience their encounters with migrant women*. This part-study is guided by the following research questions:

- How do therapists think and feel about migrant women as patients? (Article II)
- How do therapists experience their ability to offer a good reception and good treatment to migrant women? (Article II)
- What strategies do therapists use to better manage their organizational working conditions? (Article IV)

Key Concepts

Three key concepts used in this dissertation require some clarification: *migrant*, *therapist*, and *social suffering*. As regards the first-mentioned, a broad definition of the term ‘migrant’ is adopted, one which includes, but also moves beyond, the legal definitions of the concept. ‘Refugees’ in this dissertation are persons with a refugee status granted by the relevant national authority, in this case the Swedish Migration Board (based on the definition issued by the United Nation High Commissioner for Refugees, UNHCR), but also forced migrants who have received their residence permit on other grounds (subsidiary permits). In the following, the term migrant is, however, sometimes also used synonymously with ‘asylum seekers’ and, at other times, as an umbrella concept for other migrant categories such as migrant workers, undocumented migrants, and others that do not fall within the scope of the officially defined terms refugee and asylum seeker. In any case, the term migrant, for the present purposes, is most often preferable over refugee, since my point in this study is not to comment on the legal significance of the two concepts of refugee and asylum seeker (cf. Malkki 1992; Cresswell 2006; Ingleby 2009). Nevertheless, refugees and asylum seekers may in general be seen to face harsher circumstances than other migrants, since they are forced to flee. The line between forced and voluntary migration is, however, very difficult to draw, and for the sake of simplicity the broad concept of ‘migrant’ is thus adopted (cf. Ahmed 1999). That said, all participants in the first part-study in this dissertation research were former refugees or asylum seekers who now had residence permits either as quota refugees or through subsidiary permits.

The term ‘therapist’ in this dissertation covers representatives of the following professional groups: counsellors, nurses, psychiatrists, and psychologists. As it suggests, all of these professions primarily serve a therapeutic function, through the provision of either “talking treatment” or other non-medical/non-drug therapy. The purpose of the therapeutic relationship is to contribute to the ability of the persons seeking help to make changes for the better in their life. The relationship is essential in psychotherapy, since the persons seeking help share intimate thoughts, beliefs, and emotions (e.g., Borg & Kristiansen 2004). Because of such delicate and sensitive circumstances, it is important that the therapist be able to create a safe, open-minded atmosphere in which the patient can feel at ease. Consequently, trust and respect for the patient are fundamental in the therapeutic setting. In their professional capacity, therapists are expected to do emotion work: to show empathy and trustworthiness. At the

same time, there are professional rules, norms, and boundaries for the therapists telling what are appropriate emotions for them to display as well as where and how to display these (see, e.g., Teyber & Teyber 2010; Akademikerförbundet 2014 (Union of Professionals 2014)). In some sections of this dissertation, I talk about ‘staffs’, ‘employees’, and even ‘workers’, referring not only to therapists, but also to other employees in health care more broadly as well as to employees in other related fields and organizations in the country.

As Kleinman and others (1997, p. XI) have noted, social suffering is the result not just of direct exercise of political, economic, and institutional power over people, but also of the way these forms of power shape social problems. Social suffering can be described differently in terms of health or welfare, or as a legal, moral, or religious issue. Trauma, pain, and disease frequently manifest themselves differently, but none of them is merely a health phenomenon pure and simple, having also a political and cultural dimension to them. For example, to note that poverty is one of the main risk factors for ill health is just another way of stating that ill-health, just as well-being, is fundamentally a social process (Kleinman et al. 1997, p. XI). In health care, social suffering is nevertheless usually submitted to a medicalization process through which disadvantage, hardship, and grief are transformed into clinical depression or anxiety; correspondingly, ethical and moral consequences of political violence might be transformed into post-traumatic stress. In this way, social suffering is redefined, pathologized, and made into a diagnosis, a description of a mental illness. The entire procedure can then be seen as a way to reduce the human being by diminishing and uniformizing her rich and heterogeneous subjective human experience (see Kleinman & Kleinman 1991; Malkki 1992; Kleinman 2006). Yet, social suffering is very much about subjective experience. As Gunaratnam (2012) has noted about social pain, the subjective experience of pain and suffering cannot be measured and scanned in different devices but will be mediated in intersubjective (social) relationships. In this dissertation, I use the notion of social suffering to emphasize the fact that social suffering among migrants encompasses much more than what mere medical diagnoses allow for. In other words, to rely one-sidedly on the latter to describe migrants’ suffering is to rely on a reductionist perspective on what it means to be human.

Dissertation Structure

This dissertation consists of a general introduction (*kappa* in Swedish; Chs. 1–4), four self-contained articles (Ch. 5), and a concluding discussion (Ch. 6). In the four introductory

chapters, my discussion engages three different yet interrelated topics: migrant women, the psychiatric organization, and the employees of that organization, who in this case are therapists working with migrants in the psychiatric system in place in Sweden. Chapters 1 through 3 orient the reader to this general thematic area to be addressed.

The first, introductory chapter above discussed the right to health as a human right and the way the definition of health is mostly dictated by healthcare organizations, not the persons themselves who seek help for their suffering. A need for a deeper understanding of the (mental) health and healthcare needs of migrant women was identified, in light of the previous findings suggesting them to be more prone than migrant men to develop mental health problems. An argument was made that therapists in psychiatry who receive and treat (women) migrants today work in increasingly difficult conditions, due to the dominant management model that demands ever-greater productivity from them and thereby more and more of their emotion-work capability (their ability to use their emotions as tools). This, it was proposed, is likely to have consequences for the mental health of the therapists themselves and for the ability of therapists to meet and treat the migrants asking for their help. Also the concepts of health and mental health were discussed, based on definition of these provided by the WHO. Thereafter, the aim and research questions were presented, with the overall aim of this study broken down along two part-studies, each with its own specific aim and set of research questions. Three key concepts used in this dissertation – migrant, therapist, and social suffering – were presented, to facilitate the understanding of its structure and argument.

In Chapter 2, previous research in the area is then reviewed, with a special focus on gendered migration. Until recently, the literature has largely ignored women's migration as a phenomenon, along with the significance (social, political, health, and welfare consequences) that it (feminized gendered migration) might have for those living in the host societies. Research on the effects of migration with a focus on health is discussed. Pathologizing migrants' social suffering, it is argued, has been, and still is, a major obstacle to a better psycho-social understanding of it and, thereby, to the development of more patient-centred and effective care within psychiatric organizations. Next, previous research on the working conditions of the therapists receiving migrant women in psychiatry is examined, focusing on findings about the effects that increasing work pace and work demands have on therapists and

their working ability. The chapter concludes by looking at research suggesting therapists in psychiatry to resort to strategies of resistance when faced with increasing demands at work.

Next, in Chapter 3 the theoretical assumptions and the analytical framework used for the interpretation and analysis of the research findings in this study are discussed. These are to a large extent derived from post-colonial theory and post-structuralism, while the main theoretical argumentation draws upon post-colonial feminist theory and emotion sociology, besides specific perspectives on health and belonging. Related to the themes engaged in this dissertation, the question of structural discrimination is addressed. Finally, the theories of emotion work and resistance in healthcare organizations are considered.

Chapter 4, on the methods used in this study, outlines my own position and positioning as a therapist-researcher and a migrant, problematizing these from the point of view of the topic of this dissertation. The significance of the gendered approach employed is discussed, after which the methods, the participants, and the bi-partite analysis are presented. Finally, the selection process is described, followed by a comment on the ethical aspects and a short discussion on the evaluation of the results.

Chapter 5 then summarizes the four separate research articles making up the main body of this dissertation, along with their main findings. In the final chapter, Chapter 6, the conclusions from these findings are presented, yielding suggestions for further research. Also implications for practice are identified, with the study's significance for clinical treatment in psychiatry discussed from both the migrant patients' perspective and the therapists' professional point of view.

2. Previous Research

In this chapter, I discuss relevant previous research on gendered migration, mental health, and mental illness, as well as the reception of migrants in the Swedish society, especially as concerns its institutions and organizations of psychiatry. While the focus thus covers a relatively wide field, it, at the same time, narrows down on a more specific area within migration research – migrant women's subjective understanding of their mental health and the reception of these women in psychiatry as viewed from the perspective of Swedish therapists.

In what follows, I first review existing literature on migration as a gendered phenomenon and as a phenomenon that poses significant challenges to migrants' mental health (e.g., through feelings and sense of unfamiliarity, exclusion, and alienation). In this connection, I also discuss extant research on the challenges people must overcome to secure help for their ailments. After that, I look at previous research on healthcare working conditions, considering the requirements of emotion work vis-à-vis patients, colleagues, and the organization, as well as research on everyday resistance and organizational misbehaviour by healthcare workers and staffs as ways to deal with increasing work-related demands and pressure.

Gendered Migration

One result of the on-going globalization is increasing migration. While the phenomenon in itself is as old as human history, its magnitude and patterns have changed radically since modernization. The numbers of people who migrate have increased dramatically, and the distances that people cross are today far greater than before. Migration has also become both more feminized and more political (Castles & Miller 1993; Castles et al. 2014).

Having been mostly an emigration country in the early part of the 20th century, the post-war period saw Sweden turn into an immigration country. The transformation began with labour migration, mostly to satisfy the growing need for workers in the industry, and culminated in the current refugee migration and family reunification migration that began in the 1980s and has continued to the present (Johansson 2005; Castles et al. 2014).⁹

Parallel to this process, as pointed out by Castles et al. (2014), we have also witnessed what can be termed a feminization of migration. The concept was first introduced by the United Nations in 2007, to denote the growing share of women among all migrants. Although the phenomenon has been considered relatively recent, women have, in fact, for quite a long time already constituted a significant proportion of the total worldwide migration (e.g., Morokvasic 1983, 1984; Morokvasic et al. 2003; Anderson 2015). While this much was evident from the earliest demographic studies on migration already, the fact was nevertheless not recognized in any notable manner until much later (cf. Ravenstein 1885, cited in Donato et al. 2006, p. 8). The same was true also of the early post-WWII migrants arriving in Sweden: these were

⁹ In 2015, those foreign-born in Sweden were estimated to comprise about 16 per cent of the country's total population (www.migrationsverket.se).

mostly women coming to work as domestic labour or in the textile industry, a circumstance mostly passed over by research (de los Reyes 2002, 2006; Rauhut 2011).

The recent changes bringing about distinctly more gendered migration patterns are mostly due to the fact that more women today migrate independently, rather than co-migrating with their husbands or joining a family already abroad (e.g., Brettell & de Berjeois 1992). Another aspect of the feminization of migration is an increasing awareness among academics and policy makers of the gendered nature of migration: gendered and feminized migration is today broadly identified as a major factor structuring the migratory processes (e.g., Piper 2005). Migrants frequently “do gender” when, for example, looking to perform traditional women’s chores abroad as cheap labour force contracted to handle care work and domestic work (e.g., Mahler & Pessar 2006; see also Morokvasic et al. 2003; Carling 2005; Pessar 2005; Piper 2005; King 2012; Siddiqui 2012).¹⁰ Parallel to this fundamental recognition, women migrants are today also becoming recognized as an important global economic factor (e.g., Sassen 2002; Ehrenreich & Hochschild 2003; Franck & Spehar 2010). Hondagneu-Sotelo (2003), for instance, has looked at the specifically feminized area in gendered migration that is made up of a large number of women moving across the globe in search of jobs as domestic workers and carers for children and elderly people; and Ehrenreich and Hochschild (2003), Sassen (2002), and Parreñas (2001), in their important empirical and theoretical investigations, have found the reasons behind the huge increase in this type of labour migration to be rooted in the overall global economic inequality, with consequences for (individual) women and their families. Gendered labour migration has, however, not only come to play a major role in the global economy: it also carries a major emotional impact in that women forced to migrate for economic reasons (to prevent poverty in their communities of origin by sending large amounts of money back home) also have to leave their loved ones behind (cf. Shmulyar Gréen 2013).

Gender is thus an important element in global migration, as it has always been. In this regard, it is symptomatic that research has largely ignored this aspect of migration until beginning to look at and highlight the circumstances for women in migration processes (Piper 2005; Passerini et al. 2007; Oso & Ribas Mateos 2013; Akman 2014). This notwithstanding the fact

¹⁰ In such cases, migrant women perform gender according to expectations to the global labour market (cf. West & Zimmerman 1987).

that “[g]ender is one of the fundamental social relations anchoring and shaping immigration patterns, and immigration is one of the most powerful forces disrupting and realigning everyday life” (Hondagneu-Sotelo 2003, p. 3). As Hondagneu-Sotelo and Cranfoord (2006) have noted when reviewing migration literature across different disciplines, migration research has almost exclusively focused on male migrants, with the concept of migrant interpreted as a man in the migration trajectory.

In this view, women have been taken to be followers, not actors pursuing their own will to migrate independently (see Simon & Brettell 1986, p. 11; Brettell, 2003). This has probably had an impact on how migrants are perceived also by healthcare actors, along with other institutions in the receiving societies (see, e.g., Grip 2010). The care needs of the migrants are likely to have been interpreted based on pre-conceived notions built around the construction of the male migrant. In the domain of health care, to be sure, this is probably a bias not restricted to the case of migrants only, drawing as it might, instead, on a general perception of the patient in both medicine and health care as something “male” (see Smirthwaite 2007).

Although the meaning of what the categories of “men” and “women” denote are changing, traditional notions of “male” and “female” still inform social practice. This includes also practices of discrimination against such socially constructed categories (cf. West & Zimmerman 1987; Lindgren 2001; Holmes 2007). Like ethnicity and class, gender signifies an essential aspect of social inequality structures and needs therefore to be taken into account (e.g., Anthias 2001; Lykke 2003; de los Reyes 2003, 2004).

Due to this complexity and the fact that ‘woman’ and ‘female’ are social constructs whose contents vary across time and space, there are several borders and boundaries that migrants must negotiate and cross: not only national, but also structural, discursive, intersectional, and agentic ones (Zhou & Bankston 2001; Yuval-Davis 2006; Hondagneu-Sotelo 2013). As also this study highlights, some of these are even very mundane and on the level of one’s everyday life. There are, for example, boundaries between being ill and being well, between belonging and non-belonging, and between different types of gender positions encountered or assumed in the migrant’s everyday life.

In this context, Hondagneu-Sotelo (2013) has called into question the notion of women migrants as merely oppressed and victimized, arguing for a wider, more transgressive

perspective on gender and migration. In her interview study on Turkish migrant women in London, Erel (2003) has shown how these created new practices and meanings of belonging across boundaries. Also elsewhere in the literature migrant women have been shown to be actively participating in their own lives to create conditions to bond and to belong (e.g., Bailey 2012; Erel 2016; Okeke Ihejirika 2016).

These labour-migrating women may, however, have had options to choose among, which makes any direct comparisons between them and the forced migrants in this study complicated. Nevertheless, they, too, serve well to illustrate the tremendous emotional consequences that migration can have for women migrants and the significant others separated from them (first and foremost their children). At the same time, it is also the case that labour migrants, in finding themselves forced out for economic reasons, are a category showing how difficult it is to make any clear-cut distinctions between that which is “forced” and that which is “voluntary” in one’s decision to migrate (cf. Ahmed 1999).

As already hinted at, previous research on migrant women has often assumed a perspective emphasizing their victimization or victimhood. This is especially the case with research on refugee women, who are typically depicted as nothing more than victims to violence, sexual abuse, and religion (e.g., Salzman 1998; Raj & Silverman 2002; Raymond 2002). As Brune (2015) has noted, media plays an important role in promoting this narrow, one-sided view of migrant women as merely victims. Furthermore, as Peisker and Tilbury (2003) have pointed out, also the medicalization of the refugee experience may have an impact here, contributing to the tendency to depict refugees as victims basically stuck in their passive role.

Not always, however, are migrant women portrayed as little more than vulnerable victims. There are studies, for instance, describing migrant women’s endurance and survival strategies, highlighting their active resilience.¹¹ A particular mention here can be made of Edward’s (2007) study of South Sudanese refugee women in Cairo. As the study found, these women used their newly acquired skills, knowledge, and experience to challenge their everyday life in a number of ways, resisting the popular image of refugees as dependent; they were not only vulnerable and in dependent positions, but also very much creators of knowledge and agents

¹¹ ‘Resilience’ here means reduced vulnerability to environmental risk factors, ability to overcome adversity and stress, and relatively good adaptation despite risks (see, e.g., Rutter 2006, 2012).

of social action and change. Similarly, also Grønseth (2006), in her study on refugee Tamils in northern Norway, has recorded acts of endurance, survival, creativity, and imagination crucial for maintaining hope for the future as part of the migrant resilience. Passerini and collaborators (2007), for their part, have provided a broader overview of migrant women as active subjects creating possibilities and taking decisions in their own lives; the picture that emerges from their work is one of migrant women establishing and maintaining personal, social, professional, and intimate relationships in their everyday life in the new society. Migrant women, in other words, can then clearly be both vulnerable and active as agents. This duality, moreover, involves no necessary contradiction, as will be seen from this study as well; the victim-only position of women migrants might therefore be seen as mostly a label affixed on them by the media, along with healthcare and other authorities (cf. Brune 2015). Yet, this observation should not detract from the great magnitude and scope of the challenges and difficulties that migrants face in their new society and new cultural context, challenges that therefore always need to be taken into consideration in any analysis of everyday life and existential reality after emigration.

Transitions

As Andersson et al. (2010) have shown, the time spent in transition as an asylum seeker, characterized by insecurity, loss of social bonds, and possible health impacts, has thus far not been adequately problematized in research. Yet, living conditions in the receiving country greatly impact migrants' health and well-being, perhaps even more so than past events in the home country prior to the flight. Physical confinement (sometimes detention), work restrictions, poor housing, and limited or no right to education and welfare, along with fatigue, isolation, and experience of discrimination all greatly impact asylum seekers and their state of health (Silove 2000; Lindencrona et al. 2008; Ekblad 2009). In Sweden, there were signs detected of elevated risk of illness among asylum seekers as early as in the 1990s, attributed to the living conditions they faced in the country and the consequences of the restrictive refugee policy in place (Andersson et al. 2010). Among other things, the migrants often suffered from low mental well-being, due in particular to their sense of vulnerability and feelings of unfamiliarity and exclusion. Finding ways to deal with such emotions in everyday life therefore becomes an important task (e.g., Casimiro et al. 2007; Wettergren 2013).

In their new social situation, migrants in transition often suffer from restricted or reduced social relations or entirely broken social bonds (see Article III). For this reason, focusing on migrants' social relationships is important to counteract health problems among them (Björnberg 2010; Umberson & Montez 2010; Simich & Andermann 2014). The importance of the social environment, trust, and social recognition has been shown for the creation of resilience and belonging in this group of people (e.g., Castro & Murray 2010; Gonzales et al. 2013). Social recognition and trust are themselves both embedded in both informal relationships and formal settings. Yet, partaking in social relationships as such does not automatically translate into a sense of belonging (Björnberg 2010). What the latter requires is that the relationships are mutual and thus involve feelings of trust and recognition. The quality of the relationships is thus a crucial variable in the ability to develop a sense of belonging. Trust and social recognition, to be sure, result from social interaction, but at the same time also constitute a prerequisite for even wanting to establish sustainable social bonds (Scheff 1997; Berger Schmitt 2000). Becoming "visible" and socially recognized has a strengthening effect on one's self-esteem (Scheff 2003; Ronseneil & Budgeon 2004), with a supportive social environment contributing to one's ability to master and handle adversity and stress and thereby promoting mental health (Herman et al. 2005). Resilience is thus a function of the dynamic interaction between persons and their psychosocial context (Björnberg 2010; Castro & Murray 2010; Gonzales et al. 2013). Thereby, also health care and interaction with therapists in psychiatry can become a platform for recognition and the development of feelings of trust and belonging, especially among the more vulnerable groups such as care-seeking migrants.

Health and Migration

The impact of migration on health in general has been quite extensively studied. Migration has, for example, been linked to microbial threats: it can help spread diseases such as influenza, tuberculosis, and HIV around the globe (e.g., Smolinski et al. 2003; Knobler et al. 2006; Lakoff & Collier 2008). When it comes to migration and mental health, however, research has largely explained the former's risks as an individual-level variable pertaining to some migrants. Yet, diagnoses such as of depression, anxiety, and post-traumatic stress disorder have been notably common in the migrant population (e.g., Selten & Cantor Graae 2005; Straube 2012; Eyles et al. 2013). According to one overview of previous studies on the occurrence of schizophrenia among migrants (Cantor Graae & Selten 2005), for instance,

there appears to be a heightened risk of schizophrenia for people with an individual or family history of migration. Understanding certain symptoms of personal suffering this way as signs of psychopathology has, however, been strongly criticized, especially by Kleinman (1988) and Fernando (2010). According to them, the concept of schizophrenia has no cross-cultural validity, and therefore cannot avoid having discriminating and racializing connotations to it when used in these conjunctions. As Fernando and others (1988), for example, have noted, black Caribbean men in the UK have disproportionately often been diagnosed as schizophrenic when demonstrating aggressive and deviant behaviour, as one instance of the way signs of suffering and illness are racialized (cf. Fanon 1967). Racism acts as a chronic stressor, and to continuously be subjected to it and forms of discrimination deriving from it can accelerate suffering and sense of illness (Bhugra & Ayonrinde 2001).

There is an emerging field of research and critique that looks at the labelling of signs of illness and the pathologizing of them into diagnoses (e.g., Bracken & Thomas 2001; Summerfield 2004; Kirmayer & Bhugra 2009; Horwitz 2010; Bracken et al. 2012). Also research on social aspects affecting the course of illness and suffering has become increasingly prevalent, with the focus on the social world showing potential to make a difference in the way health and ill-health are approached. Umberson and collaborators (2010), for example, have looked at the impact of social relationships on health outcomes, finding it to be notable: the adults in their study who were socially more connected were significantly healthier and lived longer. Similarly, Link and Phelan (1995) found individual factors to be insufficient as explanations for distress and illness, arguing health and ill-health to be primarily a social condition (see also Brown 1995; Sachs 2012; Kleinman et al. 1997; Cohen 2004; Umberson & Montez 2010).

As Ingleby (2009) has shown, health is an important aspect affecting both the well-being of migrants and their integration into the new society. Where not effectively managed and treated, bad health and illness can further worsen migrants' prospects for integration and inclusion in the new society, thereby exacerbating the sense of exclusion and alienation among them (Ingleby & Watters 2005). Marginalization, poverty, and discrimination can then, in turn, all have their own severe negative health impacts. Since access to good health care can then be considered an important factor influencing the social inclusion or exclusion

of migrants, it is thus of great importance to investigate the quality and accessibility of health care for migrants (see also Scheppers et al. 2006; García-Sánchez & Tirado 2008).

As The Public Health Agency of Sweden (Carlson 2007) points out in its report on social capital¹² and mental health, women in Sweden born outside of Europe are twice as likely to have mental health problems as women born in the country. The report discusses social capital in terms of emotional support, access to individuals who can provide practical help, and the degree of one's involvement and activity in the local community, suggesting that possession of it can have a protective mental health effect. The report also shows both women and men with higher levels of social capital to in general have mental health problems or symptoms of mental ill-health significantly less often than those with lower levels of it. These findings are both in line with the findings and proposals of the WHO regarding resilience (cf. Schweitzer et al. 2007; Daud et al. 2008; Björnberg 2010; Hooberman et al. 2010; Montgomery 2010).

Thus far, research on mental health and migration in Sweden has for the most part been carried out within the frameworks of psychology and psychiatry (e.g., Lindencrona et al. 2008; Johansson Blight et al. 2009; Bäärnhielm 2014). At the same time, there is a new, emerging field in the area that looks at migration and its effects from the perspective of the sociology of emotions (e.g., Flam & King 2007; Gray 2008; Skrbiš 2008; Wettergren 2010, 2015; Naldemirci 2013). Naldemirci (2013), for instance, in his study of elderly Turkish migrants in Sweden has shown how emotions play an important role in influencing not only migrants' actions, strategies, and decision making, but also their understanding and imagination of health care in Sweden. Examining how elderly Turkish migrants in the country constructed their expectations and desires regarding health care in the diaspora, Naldemirci among other things, found that access to (the often over-idealized "good" Swedish) health care tended to increase feelings of belonging and thereby also one's sense of inclusion in the society.

Local medical knowledge is not arbitrary, but grounded in local culture and local beliefs (e.g., Lock 1991). In other words, our understanding of health and illness is always to some degree

¹² The term, broadly speaking, refers to beneficial social relations and resources that are important for one's sense of community (see, e.g., Bourdieu 1986; Putnam 2001).

culturally influenced. Western psychiatry, too, is then a particular product of the industrial Western society, along with its ideas about specific, sharply delineated medical systems differentiated and distinct from other social institutions and organizations and disease as a strictly medical category disconnected from social and cultural conditions (Lock 1991). Biomedicine thus both constitutes and is constituted by society (Gordon 1988), drawing as it does upon major Western philosophical traditions like post-Cartesianism and other currents positing the priority of objective “truths” over subjective knowledge (Kirmayer 1988; Lock & Gordon 1988). Consequently, we can propose there to be a culture of psychiatry and cultural assumptions that even in our time influence and reinforce many of the current mental health practices in countries like Sweden (cf. Kleinman 1980; Kirmayer 2000; Hörnfeldt 2005). Here it is, furthermore, also important to note how medicalization can function, and often openly functions, as an alternative form of social control, with medical institutions and professionals acting as the new arbiters of “normal” and “abnormal” behaviour (see Kleinman 1991, p. 9).

In the efforts to counter the influence of such cultural factors and overcome the barriers, borders, and boundaries they contribute to, cross-cultural or transcultural psychiatry has been presents as one option. According to its advocates, among them Fernando (2014), Kirmayer and Pedersen (2014), and Bäärnhielm (2014), transcultural psychiatry seeks to expand traditional Western psychiatry by embracing difference and diversity, such as in terms of ethnicity, gender, class, and different understandings of health and illness (see also Ekblad et al. 2013). Transcultural psychiatry does not, accordingly, focus on any particular ethnic groups, but on knowledge production per se that result in differing understandings of health and illness (see, e.g., Bäärnhielm 2014; Kirmayer et al. 2014). People arriving from different parts of the world to live together in a new place there challenge health care and psychiatry in various ways, demanding approaches and responses different from what the existing healthcare system may be prepared, and was in the first place designed, to deliver (*ibid.*). One obvious example here is persons contacting psychiatry and presenting their need for help in bodily or social terms. As things stand, however, present-day psychiatry, at least in Sweden, has almost no means at all at its disposal to respond to issues considered as beyond the confines of psychiatry as developed and defined in the West.

Put simply, transcultural psychiatry can in this context be defined as a view of clinical work presenting it as intercultural interaction. What this implies in practice is that different people

from different backgrounds are welcomed to talk together about social suffering (e.g., Kirmayer et al. 2014).¹³ Indeed, the latter has been a subject of extensive research in recent years. Kleinman, a psychiatrist and a medical anthropologist, has been one of the main protagonists in the area (e.g., Kleinman et al. 1997). According to him, the notion of social suffering not only refers to the subjective experience of illness, but also brings to the focus the need to understand the social meaning of illness (e.g., Kleinman 1988; Kleinman & Kleinman 1991; Kleinman et al. 1997). To illustrate the point, Kleinman (1991) tells a story about a Chinese woman expressing bodily problems such as headache and fatigues, along with thoughts about ending her life. Accordingly, the woman's symptoms neatly meet the criteria for what Western medicine would diagnose as major depression. Yet, she denied having a depression; instead, as Kleinman notes, retelling her illness narrative, she lived in a situation in which, because of the political situation in her home country, her family had become shattered, with the family members becoming ill or dying and she herself forced into a life she had not chosen but felt deeply unhappy about. Here the individual story of ill-health clearly indicated that the illness was, and could, not be isolated to the individual. To understand the woman's suffering, it was necessary to look at it from a broader perspective, both in interpreting the causes of the illness and in identifying the right treatment for it (Kleinman 1991; cf. Kleinman et al. 1997)

Human suffering is thus always complex, and thus the phenomenon is of necessity debated across multiple fields of knowledge. As Kleinman and collaborators (1997, p. IX) have summarized it, "social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems." Violent forms of suffering include feelings of shame and humiliation, as both causes and consequences in their social context (see Das 2007).

All in all, there is then a striking paradox worth noting here about our contemporary society. On the one hand, social suffering in it is pushed to the boundaries of psychology/psychiatry, leading to only more work and emotional costs for the professionals in these fields. On the other hand, however, the predominant NPM approaches, calling for an increased turnover of

¹³ There is certain limitation to this conception, however, as people we assume to share our background with frequently display notable differences rooted, for instance, in their different education, gender, and social class, which all can contribute to their experiencing life even extremely differently. There is thus always an element of interpretation and translation involved in any attempts to understand others in these contexts.

patients and an ability to respond to new organizational requirements and expectations, have brought with them an increased demand for efficiency, thus simultaneously undermining the resources available to healthcare personnel in their work and this personnel's ability to meaningfully perform the tasks expected of it (cf. Fassin 2005; Fassin & D'Halluin 2005).

Social Suffering and Therapists in Psychiatry

The contradiction between the organizational requirement for efficiency and the professionals' own assessment of what their work consists of has indeed become more prominent with the arrival of NPM. When organizational and professional interests collide, there are, moreover, emotional costs for the professionals that accrue from the conflict between the needs of their necessary emotion work and the expectation of organizational efficiency, causing increasing rates of burnout among healthcare and medical workers (Maslach 2001; Zapf 2002; Aili et al. 2008; Bezes et al. 2012). With healthcare organizations caught straddling the contradictory demands of achieving and maintaining both cost efficiency and good-quality care (as interpreted by care workers), the well-being and working ability of the involved personnel and staffs become negatively affected (Scheid & Brown 2010).

Emotion sociologists, beginning with Hochschild (2003), have studied how service work has become more commodified, resulting in a new situation in which emotion work needs to be done for organizational profitability.¹⁴ Several studies following the example of Hochschild have shown how the commodification of emotion work, such as through maintaining a friendly and funny disposition at work, pays financially off (e.g., England 2005; Mulinari 2007; Vincent & Braun 2013). The same, increasingly prevalent trend in the service sector has also been demonstrated to manifest itself in health care, bringing with it the risk of reducing professionals to mere care suppliers and the suffering patient to a mere care customer (Bone 2002; Paulsen 2010; Moffatt et al. 2014). As a consequence of the growing organizational demands for increased productivity, measurable outcomes, and cost control,

¹⁴ Hochschild's work has made a ground-breaking contribution not only to the sociology of emotions, but also to research on organizations. Her study of flight attendants working for a large airline showed how the attendants always had to remain friendly and show a smiling face to passengers, regardless of the circumstances (Hochschild 2003). In her earlier work (Hochschild 1979), she introduced the concept of emotional labour, discussing how workers were asked to manage their emotions in order to create contentment in customers.

care work on the ground has become more managed, controlled, and restricted (Scheid 2003). An attempt to shed light on the working environment of therapists in psychiatry and investigate the demands made on emotion work forms therefore an important part of the present study, promising also to yield a better picture of the response to migrants in psychiatry (cf. Skovholt et al 2014). As Bone (2002) has shown, for instance, the more reduced and restricted time available today for focusing on the relationship between the care worker and the patient has, correspondingly, also reduced the possibilities for emotion work and relating to the patient, while care staffs' (emotional) ability to ensure patient contentment remains of vital importance for their work (Aiken et al. 2002; Page 2004).

In the second part of this this research, focusing on therapists' work within the psychiatric system, I mainly rely on the work of Olsson (2008) on emotion work, while also drawing from other research on emotion work in healthcare (e.g., Bolton 2000, 2004; Bolton & Boyd 2003; James 2005; Mann & Cowburn 2005; Theodosius 2008). In the more traditional approaches, emotions are not considered part of organization management, since organizations strive for goals that are rational (see, e.g., Fineman 2000). This has been criticized by, for instance, Olsson (2008), who has stressed the crucial importance of emotions and emotion work in the functioning of healthcare organizations. Olsson's study looked at how staffs in such organizations thought, felt, and reacted when confronted with changes in the public sector management thinking following the increasing dominance of market orientation in the area coupled with budget cuts. As she showed, public healthcare workers were clearly dissatisfied with the new orientation, feeling the organization to demand from them ever-greater (emotional) efforts without rewarding or compensating them for their engagement in these. They felt reduced and unseen by their organizations and being left without any means to impact the managements in them. As a result, their sense of job satisfaction and personal well-being was negatively affected. The same study (Olsson 2008), however, also demonstrated how, in response to these developments, care workers resorted to a strategy of creating buffer groups of staff members to shield and protect themselves against the ever-increasing demands of their organization. Part of this strategy was what Olsson termed harbouring-work, or containing the emotional material within the buffer groups, which then handled the processing of the emotions arising in the course of the care workers' work with their patients and colleagues and in the healthcare organization itself.

Related to this research, Bolton (2003, 2004) has studied the complexity of the emotion work performed by nurses working in a hospital ward, comparing it to heavy physical work. Also James (1992), Theodosius (2008), and Bolton and Boyd (2003) studied nurses' emotion work, arriving at similar conclusion: that it is complex and demanding, while nevertheless typically remaining invisible. The same observation has been made by Daniels (1987) as well as Mann and Cowburn (2005), who have argued that emotion work is mostly considered a matter of course in any consumer-oriented organization and thus not given much attention (cf. also Hochschild 2003).

In any case, according to all these studies the work performed by health professionals has an important emotional aspect to it. Where the workplace then provides emotional support to these workers, much of this emotion work is made easier, from the point of view of both the patients and the individual workers handling their emotions. Where there is, however, an unsupportive or, worse still, an emotionally destructive working environment, the workers must find strategies on their own for how to deal with the emotional aspects and events of their work that are part and parcel of their everyday reality; without these, they risk severe consequences for their own well-being and for their ability to carry out their functions as intended (Zapf 2002; Larsson & Yao 2005; Mann et al. 2009). As research has shown, such strategies to facilitate one's ability to cope with one's work tasks may include efforts to distance oneself emotionally from the patient, by focusing more on practical or concrete (mostly technical) work tasks that are easier not to become emotionally engaged with (Bolton 2001, 2003, 2004; Mann & Cowburn 2005; Theodosius 2008).

Most of the emotion-work research thus far in the domain of health care has looked at hospital nurses and included also important physical aspects of their work. When it comes to those working in psychiatry, however, especially those performing therapy work, emotional relationships are essential for the care work done, and emotion work thus takes the centre stage (see, e.g., Greenberg & Paivio 2003). Yet, research on the emotion work of psychotherapists has been scarce, apart from studies on transference and countertransference in certain psychotherapeutic contexts (e.g., Racker 2012).¹⁵ There are, to be sure, some exceptions, such as Yanay and Shahar (1998) who studied therapists working at a psychiatric

¹⁵ In psychoanalytic theory, transference refers to the (unconscious) feelings that the patient directs towards the therapist and countertransference the feelings the therapist refers to the patient.

treatment centre, finding them to not only practice emotion work, but also follow a professional emotion discourse, without, however, ever having been trained in how to do either. In consequence, they ended up having to not only deal with their patients' and their own emotions and master the official discourse of emotions and emotion rules in their workplace, but also frame the output of these emotions according to all the rules, norms, and expectations involved. This constituted a huge additional workload for them. To better manage the requirements of such emotion work, Watkins (2012) has therefore suggested to implement supervision of new therapists in order to socialize them into the kind of emotion work expected from the profession. At the same time, however, there continue to be gaps in the organizational understandings of what kind of emotion work therapists actually do, demonstrating a not always clear comprehension of the fact that they do it for and with their patients. Nevertheless, such proposed supervision is likely to be both beneficial and harmful for the work of therapists: while it gives one an opportunity to talk about and explore the emotion work being performed, it may also lead to their merely saving and containing the emotions for the next supervision session (Olsson 2008; see also Article II below). Emotion work, moreover, is an important part of therapy not only due to organizational demands, but also because it can be enjoyable for care workers and thereby seen as constituting a "gift" to the patient (Bolton 2005; Olsson 2008). For all these reasons, then, care workers often refuse to subject themselves to the disciplinary regime of the organization, choosing instead to resist it in their everyday actions at work using a variety of ways to achieve their goal.

Resisting Increasing Demands

The "everyday resistance" and "organizational misbehaviour" identified in several studies (e.g., Scott 1985; Ackroyd & Thompson 1999; Karlsson 2008, 2011) refer to oppositional acts situated in everyday work life. For the purposes of this research, the two terms are taken to be to a large extent synonymous, speaking of the same phenomenon. Ackroyd and Thompson (1999) have discussed various forms of misbehaviour in the workplace, ranging from "sabotage" to "masking". The former, in their study, consisted of intentionally causing damage to, disrupting, or destroying a product, while the latter was about engaging in tasks other than those strictly forming part of one's primary work or slowing down the pace of work. All such resistance, as Foucault (1978) has proposed, represents a response to power. Accordingly, Karlsson (2008, 2011) has concluded that there is always a dynamic relationship between power and resistance: resistance is the answer to power, and more power will be the

answer to growing resistance. Following Ackroyd and Thompson (1999), Karlsson's claim is that all actions, thoughts, and feelings not expected to be demonstrated at work by an employee can therefore be interpreted as organizational misbehaviour.

Agreeing with this conclusion, in this dissertation organizational misbehaviour refers to all ordinary and innocuous-looking everyday actions and behaviour resorted to in order to resist management efforts to impose on employees organizational policies and principles that stress maximum production efficacy and output numbers, with the aim of regulating, controlling, and benefiting more from these employees' work. Examples of such misbehaviour include busying oneself with personal matters such as when surfing on the Internet without a work-related purpose or taking a longer-than-normal break in the bathroom (for more on this, see Article IV; cf. also Ivarsson & Larsson 2012). Vinthagen and Johansson (2013) have characterized this type of everyday resistance as intersectional, since it always relates to several types of power relations at once, drawing attention to also how it is always shaped by the present context and circumstances. At any rate, it can be said to always be about resistance to power (cf. Foucault 1978).

What is important to note here, however, is that this resistance and misbehaviour is not always openly expressed. Huzell (2005), for instance, showed this to be the case in her study of resistance among employees in an organization implementing a major change process (in this case, re-organization as part of another, larger organization). Striving for greater flexibility, more pronounced market and customer orientation, and increased professionalism in company operations, the company management aimed at improving efficiency in, and its control over, the work process. The employees, however, responded by stressing their right to manage their own labour processes, with, naturally, an antagonism developing between them and the management as a result. In this situation, the employees resorted to a variety of actions to display their opposition and resistance, including also open criticism of the organization and its leadership. Yet, not all of the actions they took were overt expressions of resistance; sometimes the opposition was expressed in a hidden, covert form without actively acting it out. When increasing time pressures made the employees feel prevented from doing their work properly, for example, they stopped making themselves available to help out in common tasks, citing lack of time; instead of focusing on work prioritized by the organization, they shut themselves in their offices to catch up with work tasks they

themselves felt were essential. Sometimes, the resistance was also expressed by limiting one's interactions with others, to that way silently criticize the management's idea of how co-operation in the company ought to look like.

Workers need dignity and autonomy at workplace, and if this need is not met, there will be resistance (Karlsson 2008, 2011). In somatic healthcare (body-oriented health care), there can be joint resistance in teams. As Astvik and collaborators (2013) have suggested, team formation and joint resistance against the management is often resorted to as a way to support individual workers and shield them from the excessive demands of the latter. This finding is in line with Olsson's (2008) description of buffer groups. The kind of therapy work focussed on in this study is, however, mostly solitary in nature, which means that resistance and organizational misbehaviour will be engaged in by individual therapists acting alone, and more often than not as a hidden or silent act of dissent (Bolton 2000; Huzell 2005; Karlsson 2008, 2011). The everyday actions, thoughts, and emotions in opposition to the high-demand, little-support organization therefore to a large extent serve the purpose of providing immediate personal relief in a stressful work situation, while also creating space for that in an increasingly controlled working life (Karlsson 2008, 2011; see also Article IV below). In this research, my aim is to improve our understanding of just this kind of working conditions that therapists today more and more often must deal with, to that way obtain a better picture of the forces shaping the encounters between therapists and migrants. Therewith, one can perhaps contribute, however indirectly, to therapists' ability to improve the reception of migrants in psychiatry and to provide them with good quality care.

3. Theoretical Framework

In this chapter, I present the theoretical and conceptual framework of this study, which, in the main, draws upon postcolonial theory, poststructuralism, and postcolonial feminist theory as approached from the perspective of the sociology of emotions. Also relevant perspectives on health and belonging are presented. Postcolonial feminist theory is engaged primarily to be able to discuss how migration, gender, and mental health relate to one another, and to show how conceptions of 'the Other' and the actual practices of 'othering' are connected to certain racist stereotypes of the migrant woman and structural discrimination that, I argue, continue

to shape Swedish (and Western) psychiatry as practiced today.¹⁶ To problematize the qualitatively different opportunities and rights that are created in the intersection between gender, ethnicity, and experiences of health, an intersectional approach is both theoretically relevant and politically necessary (de los Reyes & Mulinari 2005). The chapter concludes with a discussion of the theory of emotions, the way in which emotions relate to everything mentioned above, and the way health and well-being are closely related to the concept of belonging.

Signs and Symbols

The relationship between language and reality is arbitrary, and the former cannot really be distinguished from the latter (e.g., Derrida 2004). Accordingly, categories like gender, culture, and health are but linguistic constructions lacking any pre-conceived, “hard” core (James 2005). The world around us is ascribed importance through social conventions and language, and it is to be understood as a system of signs and words that obtain their significance from one another in a structured network (e.g., Barker 2001). Discourse, in this context, can be either institutional or interpersonal communication that takes place through the medium of speech or text (Van Dijk 1993). As such, it plays a crucial role in the production and reproduction of prejudice and racism, acting as it does as a mediator of the underlying, sometimes unconscious ideological structures and ideas (*ibid.*). Since language tends to be structured around binary oppositions (man–woman, normal–abnormal, healthy–ill, belonging–not belonging), the terms in these oppositions acquire their meaning through the contrast between them; it is the opposing sign that always creates the significance here (cf. Potts 2002). At the same time, however, the relationship between the binary terms is quite often asymmetrical, with one term assuming superiority over the other that is seen as weaker and subordinated to it (e.g., Gilman 1985; Williams 2006). In the hegemonic Western discourse, for example, migrant women are frequently presented as subordinated, weak, frail, and ill, thereby contrasting with “emancipated” Western women (see Lutz 1991, 2010; Ang 2003). Creating meaning through a system of dichotomies is, however, simplistic and reductionist, as the categorization only gives two options, either this or that, but not both or

¹⁶ Discriminatory discourses can be hidden in their expression or in terms of differentiating between ethnicity and culture (see Jonsson 1993, 2010). By deconstructing the language used, as Derrida (2004) has shown, it nevertheless becomes possible to identify and analyse the unspoken and hidden power relationships while enabling alternative meanings to emerge.

more at the same time (James 2005). This has implications for the perception of knowledge production, as it either legitimizes or questions the prevailing power structures. Knowledge in general, and scientific knowledge in particular, constitutes power structures, as knowledge is never separated from institutional practices and power relations determining what can be considered knowledge and in which context. In this dissertation, psychiatry is considered as one such knowledge-consuming and knowledge-producing organization with a capacity to decide who is ill, in what way, and who is entitled to care (cf. Foucault 1988). Postcolonial theory can be said to provide a critical perspective on knowledge production in the West in general, given its strong focus on the relationship between knowledge and power (de los Reyes et al. 2012). For the purposes of this dissertation, however, I will narrow down more particularly on postcolonial feminist theory, given the subject matter tackled.

Postcolonial Feminism

Postcolonial feminist theory highlights the difficulty of starting from a single category of women. In it, the relationship between white Western women and “other” women is problematized, focusing on the construction of ‘the Other’ and the concept of ‘othering’ (Spivak 1988; Mohanty 2003).

In dominant (Western) feminist theory, there has been a strong emphasis on equal involvement of all women. Prompted by a need to refute biologically-based statements about what women are and are not, the concept of gender, or the social sex, was introduced. Soon enough, the today well-known proclamation by de Beauvoir (1949/2011) about how one is not born as a woman, only made into one in the social context, made its way into discussions in gender theory, where it has been heavily debated ever since (e.g., Butler 1999; Connell 2002). Another important building block in postcolonial feminist theorizing has been de Beauvoir’s dissertation of woman as always “the Other” to man’s “Absolute” (de Beauvoir, 2011). Butler (1999) has taken this thesis even further, arguing that sex itself is nothing more than a construction, noting, moreover, how the definitions of biological sex are emotionally charged.¹⁷ The latter, according to her, carry meanings arising from culture, reflecting characteristics of the social structure and social processes embedded in it, and thus vary over time. There is therefore a need, Butler argues, to cease talking about “women” and “men” in general, on the theoretical level. Instead, we should understand gender as something emerging

¹⁷ See also Butler’s discussion of the construction of the “Arabic Other” after 9/11 (Butler 2004, 2010).

from, and shaped by, the matrix of society, through each individual's (not necessarily intentional) actions in "performing" gender.

In Western feminism overall, the notion of woman has been defined in relation to that of man, forgetting or ignoring that there is not *one* woman (just as there is not *one* man) but a diversity of women, which makes it difficult to talk of women as a unified group. There has been much focus on examining the differences between men and women, thus dichotomizing the two into separate, mutually oppositional categories.¹⁸ Biological, and to some extent also cultural, differences have been cited as grounds for this distinction, thus essentializing woman and man into relatively fixed and rigid categories. This binary view has been subjected to much criticism, however, in particular the idea that there would be a universal single female perspective, since this would clearly exclude or reduce the possibility for other forms of feminist thought. As Lorde (1984, p. 115), for example, has argued, white women tend to focus on their oppression as women, ignoring differences in race, sexual preference, class, and age.¹⁹

The focus on the construction of this distinction between men and women has played an important role in the struggle for gender equality in the West. At the same time, to state so is merely to reflect the hegemonic picture of a particular ethnocentric feminism founded on culturally specific notions of rights, freedom, self, individuality, and subjectivity, while the question, in fact, is of only one corner of the diverse landscape of global feminisms.²⁰ Feminism can hardly be reserved for the West alone. There is also, to name but a few, strong Islamic feminism, contemporary Indian feminism, and African gender activism – currents outside of the West that make the global feminist scene as rich as it actually is (see, e.g., Narayan 1997; Pereira 2004; Mahmood 2005). In the dominant Western view, there is

¹⁸ It is tempting to make a comparison here with how women are looked upon in Islam, in which men and women are depicted as equally powerful (Mernissi 1991).

¹⁹ This neatly expresses the intersectionalist spirit. Intersectionality is a concept that helps to define and analyse the simultaneous involvement of different power asymmetries, such as those based on gender, sexual preference, class, profession, age, nationality, and so forth (see, e.g., Lykke 2010). However, since the concept has (with some reason) been criticized as being an overly broad catch-all term (e.g., Jibrin & Salen 2015), in this dissertation I use it alongside more specific terms such as gender, man, and woman.

²⁰ Although, in this dissertation, I speak of "Western feminism" as a hegemonic concept, there are, quite obviously, many fractions and contradictions within that body of thought and movement even if further discussion of these is omitted due to space limitations.

therefore clearly a contradiction worth noting: in putting forth the proposition that there is only one (global) feminism and that all women are equal, one, however, at the same time assumes the superiority of the Western feminism based on the notion of the “Other” women who need to be “rescued” from their supposedly even more oppressive heterosexual partners (Spivak 1988, p. 123; Ashcroft et al. 2013).

Indeed, Western women typically see themselves as “liberated”, with women from other parts of the world looked upon as not only victims of “exotic oppressions” (Mohanty 2003), but also traditional, non-progressive, ignorant, and backward, though sometimes revolutionary as well (Mohanty 2003; Sadiqi 2003; McClintock 2013). Mohanty (2003) has presented for consideration some universal images of “the Third World woman”; these include the veiled woman, the powerful mother, the pure virgin, and the obedient wife.²¹ The discursive positioning that images like this mark can be considered as symptomatic of the postcolonial attitude manifesting itself in actual practice. The Other here, the non-Western woman, is colonized by concepts and meanings attached to her that she almost has no control over at all. Western psychiatric denominations and explanations of the Other, including Western illness descriptions and diagnoses, provide another example of the same. The patronizing attitude at work in this exercise is thus not only reductionist and humiliating, but also geared to colonizing the mind of the Other. At the same time, however, as this study, too, shows, migrant women also exercise some control, agency, and resistance vis-à-vis such efforts at subjugating them (see Article I).

Frantz Fanon, one of the major architects of postcolonial philosophy (e.g., Fanon 1967), was an important theoretician also in the field of psychiatry.²² Somewhat akin to de Beauvoir, one of his key claims was that one was never born into something but rather made into it, under

²¹ The colonial binary positioning of the colonizing “us” versus the colonized “them” continues, in its multiple variations, to be of interest to postcolonial theory. Compared to the Western “civilization”, the Islamic world, for example, is described as barbaric, fanatical, extremist, fundamentalist, and violent (cf. Brune 2015). Muslims are fundamentally associated with the image of the dangerous Muslim man, quite possibly a terrorist. The Muslim woman, in contrast, is for the most part depicted as a victim oppressed by the patriarchal Muslim society. The very nature of this woman is characterized by passivity, apathy, ignorance, irrationality, and lack of independence (Mernissi 2003). This image of the Muslim woman, moreover, has also become the image of the migrant woman in various (national) discourses, such as in the domains of health care and psychiatry.

²²A psychiatrist trained in France, Fanon became involved in the Algerian liberation struggle before his death at the age of 36. During the war, he received severely traumatized patients at his psychiatric clinic in Algeria, attributing the causes of his patients’ ill-health to the violence in the surrounding colonized society (Fanon 1963; see also Kumm 2008).

the influence of one's context. There was no such a thing as a born "negro" or "white" (terms used by Fanon): these were merely categories created in and for the sociolinguistic context (Fanon 1967; cf. Lundahl 2005). Language thus controlled and limited human existence. What is of relevance here for this dissertation is that no one, in other words, is then weak by nature, or a "migrant woman with symptoms of anxiety and depression"; one is rather made into such in the conditions of the present society and the prevailing psychiatry. As Yuval-Davis (1997) has noted, there is, moreover, a strong essentialist element in the construction of the Other involved in this making. Stereotypes used to enforce the outcome typically work to fix binary oppositions, such as gender polarities assigning, for example, refugee women the position of crying victims (cf. Fair & Parks 2001). Elsewhere, Alexeyevich (2012) has addressed the mechanisms behind these stereotypes in her book entitled *War's Unwomanly Face*, about agentic war narratives of women that were systematically suppressed in the then Soviet Union. Through its collective narrative of forced mutism, the book effectively illustrates just how dominant the hegemonic image of the woman and the victim position has been (and continues to be even today).²³ The same, to be sure, is true about the discourse centred around the "other" woman (cf. Spivak 1988). The notions of what femininity and masculinity are about, including the views about how gender in each case ought to be practiced, differ depending on the context. The conditions influencing this are not simply rooted in ethnicity, gender, or social class; all these intersect in real life, affecting and influencing one another.

To reiterate, postcolonial feminist theory does not look at women as a clear distinct entity of any kind. Instead, it approaches gender as something intersecting with other systems of privilege and oppression such as race, class, age, and sexuality. Accordingly, for it gender cannot be understood as any one, single system of domination and oppression: it is always articulated with other structures of inequality (Mohanty 2003). Yet, we in the West appear to continue employing our colonial gaze that racializes the "other" women, doing so also, and perhaps especially, in institutions and organizations aimed to help and guide individuals, including these very women. For a good example of this type of construction of the "other"

²³ There are also counter-narratives presenting a different picture, however. For just one example, the women (Kurdish) Peshmerga soldiers are frequently highlighted for their fierce quality and powerful role as fighters in the war against Daesh/ISIS.

woman's plight, one need to look no further than the on-going discussion in Sweden about honour-related violence in the country's migrant communities (de los Reyes 2003).

Inspired by Fanon, Ahmed (2007) has argued that "Whiteness" can be defined as a continuing and unfinished account affecting how space is used. The space affected here is not only the nation space, but also the space of (national) organizations, those of healthcare and psychiatry included. As Molina (2010, p. 79), referring to Ahmed, has noted about the refugee policy currently pursued in Sweden, refugees are welcomed in the country,²⁴ but the entrance for the racialized Other remains conditioned and controlled by the white majority (cf. Fanon 1967; Ahmed 2007, p. 150).

Discrimination and Traditional Western Psychiatry

Terms such as institutional racism, structural racism, systematic racism, and systematic discrimination all refer to what, for me, can be compactly summarized as being about structural discrimination. In the Swedish context, this latter concept is widely used and derives from a government-commissioned report on structural discrimination in the country (Kamali & de los Reyes 2005). In the report, structural discrimination is proposed to not only constitute a problem for individuals, but also threaten the very foundation of human rights. Extending on this general observation, this study adopts a narrower perspective on the topic, examining how structural discrimination operates in psychiatry in Sweden.

When investigating experiences of discrimination, it is important to look at discrimination as a mechanism in society, one that constantly shapes and maintains inequalities between people. It then becomes evident, as Boréus (2006) has noted, how these structures embed processes of 'othering' as the making of 'the Other'. In the context of this study, this may mean, for example, that the "other" woman can indeed have access to care, but only as someone reflecting the qualities of the Other – as weak and subservient. In this situation, it may then become more difficult for her to obtain help if she acts in a way that contradicts her expected (migrant) gender role, for instance by narrating her anger or claiming her right to health care as a citizen rather than a victim.

²⁴ To be sure, even this is today debatable, given that the country's borders have subsequently been closed due to the proclaimed "refugee crisis". In addition, public opinion in the country is changing rapidly, with xenophobic movements becoming increasingly vocal and popular, making it more and more difficult to consider refugees as continuously welcome to Sweden.

Williams and Healy (2001) have provided a concise description of what happens when patients break the ceremonial (emotion) rules in their encounter with doctors: “good” patients play by the rules, are polite, and do not openly engage in questioning and criticizing the doctor or the healthcare system, and eventually get the help that they seek, while “bad” ones acting differently do not. In other words, those who act in conformity with the Western medical order are more likely to obtain help. If not an instance of discrimination, this can be seen as at least a disciplinary expectation on the Other to behave according to the existing set of tacit rules and norms closely bound up with the prevailing power structure (cf. Foucault 1978). “Playing by the rules” does not, however, mean that the Others (here, migrants) necessarily accept the rules they play by. To adjust oneself to meet the expectations can also be seen as indicating agency, an active choice or a strategy, on the part of the migrant, as something resorted to in order to proceed with one’s trajectory to gain access to care and attain a negotiated sense of belonging. The other option, which is not adjusting to the frames of the existing healthcare system, can, namely, lead to only further exclusion (cf. Giordano 2008; Wettergren 2015).

As the very term structural discrimination indicates, the question here is about discrimination at the structural, not so much personal, level. Nevertheless, it is my experience that those working in psychiatry and medical care are hesitant to even admit and acknowledge that such discrimination exists in their society today. To speculate on the reasons for this reluctance, it is possible that it stems from the popular notion that Sweden is “different” because of its presumed lack of a history of racism and oppression (see also Swedish Government 2005b). This notion, however, ignores the actual historical record that, for instance, shows Sweden to for long have engaged in striking, government-promoted practices of classifying and treating people according to their phenotypic “race”, with people categorized as Sami, Finnish, and Roma then both described and treated as less worthy than “pure” ethnic Swedes (Catomeris 2004).

Race, however, is a social construction and a notion based on racialized phenotypes, one that enables the social construction of migrants as Others to maintain inequality and discrimination in society (Molina 2010). Broader racialized structures in society become evident when people are treated differently and unequally based on different racialized

markers of which skin colour is one (de los Reyes & Kamali 2005).²⁵ The way people are treated in everyday life is thus linked to more general power structures shaped by ideas of race and hierarchy. As Grove and Zwi (2006) have shown, the racialized Other is defined and treated as a separate category socially and culturally disconnected from the host communities in the receiving country. The fact has health consequences for both individual migrants and entire communities. It is thus important for healthcare actors and organizations to be able to challenge this discourse of othering, with the staffs in health care and psychiatry playing a critical role in these efforts in helping to reframe the discourses on and with migrants.

Despite sustained efforts in Sweden to reduce gaps between people, the institutions, legislation, standards, and established values in the Swedish society still today continue to be characterized by formal and informal power hierarchies, ethnocentrism, and us-versus-them thinking (e.g., Sernhede 2006). Individuals and groups offer evidence of their exclusion and alienation, depicting their lives in the country as being those of “the eternal migrant”, or never ceasing to be considered a migrant, even when actually born in Sweden or having only one foreign-born parent (see, e.g., Swedish Government 2006). While a better understanding and systematization of such experiences is vital for any production of effective countermeasures against structural discrimination, they, especially on the individual level, have not been adequately taken up and addressed in the political sphere (Swedish Government 2005a).

One aspect of how Western psychiatry engages in structural discrimination has to do with the notions of health and illness as employed in the field. Psychiatry as we know it in the West does not have a very long history (see, e.g., Johannison 2006, 2015; Reynolds et al. 2009). In broad terms, we can trace it back to the onset of industrialization and urbanization, which was accompanied by a more individual-centred approach to human beings, bringing in turn implications for medicine, broadly conceived, including perceptions of mental illness and mental health (Sanner 2009).

Psychiatry in Sweden has been heavily influenced by Western values, mediated, not at least, through the diagnostic and statistical manual of mental disorders, the DSM (Kirmayer 1988;

²⁵ As evident by now, however, it is not really the colour of the skin per se that matters here but the terms in which “the Other” is perceived and presented (cf. Mohanty 2003).

Kleinman 2008).²⁶ Approaching mental illness from this perspective, however, stressing biomedical models of disease and the conception of mental problems as merely an individual and internal matter, one risks overlooking any social and economic causes of ill-health (Fernando 2005, 2010, 2014). Yet, as we know from research, social and economic circumstances greatly affect one's health throughout the whole lifespan (e.g., Dunn & Dyck 2000; Wilkinson & Marmot 2003; Marmot et al. 2012; The Public Health Agency of Sweden 2016). Indeed, the quality of the social environment and material security are often as important as factors impacting health as the physical environment (Wilkinson & Marmot 2003). Accordingly, also institutions can thus contribute to people's development a sense of belonging when approaching persons as valued, thus counteracting their feelings of being disregarded and excluded (Wilkinson & Marmot 2003, p. 13). In terms of the women migrants looked at in this study, psychiatry, as an institution, can in the same manner either reproduce and sustain structural discrimination and exclusion or promote a sense of belonging counteracting such forces; it, to be sure, can also do both. In any case, it is important to take into account that there may be significant emotional, discriminatory costs attached to agreeing to become diagnosed and labelled only so as to, through that, be able to partake in psychiatric care and that way gain a better sense of belonging in the society (cf. Gone 2008).

The official, stated aim of psychiatry is to diagnose: to identify and categorize psychopathologies in individuals (cf. Segal & Coolidge 2004). At the same time, as Kleinman (2008) has rightly stressed, cross-cultural research and practice in psychiatry has remained scarce, with different norms and cultural meanings of illnesses only seldom taken into consideration and allowed to affect practice. The cultural construction and meanings of signs and symbols have been largely ignored, with the result that diseases are mostly taken to be unaffected by their social and cultural dimensions as psychiatric diagnoses are made in conformity with notions relying on a biological understanding of bodily diseases and their symptoms (Coulter 1979; Ingleby 1982; Fernando 2004; Kleinman 2008; Moncrieff 2010). Yet, symptoms declared as signs of psychological ill-health cannot be objectively verified the same way signs of physiological illnesses can. At best, in psychiatric cases only approximate precision can be attained, qualifying the claims to objective ("scientific") validity of

²⁶ The manual presents a classification system of psychiatric disorders, published by the American Psychiatric Association (<http://dsm.psychiatryonline.org>).

psychiatric symptom appraisals and of the subsequent diagnosis (see, e.g., Topor 2001). For this reason, as Bentall (2004, 2010) and Kleinman (2008) have argued, psychiatric appraisals and diagnoses are mostly pragmatic concepts, frameworks for organizing and explaining different expressions of illness. The non-accuracy involved in them thus leaves much of the actual decision making to the institutions and staffs in psychiatry (Scheff 1970; Fernando 2004; Binfa et al. 2010).

When interpreting symptoms and emotions – and especially emotions that deviate from the culturally dominant pattern – these often come to be viewed as erroneous or pathological when measured and labelled according to the DSM manual (Thoits 1985a, 2012; Hallersted 2006; Chentsova-Dutton et al. 2007). Classifying events and episodes such as, for example, prolonged grieving as signs of a major depressive illness, one over-pathologizes vulnerable people by translating emotions into disorders (e.g. Stolorow 2007). This, quite obviously, is likely to have negative effects on help-seekers having gone through severe losses, such as migrants. Overall, then, the diagnostic process is shaped by not only influences from biomedicine, but very much also strands of thinking typical of our Western culture, including the local discourses directly or indirectly reflecting them (see, e.g., Thoits 2012; Timimi 2014). As a result, there is a clear risk of psychiatry's striving to impose its (Western) views and prejudices onto migrants seeking help for their distress, with yet another context of discrimination created instead one of healing (cf. Fernando 2004).

Understanding the subjective experience of distress and suffering is nevertheless becoming only more and more important with time. Here the idea of social suffering as a two-folded phenomenon can become helpful. The notion addresses both the suffering of the help-seeker and the compassion of the therapist opening up to that suffering in order to be able to relate to the prospective patient (for more on this, see Gunaratnam 2012).

What Is Health?

As noted in the introduction section above, the point of departure for this research is the definition of health and mental health provided by the World Health Organization. That definition has been both lauded and criticized for its breadth, the latter owing to its being seen as far too inclusive and, ultimately, too idealistic (e.g., Lukas & Lloyd 2005). All three aspects of health noted in it – physical, mental, and social well-being – are, however, in my view indistinguishable from one another. When discussing mental health in this dissertation,

both the physical and social aspects of health are therefore always covered by the term, even where this is not specifically noted. At the same time, I also adhere to a phenomenological understanding of health, to which suffering involves bodily pain, hinders everyday life, and makes it difficult to realize core life values (cf. Sveneaus 2014). Accordingly, subjective perceptions of health become central and a core aspect in the understanding and treatment of illness (cf. Lock 1988; Kleinman et al. 1997). From this perspective, definitions of health and illness ought also to draw upon people's own understanding and descriptions of themselves and their everyday life, and not only upon ready-made categories and labels of symptoms and disease (Moss & Dyck 2003).

The social suffering that migrants experience carries with itself the recognition that grief, pain, and distress are also connected to the social context. They derive from experiences of inequality, exclusion, prejudice, attributed inferiority, discrimination, and other such events and encounters of a negative nature, indicating a much larger spectrum of intersecting causes than what the narrow perspective of psychopathology can account for. The concept of social suffering thus embraces a larger context while acknowledging persons' factual suffering as such (see Kleinman et al. 2008; Fassin 2012).

As already noted above, migrants often have increased health needs due to their pre-migration but also, and in especial, their post-migration experiences. In the new society, they face many problems even in their everyday life, to say nothing of broader issues having to do with experiences of exclusion and being discriminated against – experiences that everyone having gone through a major relocation, forced or not, is likely to have familiarity with. All these experiences, events, and encounters can significantly impact migrants' health, well-being, and quality of life (e.g., Pumariega et al. 2005).

What is significant in the WHO declaration from the point of view of mental health is its description of mental health as both an individual and a collective quality or accomplishment. This emphasizes the importance of the networks of social bonds in which we live, and of the ability to think, feel, and act (cf. Thoits 1985b, 2012; Scheff & Retzinger 2001). Weak social relationships and support can then be interpreted as both a social (or structural) and a personal problem manifesting itself through social suffering, in contradistinction to the illness inhering in the individual as such.

The WHO declaration along with all the subsequent research carried out within the organization constitute an important reference point in the field of global mental health.²⁷ In one of its reports on mental health, from 2003, it is stated that 450 million people around the world suffer from mental or behavioural disorders (see Wilkinson & Marmot 2003). In the Swedish context, approximately 20 to 30 per cent of the refugees currently in the country are estimated to suffer from some form of mental illness (The National Board 2015).²⁸

Mental Health and Belonging

As already noted, the Swedish National Institute of Public Health (today The Public Health Agency of Sweden), in a 2007 report of its on social capital and mental health, found women in Sweden born outside of Europe to experience mental health problems twice as often as women in the country's general population (Carlson 2007). The report then goes on to highlight social capital as a key factor in health and well-being, suggesting it to have a protective effect on mental health.²⁹ For the purposes of this dissertation, the concept of social capital may be understood as synonymous with the concept of *belonging* in a broad sense, since both terms describe and emphasize the importance of positive social bonds and relationships for mental well-being. These findings and conclusions are directly in line with the findings and suggestions put forth by the WHO about resilience (see, e.g., Björnberg 2010; Lenette et al. 2013; Simich & Andermann 2014), a concept that in the present context can be said to denote agency such as active striving by people to relate to and belong using the opportunities available to them in the society. The question here is thus also of a striving for health and well-being, which can be promoted, among others, through psychiatry. Therapeutic relationships in psychiatry might here be seen as prospective channels, however minor sometimes, for negotiating belonging; regardless of how insignificant they might seem from the outside, such opportunities still appeared to matter to the migrant participants in this

²⁷ These include, e.g., the WHO Mental Health Action Plan 2013–2020 (<http://apps.who.int>).

²⁸ Medical anthropologists (e.g., Kleinman 1981; Sachs 2012; Grønseth 2006) make a distinction between a subjective notion of *illness* – the feeling of being ill – and the more biomedical notion of *disease* as used in Western health care, such as having tuberculosis. These have their correspondences in the notions of, respectively, *healing* and *cure*. An illness is healed when the person suffering feels content about how the difficulty has been dealt with. A disease, on the other hand, is cured when there has been a successful biomedical intervention to take care of it, such as through medication recommended for it (see Grønseth 2013).

²⁹ Social capital as used in the report refers, broadly speaking, to beneficial social relations and resources that also are important for one's sense of community (cf. Bourdieu 1986).

study, too, supporting as they felt they did their imagined sense of belonging in the Swedish society (cf. Naldemirci 2013).

Having a sense of belonging is thus an important part of one's health and well-being (e.g., Thoits 1985b; Wilkinson & Marmot 2003). According to Antonsich (2010), this sense should be analysed both as a personal, intimate feeling of belonging to place and as a discursive resource explaining socio-spatial inclusion or exclusion (cf. Yuval-Davis 2006). Belonging interpreted as an emotional feeling is about feeling at home and feeling safe in a particular community (*ibid.*). There are also relational aspects at play here, involving personal and social ties that deepen the meaning of a given space (Antonsich 2010). Belonging is therefore never an isolated, individual experience, but rather one that implies a physical context, social bonds, and access to institutions (Probyn 1996). Belonging can, furthermore, also be considered political, since it implies claims to human rights such as the right to health in one's place of residence (Bhabha 1999; Benhabib 2004; Yuval-Davis 2006). Yet, as Yuval-Davis (2006) has argued, it is nevertheless the dominant groups in society that most often define the meaning and conditions of belonging, usually by reference to sameness, creating exclusion and non-belonging (cf. May 2013). Nevertheless, subordinate or marginalized groups will always continue to pursue their aspiration to belong, thanks to, as Probyn (1996, p. 9) has pointed out, our fundamental need for attachments vis-à-vis people, places, and modes of being. We can belong to diverse groups and places, and there is always an element of fluidity to it all, for which reason belonging is typically not something attained but, rather, a state of becoming (Article I). Moreover, belonging tends usually to be intersectional, since it comprehends and coheres across multiple levels and aspects of social existence. In this view, emotions then form a fundamental part of our social existence and belonging, with so much of our being and becoming negotiated through them (e.g., Skrbiš et al. 2007).

Emotions and Psychiatry

As already hinted above, emotions and an ability to work on emotions are thus important for migrants seeking help in psychiatry. Emotions and emotion work are, however, also essential for those in psychiatry treating migrants. In this section, I examine and elaborate on these two claims.

In a more conventional understanding, emotions have no place in organization management, since organizations always pursue rational goals (see, e.g., Fineman 2000). Binary oppositions

drawing an either/or contrast between rational and emotional, the organized and the chaotic, have to a large extent informed the way our Western world has organized itself. Connecting to the discussion about postcolonialism above, that world claims to represent and embody the terms organized and rational, contrasting with the non-Western world that, in this self-conception of the West, is characterized by emotions, irrationality, and disorder (cf. Said 2003). In other words, the modernist Western dichotomy positing reason and emotions as standing against each other has its equivalent in the one that posits non-Westerners as the emotional and thus un-rational opposite of their counterparts in the West, leaving the latter (in particular white Western men) with the task and indeed a mission of representing the ideal-typical rational man (cf. Williams 2000; Mohanty 2003; Said 2003).

Contrary to this notion, emotions and reason are in fact very often intertwined and equally important in their operation; they are not each other's opposites but part of the same continuum and constituent parts of the same process (Barbalet 2001, p. 45). Emotions therefore play a role, sometimes a very important one, also in action that may appear "rational" to the outside eye.³⁰ Reversely, as Williams (2000) has noted, even emotional explosions include processes of communicative reasoning unfolding in an intersubjective reality. Demonstrating one's emotions of anger or sadness can thus be part of a broader rational narrative about social suffering.

This perspective, sometimes, following Barbalet (2001), termed "the radical perspective" in the sociology of emotions, best describes also my own understanding of how thoughts and feelings operate in the fields of gender, migration, and mental health. When it comes to health, emotions are obviously always much involved, as is reason, working closely with the emotions. In line with what has already been observed above, Williams (2000, pp. 560ff.) has argued that where reason and emotion are separated, illness becomes a product of a professional labelling. As he explains it, illness has more to do with the framing process itself than the individual understanding of illness. There is no life without emotions, Williams proclaims, paraphrasing Sartre (1971) in noting that emotions are ways of being in the world and joining Merleau-Ponty (1962) in stressing the existential importance of emotions to our embodied being. Posing the question of how "rational" or reasonable society actually is,

³⁰ Wettergren (2013) has suggested new terms to describe this joint process of reason and emotion working together intertwined: 'reasonemotion' and 'emotionreason'.

Williams then calls for a reconsideration of the relationship between emotion and reason, pushing for the inclusion of an emotions perspective in all debates, discussions, and arguments related to health and illness, further proposing also a focus on mental health rather than mental illness.

Also medical sociology has challenged the accuracy of the narrow, basically biomedical picture of health and illness that characterizes our late modern era. Here the argument has been that a more sophisticated conceptualization is needed in order to describe the continuous interlacing of emotion and body in our experiences of health and illness (e.g., Bendelow 2009, p. vii). Williams (2000), for his part, speaks of the possibility of a joint sociological and biological model and its potential capacity to help us move beyond the presumed opposition between the two: human beings are, after all, besides deeply social, also a complex mixture of biology, lived and experienced emotions, and a cognitive apparatus. Accordingly, one should make every attempt to avoid medicalizing mental health and, instead, reclaim emotions as something intersubjective in nature and located in bodies acting in everyday life. As Williams concludes:

If...we need a *full bodied*, if not sensual or passionate, approach to emotions in social life – one which no longer falls into irrational traps, pathological ruses to mind/body divides – then the very notion of sociology of ‘mental health’ becomes something of a contradiction in terms. (Williams 2000, p. 574)

Viewing health through emotions, James and Gabe (1996) have placed the focus on the subjective experience of health and illness rather the aspect of morbidity and mortality. Bringing the perspective of the sociology of emotions to bear on the sociology of health and illness enables one to address both individual and organizational issues (James 1993; James & Gabe 1996; Fineman 2000). In this connection, as already mentioned in Chapter 2, Hochschild (2003) has coined the terms emotion work and emotional labour, building her theory of emotions partly on Goffman’s (1959) dramaturgical perspective and interaction order, with a distinct emphasis on emotions.³¹ As Hochschild explains it, we not only seek to

³¹ Goffman (1959) depicts everyday life metaphorically as a theatre, with actors playing different roles, going on and off the stage wearing masks to manage the impression formation of the audience. This can, to some extent, be related to the argument of Fanon (1967) about how black people are forced to act according to “white” rules in order to exist in a white society.

express emotions in social contexts, but also attempt to feel them by creating an experience that is consistent with the emotional expression – something akin to what takes place in impression management.³² At the same time, however, emotions are usually expected to occur “naturally” (see Wettergren 2013), even where there are emotion rules in society that one needs to be able to relate to (Hochschild 1979).

Hochschild (2003) explains emotion work in more detail by discussing its components surface acting and deep acting. Of these, the latter is about showing an emotion that feels authentic to the emotion worker; this is the case, for example, when showing grief at the thought of a funeral. Surface acting, on the other hand, is what is happening when one shows emotions not corresponding to how one actually feels.

Hochschild’s terminology of emotion labour and feeling rules are important not only for the advancement of research in the field in general, but also for the particular focus of this dissertation. The notions of emotion work, emotion labour, and feeling rules for displaying emotions according to formal or informal norms all help us better understand how socio-culturally defined our emotional life ultimately is. At the same time, they also help us analyse how, with the increasing focus of psychiatric organizations on efforts to increase their production numbers, there is also the expectation within them that reliance on more effective emotion work will help facilitate this transition to greater productivity.

In the making of psychiatric diagnoses, as Thoits (2012) has shown, deviations from the dominant feeling and expression rules are likely to be interpreted as emotional expressions of states of ill-health or illness, since difficulties in affect regulation and control are considered an important indicator of psychiatric symptoms (see also Tull et al. 2007). As demonstrated by Reddy (2001), however, there is a wide range of emotional structures, or emotional regimes, in society that affect the way we are supposed to feel and express our emotions. Different societies, too, have different emotional regimes, although these also depend on a number of intersectional factors and are thus never fixed or solid.

Similarly to Reddy (2001), also Johannisson (2009) has examined how signs of suffering and illnesses have, at different times, been attributed different meanings by both individuals and communities. Analysing the concept of melancholia/depression, Johannisson shows how in

³² Impression management is about controlling or manipulating other people’s impression of us (Goffman 1959).

different periods emotions are either accepted or transferred, with feelings explained or described differently in different cultural contexts. Feelings, or, rather, emotional expressions, are, in other words, formed by their context and influenced by the spirit of the times. From being expressed as wild despair, as rapture and empathy, to later becoming interpreted as a sign of lack of control or – as in our time – merely severe sadness, melancholy as a phenomenon has transitioned from being a passionate expression of pain, of an illness of bourgeois men, to becoming a diagnosis of a disease afflicting low-status women.

During migration, different people and cultures, different perceptions of what constitutes good life, and different understandings of health and illness, including their emotional expressions, come into contact with one another and clash in the context of the host society characterized by a set of hegemonic notions governing actions and expectations in all of the areas involved. In such encounters, assessment of the possible success of affect regulation is made in close connection with the dominant feeling and expression rules (the ‘emotional regime’). Overt displays of anger, untempered expression of sadness, and dramatic gestures overall, for instance, clearly violate the terms and rules governing Swedish coolness, making them stand out as something strident and notably “off” (cf. Stearns 1994; Rosenberg 2002; Azar 2006). Adapting to the host country’s emotion rules thus becomes an important part of any integration for migrants, entailing a learning process for which they may or may not find support in therapeutic encounters. The migrant women in this study responded to this need by developing a multitude of beings for themselves, a process that, in Article I below, I try to capture using the term ‘alien habitus’.

A further consideration here is that at least in Sweden, as already noted, people seeking help from psychiatry are all examined and evaluated according to the DSM and also finally diagnosed according to it. As Kirmayer (2006) has argued, however, there are both practical and conceptual problems ensuing from this. It is not just that those working in psychiatry are simply obligated to diagnose everyone seeking help from them: diagnosing has also become the sole means through which the social suffering of the migrant is legitimized. Without it (when not described according to Western diagnostic frames), this suffering will remain officially nonexistent. This has very concrete consequences for the migrants and their lives, in that they, particularly asylum seekers, in order to qualify for certain rights and social benefits (prove their suffering), must make their case using documentation from healthcare

professionals (see, e.g., Fassin 2005). Any suffering must therefore be first evaluated and interpreted as to the validity of its signs by Western healthcare professional before it can be considered authentic and “real”. Autobiographical accounts by migrants themselves are not sufficient here as a description of one’s ill-health and a plea for help.

Emotion Work and Therapists

As just noted, Hochschild (2003) has made a useful distinction between emotion work and emotional labour that can be productively applied in the analysis of healthcare encounters between migrants and professionals. In their daily routine, healthcare workers today must find ways to manage the increased expectations placed, under the influence of the New Public Management thinking, on their productivity. The strain and stress caused by these demands is, if anything, only exacerbated by the concomitant demand for more efficient emotion work on their part (Bolton 2000; Bolton & Boyd 2003; Husso & Hirvonen 2012; Hirvonen 2014). In this situation, healthcare workers resort to what Olsson (2008) has termed harbouring work, a strategy to contain the emotional material of their patients and their own emotions as well as to manage the emotional demands emanating from within the organization itself. Ideally, this work can be shared within a buffer group, consisting of oneself and relatively like-minded colleagues (see, e.g., Bolton & Boyd 2003; Bolton 2005). However, even the existence of such groups tends not to provide workers in psychiatry with a sufficient framework for sharing their stored emotions with their colleagues, since, in that field, one usually works for the most part alone (cf. Tudor-Sandahl 2015). While the emotion work expected from one in these cases is both notably demanding and dense, and should therefore be valued on par with physical work, it nevertheless remains largely unnoticed in the organization, being carried out most often in silence (James 1992; Bolton 2000). One likely reason for this is that emotion work tends for the most part to be done by women: also in health care and psychiatry, traditional conceptions of sex roles still very much hold sway, with women expected to shoulder the main share of any emotion-oriented caring work (Lindgren 1992; Erickson & Ritter 2001; Rasmussen 2004; Hülshager & Schewe 2011).

To reiterate just very briefly, emotion work is carried out in accordance with both spoken and unspoken rules, with societal norms showing where and how emotions can be and ought to be expressed. It is thus about managing one’s emotions in close relation to one’s context.

Emotional labour, on the other hand, usually refers to emotion work done against payment or

other compensation, with the term ‘labour’ pointing to resemblances, but also differences, that emotional labour has with physical labour (for more on this, see Hochschild 2003).

Nevertheless, there are some, like Olsson (2008), for instance, who have argued that all emotion work carried out in one’s professional capacity should be considered as emotional labour. Be that as it may, emotional labour usually implies a trained professional response to help the patient manage her emotions in health care (James 1993; Mark & Mann 2005; Gray & Smith 2009; Smith et al. 2009).

In this study, however, the term emotion work also covers certain less-articulated, more implicit aspects involved in therapists’ work on their emotions. The emotion work analysed in it very much involved emotional labour as well, but since it was impossible to untangle the two in the context of this research, a decision was made to use the broader notion of emotion work as an overall term, instead of separating the two every time. To give just one example of that difficulty, emotion work of expressing empathy and compassion in treatment is required from professionals working in psychiatry, implying that it is, then, also emotional labour. At the same time, however, these professionals also feel personal empathy and compassion towards their patients as fellow human beings, without any organizational requirement compelling them to do so. This emotion work could thus be regarded as a “gift”, and therefore not as labour (cf. Bolton 2005). Yet, to complicate the picture even further, emotional labour should not only be restricted to the relationships between therapists and patients, but must comprehend all the emotions born or otherwise operationalized in all the relationships in the workplace (James 1992; Larsson & Yao 2005; Olsson 2008). As noted above, it is often difficult to distinguish between cases where emotions are required and cases where they are expressed for other reasons.

In any case, difficulty in controlling one’s emotions leads to emotional dissonance (Hochschild 2003; Tracy & Tretheway 2005; Wettergren 2010; Tuckey & Heyward 2011). The term refers to the difference between what one feels and what one *should* feel, or manage by attempting to change either the feeling or the expression of it. The dissonance then arises when, for instance, one wants to show a particular emotion but cannot (Hochschild 2003, p. 90; Olsson 2008). When the case is about an employee doing her best to thrive in the workplace but ending nevertheless feeling this to be impossible, the response is, typically, an

attempt at changing one's feelings in order to resolve the conflict between them and the reality (Olsson 2008, 190).

As already mentioned, however, people working in high-pressure work environments also often develop strategies for coping with the increasingly heavy demands on them. When the question is of a psychiatric organization, these have been shown to include resistance and everyday misbehaviour (Lindgren 1992; Rasmussen 2004; Hirvonen & Husso 2012).

Resistance, to be sure, is something encountered in more or less all professional organizations, and it can be safely assumed to be an ancient phenomenon (Karlsson 2008, 2011). In understanding and describing resistance and organizational misbehaviour, somewhat different ways to define it can be identified. To begin with, Ackroyd and Thompson (1992, p. 2) have described resistance as "anything you do at work you are not supposed to do." Huzell (2005, p. 50) picks up this definition but slightly modifies it, stating it to be anything the management does not want you to do, think, or be at work. Finally, Karlsson (2008, 2011) adds to the above the observation that this resistance is directed towards the upper echelons in the organizational hierarchy.

That workers in an organization always adjust and respond constructively to the orders of the management, declare Ackroyd and Thompson (1999), is a "delusion": workers do not obey simply because they get paid to do so, and nor do they just passively wait for orders if they find something to be not quite right. Indeed, managers are often overly confident in their faith in their ability to align and conform their workers to the rational corporate goals of their organization. Workers also need autonomy and dignity, as Karlsson (2008, 2011) has pointed out, finding it vital for their sense of meaning and satisfaction with their work. Very frequently, however, this need is not compatible with the requirements of productivity and profitability in the organization. In such cases, employees are then likely to resort to misbehaviour and resistance vis-à-vis the organizational management (Karlsson 2008, 2011). When the latter becomes aware of such having happened, it will respond by making an effort to change the behaviour of the employees (Ackroyd & Thompson 1999). In these situations, however, further control tends only to lead to further resistance.

The kind of resistance coming into question in these cases varies somewhat in its form and intensity. Among the therapists studied in this research, it was usually not dramatic in its display and was not carried out on any grand scale. In fact, it was only rarely expressed

openly, and essentially took the form of mere everyday resistance and organizational misbehaviour (Huzell 2005; Karlsson 2008, 2011). Yet, to return to the theme of emotion work in psychiatry, even in such situations the management may, in response, wish to extend its control over therapists' emotion work in the organization. This, in turn, is then likely to not only increase employee resistance, but also direct it towards the prevailing feeling rules and emotional regime, and not necessarily in the organization in question only but, possibly, in the field psychiatry itself as well and, further still, in the society (Bolton & Boyd 2003; Hochschild 2003; Bolton 2005; Brook 2010). As shown by previous research, furthermore, there are a number of ways to resist, even if individual (as opposed collective), mostly hidden acts of resistance seem most common in psychiatry (Huzell 2005; Lundberg & Huzell 2010). In any case, if resistance, as suggested above, consists of everything the employees think, do, and act that they are not supposed to, the range of possible acts of resistance becomes quickly quite broad.

4. Methods and Data

This chapter describes the methods and data collection procedures used in this study. First, however, my own position and positioning as a psychotherapist and researcher in the field in question is discussed. After that, the data collection for the overall study making up this dissertation is described. The research carried out was qualitative in nature, and it was completed in two stages. Before, finally, discussing issues having to do with the evaluation of this study, its ethical aspects are considered.

Researcher's Position and Positioning

As a professional psychologist and psychotherapist working at a psychiatric outpatient clinic for refugees, I can be considered an "insider" in the field involved and thus quite familiar with the Western tradition and field of psychiatry overall. In my day-to-day practice, I had encountered many occasions where I felt there to be an issue that I could see and grasp in my capacity as a psychotherapist, but which otherwise was easily ignored either in research or by the surrounding society. It could be question, for example, of migrant women coming to meet me and complain about having, often multiple times, sought therapy in psychiatric care even before, only to end up being denied treatment for some reason or another. This, to me, seemed to run directly counter to research claiming migrant women to not tend to seek psychiatric

care for their psychological ailments (e.g., Leong & Lau 2001; Nadeem et al. 2008; Kirmayer et al. 2011; Clement et al. 2015; The National Board 2015). After being repeatedly confronted with experiences like this, I felt obligated to look at them a little more closely.

In their book *Choosing Methods in Mental Health Research*, Slade and Priebe (2006, p. 3) have proposed that research should identify its purpose and goals by asking the question “Who is the research for?” The present study represents an attempt to respond to this call, having as its aim to contribute to an improved understanding of how to effectively deal with migrant women’s social suffering and access to treatment. At the same time, however, it also aims to highlight professionals’ working condition in psychiatry, to that way help, however indirectly, to bring about changes in them that promote positive outcomes, and not only for those seeking help, but also for the staffs working in the field.

My point of departure in this study is the epistemological tradition stressing how knowledge and knowledge production are always embedded in a context. Thereby, this dissertation also joins the tradition of feminist research as well as other social-science research that rejects the idea of an objective world out there that can be explored by a neutral and independent researcher (cf. Lykke 2010). The topic of this research, migrants’ mental health and reception in psychiatry, is approached from the position of a researcher in psychiatry who at the same time is situated in the field as a practicing psychologist, whilst also herself being a (non-forced) migrant in Sweden. A fundamental impetus in this quest has been the following observation by Sandra Harding:

There’s been a tendency to think that only the dominated, only the marginalized can use their social location as an instrument of the production of knowledge.... [B]ut it’s also the case that the people in the dominant groups can learn how to use their position...to ask the kinds of questions and think the kinds of thoughts that would make use of the resources of that particular position.... For example, I’m very familiar with Western philosophy...[and] know that tradition fairly well, so if I...turn my critical lens on it, I can learn; I’m in the place to be able to do that. And it’s something that I have an obligation to do. (Cited in Hirsch & Olson 1995, p.19)

Just as Harding feels about herself, so do I, too, find myself obligated to critically examine that which my particular position enables me to see, hear, and perceive, so as to hopefully develop ability for “double vision” (hooks 1984), or, a capacity to see and inspect phenomena in psychiatry through the lenses of both an insider and an outsider. Any knowledge yielded by

this dissertation remains thus fundamentally situated, local, and partial, rather than aspiring to represent some objective truth. In doing so, it leaves the responsibility for the knowledge produced to, ultimately, its author only (cf. Haraway 2004, pp. 81–98).

My position in the generation of this knowledge is articulated in the double focus of this dissertation research. In it, I approach the problem area from the perspective of certain groups or categories of people involved in the field: migrants seeking help in psychiatry and therapists in psychiatry working with migrants. As a migrant myself, I share some of the experiences reported by the migrant participants in this study, and thus can readily relate to them and their accompanying emotional responses as they themselves described these to me. Yet, I also differ from my participants in some important respects. For example, I was never forced to migrate, I physiologically look like a stereotypical ethnic Swede, and only my accent will reveal me as a non-native-born when I speak. To all accounts, the migrant women interviewed for this study nevertheless saw me as their fellow migrant, another “*svartskalle*”³³ despite my blond hair; there was thus always a certain sense of a shared situation and shared feelings on the part of the women interviewed. The racializing gaze is not only about the phenotype, but also about all the minute details of being, doing, and feeling in the everyday life as a migrant. This shared ground was sometimes explicitly articulated in the interviews, sometimes it could only be sensed through wordless communication. At the same time, it is important not to assume too much based on this, for example that one can understand more when there are such similarities (cf. Rubin & Rubin 2011). Any success in drawing upon, but also understanding the limitations of, such a research position thus depends on one’s ability to maintain a delicate balance between being at once an insider and an outsider (for more on this, see, e.g., Miller & Glassner 1997; Grip 2004).

In addition to my migrant role, I am also in the position of a professionally practicing psychotherapist, which was communicated to the participants from the outset but did not, in my estimation, prove to be a significant factor in the interviews. Nevertheless, there may have been some blind spots that I, unawares, made myself guilty of in matters of a more delicate nature, which therefore must be taken into consideration. At any rate, what remains crucial here is for the researcher to try to deconstruct her or his previous professional and tacit

³³ “Blackskull”: a derogatory term for migrants in Swedish, also used by migrants themselves to express solidarity with their like.

knowledge: to possess “knowing-before-hand” is both an advantage and disadvantage (Chenail & Maione 1997). For this reason, during the research and the subsequent analysis it was important for me to constantly and critically reflect on my own thoughts, emotions, and assumptions, asking myself “why” and “how” type of questions about my reasoning (cf. Alvesson & Sköldbberg 1994; Chenail & Maione 1997). This applied also to the second part of this study. As a practicing psychotherapist, when interviewing colleagues and other care workers in psychiatry I came with, and gained new, inside knowledge and insights about working within the system, sharing certain commonalities with my interviewees from the very outset. Here, my working assumption was that this position of mine would allow me to gain a deeper understanding of their working conditions and would not prove an obstacle for dialogue. Indeed, it enabled much sharing of tacit knowledge in the course of the interviews, which knowledge, to be sure, sometimes also became expressly articulated.

The auto-ethnographic elements in my research method, described in more detail in subsequent sections of this chapter (Part II), have thus very much to do with my dual role as both a practicing psychotherapist and a researcher (cf. Haraway 2004). As a psychotherapist, I come with a unique understanding of the work done in psychiatric care, drawing also inspiration from my experience in treating migrants within the country’s psychiatric system. As already noted, this way being an insider has both its advantages and disadvantages when it comes to conducting research in the field. What is important about it, in any case, is that it offers one a valuable means to gain access to intimate knowledge about the participants one interacts with (including their subjective perspective on relevant matters), and to closely understand their working conditions (including what they do in their work, and what in it perhaps goes beyond the persons’ official job descriptions). In this research, this mattered both for the part of the study focusing on migrants and the part of it looking at therapists working with migrants (cf. Kristiansen & Krogstrup 1999; Hollway & Jefferson 2000; Ellis 2004; Baarts 2010; Malterud 2014). The resulting ability to investigate these study participants’ emotion work and, on the part of the therapists, also everyday resistance thus enabled maintaining the twin focus of this research throughout its duration, from the interviews to the final analyses and observations (cf. Bolton & Boyd 2003; Huzell 2005; Olsson 2008; Scheid & Brown 2010). That is to say, my position and positioning as a researcher in this project naturally also influenced the analysis of the materials collected and the conclusions drawn from them, given that that work really starts already at the empirical

material collection stage (see, e.g., Johansson 2005). During the whole process, therefore, it remained essential to keep critically reflecting on the manner of one's proceeding (cf. Gunaratnam & Oliviere 2009; Corbin & Strauss 2014).

A Gendered Approach

As Hydén (2000) has noted, there is much to question about the normative coherence of the discourse on “women” and the concomitant assumption that we can speak of a “women’s perspective” (see also the discussion on postcolonial feminism in Chapter 3). The same way, one can then problematize previous research focusing on “women’s experiences”. Thus, in the interest of steering clear of any conception of “women” as a coherent, homogeneous, pre-social group, the ambition in this research was from the start to maintain an open and flexible approach to the persons being interviewed. Neither women in general nor women to have undergone migration can be understood in terms of seriality (Young 1994). To avoid essentializing the participants (cf., e.g., Lewis & Naples 2014), yet still be able to point to some collective conditions involved in migration and being a woman, the term used in this dissertation is therefore the abstraction ‘migrant women’.

According to Hydén (2000), one central aspect of feminist knowledge is to regard women as subjects with first-hand knowledge of their life and being (see also Mulinari and Sandell 1999). Throughout history, women have been denied access to their own stories and experiences. The stories of women’s lives and concerns have been silenced or left out as one way or another problematic or unimportant. The question here is not just of ignorance about the subaltern (Spivak 1988). As Hesse-Biber and Leagy (2008, p. ix) have stressed, feminism is not a thing, nor is there any one single feminist methodology (cf. also Chapter 3 above): feminism is multi-vocal, with a simultaneous presence of different voices speaking. Similarly, it is also an accepted fact today that women’s experiences more generally are gendered, being also conditioned by race, class, age, ethnicity, and other such variables. The qualitative methods used in this dissertation attempt to reflect the kind of feminist approach implied in all these criticisms put forth. In the words of Hesse-Biber and Leagy (2008, p. 4):

By documenting women’s lives, experiences and concerns, illuminating gendered based stereotypes and biases and unearthing women’s subjugated knowledge, feminist research challenges the basic structures and ideologies that oppress women.

As discussed above, as a researcher I can thus neither avoid the representation problem, not being able to completely stand outside the parameters of the Western discourse or knowledge, nor become completely detached from the Western psychiatric discourse. During this study, my aim was therefore to remain persistently aware of my very particular role and position in the research process and to openly reflect on these. Thus, my aim was to be as transparent in my approach as possible. As Lykke (2010) has pointed out, there are always several different conversations going on at the same time, which forces the researcher to constantly revise her or his positionality. Maximum transparency is thus necessary in order to detect and discover the other stories, thoughts, voices, and words (Trojer 2009; Lykke 2010).

A Study in Two Parts

This study was carried out in two parts: one dealing with migrant women and the other with therapists in psychiatry. These part-studies are, however, not separate and independent of each other but closely interrelated. Together, they correspond to my two-fold aim of exploring and illuminating lived experiences, cultural representations, and organizational conditions that influence how therapists in Sweden receive and treat migrant women.

The two parts of the project both began with a qualitative segment, given the need for initial exploration of subjective perceptions and experiences. In the focus of this study are, namely, subjects constituted through experience, and it is then the subjective experience of the participants that must count as the required empirical “evidence” for it. As Scott (1991, p. 777) has put it, “what could be truer, after all, than the subject’s own account”. Although some such experiences might seem individual and unique, they can nevertheless generally be taken to have been shaped through discursive practices, thus throwing light on underlying structures, practices, and discourses (cf. Foucault 1978). The narratives of individuals therefore have larger implications going beyond mere illumination of one person’s particular perspective and experiences.

In carrying out this project as a whole, just as in its two individual parts more specifically, reflection, or, as Alvesson and Sköldbberg (1994) have defined it, critical thinking about one’s own thinking, played an important role.³⁴ It was important to reflect, analyse, and interpret the individual stories collected by relating them to a larger context, so as to learn from them about

³⁴ For a further discussion on reflexivity and its importance in qualitative research, see Watt (2007).

subjective experiences but also to be able to identify how larger forces such as structural discrimination perhaps impinged on the experiences narrated in them (cf. Shortell 2016).

Before presenting the two constituent parts of this research, a brief description of the methods used in them is in order. As stated, the first part of the overall study investigates migrant women's perceptions of their mental health and reception in the Swedish system of psychiatry. The second part then looks at those working within that system, the therapists, focusing on their understandings of the reception of migrants in psychiatry. In the first part, a narrative approach was used, more specifically the life-story interview method (see Hydén & Brockmeier 2008). Interviews were conducted with twelve migrant women, who all had, at some point, had contact with psychiatric care in Sweden. In keeping with the method employed, the interviews were all individually conducted. In the second part of the study, a qualitative interview method was used, combined with certain auto-ethnographic elements (see, e.g., Ellis 2004; Baarts 2010). The empirical data was collected using focus group interviews (three sessions) with the same six therapists who participated in the individual interviews. The focus group interviews were supplemented with five additional interviews (all individual) with therapists working in areas of psychiatry other than those represented in the focus group. These, too, however, were all individuals with experience of treatment of migrants in psychiatry.

Part I: Exploring Migrant Women's Perceptions of Their Mental Health

The material for the first part of the overall research was collected in one mid-Swedish county between 2009 and 2014, using the qualitative life-story interview method. The interviews were conducted in locations chosen by the participants, such as their homes, a quiet corner in the public library, or some other public or semi-public place. The criterion behind this selection was that the participants should feel comfortable enough in the environment in question to speak about sensitive matters. The twelve migrant women participating in the interviews were recruited using the so-called snowball method (see Svennig 2007; Gile & Handcock 2010). Their selection was preceded by information disseminated about the project through different migrants' associations, either by this researcher personally or by the individuals acting as contact persons for the groups in question. Additionally, information about the project and the possibility to participate in it was spread through one individual engaged in voluntary work with migrants, who offered suggestions about qualifying

candidates and other potentially interested individuals. In keeping with the idea behind the snowball method, one contact then led to further and ever further ones. In the end, twelve women accepted to participate, out of whom two knew each other from before.

Narrative Method

Since the focus in the first part of the study was on the subjective experiences of migrant women in the Swedish society, including their understandings about their lives, health, and dreams of the future, a narrative method, or, more specifically, the life-story interview method, was used for it. In this approach, the individual story narrated is placed at the centre, while the personal experiences related to it are not disconnected from their context; on the contrary, they remain always interwoven in the narrative and referred back to social structures and the social setting in which they are lived, experienced, and told. Narrative approaches including life-story interviews are a frequently used method in migrant research, since they direct attention to the agency and subjectivity of the narrators (e.g., Erel 2007). Furthermore, as Eastmond (2007) has noted, they very often also provide the only means to gain access to the knowledge inherent in the experiences of migrants.³⁵

The interviews were conducted over five years in 2009–2014. All sessions began with a short presentation of the researcher and the research project, including a clarification of the ethical considerations involved. Written or oral consent was obtained from the participants before proceeding with the interviews. In the sessions, the interviewees were asked to tell about their experiences of their migration, their daily life in Sweden, and their health including any possible health issues. All interviews were conducted in Swedish.³⁶ Each interview lasted for about one and a half hours, and they were all digitally recorded and transcribed.

Participants

The twelve participants were all migrants having come to the country as either asylum seekers or quota refugees. At the time of the interviews, they all had been granted permanent residence permits and had been living in Sweden for quite some time already, ranging from

³⁵ As Stephen and Trahar (2012, 59) have suggested, there is reason for special caution with this method, however. It may entail particular ethical issues, such as the risk of reproducing colonial attitudes and patterns through it.

³⁶ Initially, the plan was use interpreters in order to allow the participants to speak in a language of their choice. Securing interpreter services, however, turned out to be both complicated and far too expensive to be realistic. In the end, since all participants spoke fair Swedish, no interpreting was thus involved.

more or less one year to almost twenty years. Three of them had been admitted to the country as quota refugees, with the other nine having been granted subsidiary protection. They were aged between twenty and sixty and came from a variety of countries in Africa, Asia, the Balkans (Europe), the Middle East, and the former Soviet Union. When arriving in Sweden, two participants had been in their teens whilst the others had come as adults. At the time of their interviews, three of participants were illiterate, which then rendered the narrative approach even more appropriate for their part, enabling as it does detailed access to experiences even orally (cf. Eastmond 2007). Two came with an academic degree obtained in their countries of origin. Before migrating, seven of the participants had been staying at home taking care of the home and the children, while the remaining five participants had worked outside the home. Five participants had lost their partners to violence. At the time of this study, only three were in a relationship, while eight had children and one had grandchildren. Eight participants were current students, two were employed outside the home, and two were on disability pension. All participants had witnessed or personally been subjected to severe atrocities and maltreatment of various kinds before and during migration. In Sweden, they similarly all had had experiences of what could be termed structural discrimination (see Chapter 3 for a clarification of this term). Furthermore, as already mentioned, all had also at some point during the stay in Sweden been receiving therapeutic treatment from the country's psychiatric services. For ethical reasons, none of the persons selected for the study were my patients.

Migrant women, to repeat, do not form a homogenous group but differ even greatly from one another, in a number of aspects. Such differences, however, can never be fully described or even grasped by an outside researcher. For practical purposes, as stated earlier, in this study the concept of 'migrant women' is nevertheless used, for both those participating in the study and those belonging to the category more in general, even at the risk of thereby essentializing its addressees. At the same time, every effort is made to provide a pluralistic picture of both the women involved in this research and the broader group of women moving from one place or country to another worldwide, in keeping with the spirit of postcolonial feminist theory.

Analysis

Following the interviews, the recorded discussions were listened through and examined several times over, in order to get a good picture of the narrated stories as a whole and to

clarify the specific details of each story. The actual analysis of the material thus began with listening. (To be sure, one might also argue that it begins already at the interview sessions themselves, where certain directions are chosen for the conversation but not others; see, e.g., Johansson 2005). After that, all the recordings were transcribed verbatim. As a first step towards a thematic analysis, notes were made on the printouts concerning the content of the discussion and/or the narrated story and other relevant details and observations. The annotated transcripts were then compared and contrasted with one another so as to identify any patterns possibly emerging from them (cf. Ehn & Löfgren 2001). Following this, the observation could be made that the necessary material had now been gathered for the study, including all the details needed, and a decision was taken to not conduct any further interviews (cf. Glaser & Strauss 1967).

When speaking during their interviews, the twelve participants moved on and between several different levels, performing, remembering, telling, and retelling meaningful moments from their past, present, and imagined future lives. As common with narratives of this kind, these moments and events were, however, not presented in any neat chronological order that would have structured the stories told. Sometimes, these contained surprising elements, and contradictions in them were common. Related to these characteristics of them, Squire (2008) has emphasized how we can see narratives as telling about experiences rather than as frank and coherent descriptions of events (see also Georgakopolou 2006). Interviews can therefore be considered as “narratives in interaction” (Bamberg 2006) or “small stories” (Georgakopolou 2006). This allows better attention to not only past events but also current or on-going events, as well as imagined future events. Approaching interviews as “small stories” also gives more room for free association between thoughts and ideas (Hollway & Jefferson 2000; Phoenix 2008).

The main process of analysing the interviews started out with abductive analysis, meaning constant back-and-forth movement between the empirical material they contained and any emerging theoretical interpretations of these (Alvesson & Sköldberg 1994; Kvale & Brinkman 2009). As a next step, a thematic text analysis of the interviews was carried out, based on the identified themes and resulting in hypothetical patterns yielding the material for the next analysis. On the part of Article I, “Like a White Crow: Migrant Women and Their Emotion Work in Sweden”, the empirical material consisted of only six interviews, or those

that had been completed at the time for the purposes of this independently written and published article. An additional six interviews were conducted later, with all twelve interviews then providing the material for Article III, “Migrant Women’s Negotiation of Belonging through Therapeutic Relationships”.

Part II: Therapists’ Views

Also for the second part of the project, on the reception of migrants in psychiatry from the perspective of therapists, a qualitative method was used, one inspired, first and foremost, by what Epstein (2009) has described as data mining, an approach used in both interviews and work situations. Frequently used in social work and health care, this method is specifically targeted to practitioners. Epstein (2009, p. 84) describes it as a practice-based approach whereby practitioners-researchers systematically retrieve, codify, analyse, and interpret data from their own as well as similar agencies in order to reflect on practices, programmes, and/or policy implications. Data mining has been used, for example, to study recipients of child welfare benefits. In this study, it allowed me, as a professional embedded in the field of psychiatry, an opportunity to grasp new things not noticed before, such as the problem of whether that which the clinics in Sweden actually offer indeed matches the needs of the help-seeking persons and what they ask from them. Generally speaking, data mining is a very down-to-earth method, asking basic, yet highly pertinent questions such as “What is this clinic trying to achieve?”, “How well do you do with this task?”, “Who are you trying to serve?”, and “How do you know you have done a good job?” (Epstein 2009). These questions are ones that also I have constantly had in my mind when working as a psychotherapist and a researcher. In the study, they were not always presented explicitly or in the exact form given above, but, thematically, they were deeply involved in the discussions in both the interviews and the everyday working situations.

The main focus in this part of the project was on interviews, with other empirical material, such as field notes, mostly processed in the background. The data for it was collected primarily through focus group interviews with six therapists working for an outpatient psychiatric clinic. The choice of method here was, in addition, much influenced by ethnological approaches to the study of everyday life (e.g., Ehn & Löfgren 1996) – all the little things and un-reflected actions – not least in order to better be able to examine how individuals become part of a larger collective group and how attitudes and values are created

and maintained. The focus group interview method was chosen in order to facilitate a conversation between different standpoints and experiences on the question of how it was to be a therapist working in psychiatric care (cf. Wibeck 2010). There was, however, also another, more banal reason for the choice: it was essentially the only method that could be applied during normal working hours. Questions about participants' feelings and perceptions about the treatment of migrants were presented to the group as a whole and discussion was encouraged. Given the limited time available for the purpose each time (one hour per session) due to conditions at participants' workplace, it was important to ensure that the various themes were given adequate attention. Thus, a decision was made to have the focus group meet a total of three times, so that the themes from the previous session could be discussed further in the next one and thus more freely develop in different directions. All of the six therapists invited for the study participated in all the three focus group sessions.

To broaden the perspective and add to it yet a further one, the focus group interviews were supplemented with five individual interviews with additional therapists who also worked in psychiatry but elsewhere, at other outpatient clinics and in a closed ward. The purpose of these interviews was to provide for an opportunity to delve deeper into the question of migrants' reception, by broadening the scope of the research to cover also other parts of the psychiatric organization (cf. Epstein 2009). Unlike initially intended, the interviews were, however, conducted only once due to the participants' lack of time. All of the individual interviews and focus group discussions were digitally recorded and transcribed.

Participants

Those participating in this second part of the project could all be considered therapists in psychiatry, in the sense that they had been engaged in relationship-based psychotherapy given to psychiatric patients. At the same time, they came from differing professional and educational backgrounds, including nurses, psychiatrists, psychologists, and social workers. In the recruitment, only candidates who were therapists with experience of migrants were considered, for which reason the question here can be said to have been of a convenience sample (Bryman 2011). While the six therapists in the focus group formed a natural group (they all worked together also in their jobs, not only in the focus groups) and were familiar to me from before, the five therapists in the subsequent individual interviews did not and were not. All of them, however, were recruited through contact persons in their organizations. All

participants in this second part of the project were women except one, reflecting well the gender balance among Swedish therapists in psychiatry overall. One therapist invited to participate in the study withdrew her participation after having first consented to it, for reasons explained below in the section on ethical considerations. The interviews were conducted in fall 2014 through spring 2015.

Throughout the research process in this part of the study, the context involved in psychiatry was subjected to constant reflection and critical interpretation (cf. Alvesson & Sköldbberg 1994). While a certain pre-existing familiarity with it was important for the data collection and analysis, so was also the researcher's ability to detach from the context, for example through, precisely, critical reflection on vocabulary and power structures (*ibid.*). In addition, critical attention was paid also to the contradiction between the individual and the prevailing psychiatric discourse, or the dialectic between the individual and the structured patterns of that discourse. As individuals, we are all immersed in the surrounding culture and society with their collective ideas, norms, and rules regarding acceptable and unacceptable behaviour. As noted earlier, however, it is therefore hard to detect one's own blind spots. At the same time, cultural patterns also constantly change. The complexity and dynamics in the narratives provided are therefore also based on their tellers' creativity, resistance, and vested interests (e.g., Ehn & Löfgren 1996). As Olsson (2008) has stressed, emotions have a variety of important functions in one's work, owing to which it was important to place a particular focus on them in this research, too.

Analysis

Just as in the first part of the study, also in this second part the analysis relied on an abductive approach. In this approach, an observation is tied to a theory or a theory is linked to an observation, bringing a kind of oscillation between empirical data and theory. The outcome of the analysis then becomes, not an absolute, but rather a plausible interpretation. In both the first and the second part the theoretical apparatus drawn upon was derived from grounded theory, given its closeness to the empirical material (Miles and Huberman 1994; Corbin & Strauss 2014).

The interviews were transcribed and analysed immediately following each interview. They were first listened and then read several times over in their transcribed versions to locate in them any theoretically fruitful "sensitizing concepts" (Blumer 1954) and thematic units,

obtained through abduction. This was done, in part, by presenting questions to the material in general compliance with the grounded theory approach (see, e.g., Starrin et al. 1991). Since the empirical material revealed not only emotions in relation to patients (migrants in psychiatry), but also emotions arising in the workplace and in relation to the organization, they were all assigned importance and plausibility in the abductive analysis. In the empirical material, there were, for example, recurrent indications of various feelings of tiredness and fatigue, of emotions being shut off, and of emotional bluntness. This then gave reason to introduce in the analysis the concept of functional emotional numbness, presented and discussed in Article II, “Organisering av tid och emotioner i psykiatrin” (Organizing Time and Emotions in Psychiatry).

Ethical Considerations

My own pre-conception of the field, or “knowing-before-hand” as Chenail and Maione (1997) have called it, has already been discussed in detail above in this chapter and will therefore not be further addressed under this heading.

The study methods were approved by the Regional Ethical Review Board in Uppsala, Sweden, and the study itself was carried out in conformity with the guidelines of the Swedish Research Council. Full informed consent (oral and/or written) of each study participant was obtained prior to the interviews. All information that could reveal the identity of the participants has been changed, and all participants are addressed as a she. The empirical material for Article I, “‘Like a White Crow’: Migrant Women and Their Emotion Work in Sweden”, was also used, and expanded with six additional interviews, for Article III, “Migrant Women’s Negotiation of Belonging through Therapeutic Relationships”. However, the participant names in the two articles do not match, as an extra precaution taken to protect the participants’ anonymity. Yet, special care was taken to preserve the original character and content of the statements provided by them. All translations from the original Swedish are by the author.

At a very early stage in the data collection for the first part of this project, there, for ethical reasons, at one point arose a need to step out of my role as a researcher. At the beginning of one interview with a migrant woman participant, the interview had to suddenly be interrupted to assist the interviewee in getting urgent care. In consequence, the person was not included in this study. As the incident shows, sensitive matters surfacing in individual interviews can

sometimes lead to participant reactions that cannot be ignored, both in one's role as a researcher and a therapist.

In the second part of the study, one therapist withdrew her participation in the study after having first consented to participate. Her stated reason for this was her migrant background and her fear that her statements might nevertheless be traceable to her because of this. This, she was afraid, might then have brought consequences for her work and employment situation. (The information here is supplied here with her permission.)

Evaluation of Truth Claims and Transparency

The question of how to evaluate qualitative research has been addressed by several researchers (e.g., Alvesson & Sköldbberg 1994; Patton 2002; Holloway 2005). In this section, I draw upon the typology developed by Larsson (1994) that gives five criteria based on which to evaluate qualitative studies: 1) the discourse criterion, 2) heuristic value, 3) consistency, 4) the pragmatic criterion, and 5) the empirical anchoring.³⁷

Firstly, the discourse criterion evaluates the researcher's arguments and reasoning compared to alternative reasoning. In this study, this criterion has been observed at multiple conjunctions, in comparing and contrasting the argumentation from different angles such as by looking at subjective illness descriptions in relation to psychiatric descriptions of diseases. Secondly, heuristic value depends on the extent to which the work manages to contribute with something new, for instance by providing new classifications or developing concepts or theories. In Article I, the criterion for heuristic value is met through the introduction of, for example, the new concept of 'alien habitus' and the novel understanding of migrant women's needs to relate to others and gain a sense of belonging in relation to health issues. In addition, the article also contributes to an improved understanding of the consequences that increased productivity demands under NPM thinking bring for therapists' emotion work in psychiatric organizations. Thirdly, the consistency criterion, which has to do with the coherence and internal logic of results, requires that this study be presented as a coherent whole lacking any major internal contradictions. The fourth, pragmatic criterion involves testing the pragmatic value of the results obtained in the study. To increase this value of the study, workshops were organized for clinicians in psychiatry to discuss its preliminary findings and enable broader

³⁷ The criterion names translated from the original Swedish by the author.

assessment of their generalizability and applicability to practice. The question here was of whether the results might prove useful to practitioners, for example by providing guidance or refuting misconceptions. The response in the workshops was positive, leading to suggestions for practice-based solutions deriving from the findings of this study (for more on these, see the concluding discussion of this dissertation in Chapter 6). Finally, the fifth criterion examines whether the researcher's interpretations are embedded in the empirical material. Towards this purpose, professionals with both clinical and research experience reviewed the study, the analysis, the theoretical argumentation, as well as the individual articles related to them, finding this to be the case. The empirical basis is demonstrated by the interview excerpts included in the analysis sections of the four articles making up the main body of this dissertation.

5. Summary of the Articles

Article I

Title: “‘Like a White Crow’: Migrant Women and Their Emotion Work in Sweden.”

Published in the *International Journal of Work Organization and Emotion*, Vol. 5, No. 3, 2013, pp. 229–245.

Author: Mona Lindqvist

The article explores the role of emotions in the process of migrant women's integration into present-day Swedish society. Focusing on migrant women's accounts and experiences of their emotion work, it investigates the ways in which these women's emotional processes and emotion negotiation might play a supportive role in their integration process.

Thus far, the emotions of migrants have been approached mostly through the lenses of medical and behavioural science. The terms of reference in the analyses have centred on pathology, clinical mental health issues, and diagnoses like post-traumatic stress disorder (PTSD), to that way enable symptom assessment and determine a treatment for the “patient” (Hollifield et al. 2002; Søndergaard & Theorell 2004; Fazel et al. 2005; Porter & Haslam 2005; Pumariega et al. 2005). The sociology of emotions, however, offers a broader perspective on emotions, stressing the wide-ranging power and utility of emotions identified

in play in diverse contexts and interactions (e.g., Flam & Beauzamy 2008; Gray 2008; Svasek 2010; Wettergren 2010). With the growing body of research on the role and significance of emotions, it is important for also research on migrants to learn from the perspective of the emotion sociology, in order to promote a broader and more in-depth understanding of the integration trajectory.

In examining migrant women's accounts of their integration experiences, the focus in the article is on how emotion negotiation can play a supportive role in that process. As the article shows, even what at first glance might seem like incidences of derogatory treatment or disparaging language use (e.g., use of terms of address like *svartskalle*, the Swedish equivalent of "wog"), can, with the help of emotions, be reversed in its intended effect and made into a supportive emotional resource for migrants (Lindgren 2001; Lacatus 2007; Jonsson 2007; Olsson 2008). Emotional negotiation can thereby become a beneficial part of the integration process, enabling opportunities for migrants to both change and blend in.

The study utilizes the method of life-story interviews. Six migrant women were interviewed. On-going impressions and experiences related to being a migrant in the Swedish society are highlighted and analysed through an examination of these women's narratives (cf. Johansson 2005). A further analysis considers the prevailing emotion culture and emotion regime in Sweden from the migrant women's perspective. The dominant rules and norms regarding expression and behaviour in society left the women with a sense of shame for being "different"; yet, they learnt to also modify these rules to their advantage and begin conforming to them without losing their sense of a coherent inner self. This process is analysed as the development of an 'alien habitus' in the migrant women, which enabled them to perform adequately according to the prevailing emotional regime until this was sufficiently habituated (cf. Blix 2010). At the same time, rule reminders such as the "correcting gaze" could heighten the feelings of being just "alien" and apart. Integration for these women was thus not only a matter of cognitive re-adjustment such as through learning the new language, customs, and so forth: at the core of all these encounters was emotion negotiation (cf. Reddy 2001; Graham 2002). In order to fit in and win acceptance in different social contexts, the women made use of markers specific to groups they wanted to belong to in Sweden. To better cope with the cool, detached emotionality prescribed by the prevailing feelings rules in the

country and to facilitate their sense of belonging and mutual understanding in the society, the women drew strength from an emotional community, a buffer group of other migrants.

Major Conclusions

The migrant women constructed an ‘alien habitus’ by learning how to conform to prevalent feeling and expression rules in Sweden, yet retained a lingering sense of remaining alien caused by rule reminders. Integration, for them, was thus not only a matter of cognitive adjustment to the host society, but also, and even primarily, something achieved in emotion negotiation in interaction.

Article II

Title: “Organisering av tid och emotioner i psykiatrin” [Organizing Time and Emotion in Psychiatry]. Published in *Arbetsmarknad & Arbetsliv*, Vol. 22, No. 1, 2016, pp. 27–41.

Author: Mona Lindqvist

Working with migrants in psychiatry often entails heavy emotion work requiring time-consuming reflection on the part of those providing the care. At the same time, therapists also face much pressure from the constantly intensifying pace of their emotion work, being employed in organizations where, due to increased productivity demands, human suffering is today busy being made into a market-economic entity. In this situation, to be able to continue carrying out their work, therapists resort to new strategies to avoid being drained of their emotional energy.

While therapists’ job is to respond to migrants with mental health issues in a dignified and respectful manner, their increasing need to orient themselves towards quantitatively measurable work outcomes takes time from patient care, creating a sense of stress in them combined with increasing feelings of regret for not having enough time to adequately attend to patients. The main sources of stress among therapists in psychiatry is no longer their patients’ stories about their difficult, sometimes harrowing personal experiences, but the tight organizational structures of today that make therapists’ reflection on their emotion work increasingly difficult if not entirely impossible. Emotion work in psychiatry, however,

continues to be as necessary as before, and therapists' encounters with patients even more generally can be compared to manual labour in their intensity (Hochschild 2003).

All this is reflected in therapists' descriptions of their working environment, which they characterize as one marked by steadily increasing demands on efficiency. These demands have consequences that make the emotion work engaged in by therapists far more complicated and difficult to carry out. Besides listening to and incorporating their patients' narratives, therapists must also be able to always remain calm and show empathy. Faced with demands for an accelerating work pace then puts them at an increasing risk of emotional drainage, empathy-fatigue, and secondary traumatization, causing in them symptoms similar to those encountered in their patients.

Looking at these aspects, psychiatric work can thus be viewed through the perspective of the emotion work carried out by therapists in the field. In this article, that work is described and analysed in cases where the patients treated are migrants, with a focus on the kind of consequences that the demands for increasing efficiency bring for the emotion work of therapists. The study uses qualitative methods inspired by Epstein's data mining approach, including interviews and participant observation. The empirical data is derived from focus group interviews and from additional individual interviews. All but one of the study participants were women, reflecting well the gender balance among therapists in Sweden.

Emotion work by therapists is a pre-requisite for successful treatment in psychiatry, with emotions providing them with essential tools in also other respects, such as (not least) in the necessary use of empathy. In this study, too, migrants' narratives of atrocities were not perceived by therapists as forming the heaviest aspect of their work; this was, instead, stated to be the increased demands for measurable results at their workplaces, which left them with less and less time for their professional priorities and more and more of a sense of stress. In this process, patients were becoming increasingly to be seen as mere production units. The demand for increased production achievements, combined with decreased time, brought with it a growing sense of alienation from one's work and self among the therapists studied, causing many to become ill themselves.

Having a good ability to empathize is a key requirement in a therapist's work, as is the ability to harbour large amounts of emotionally charged material from patients (see, e.g., Olsson

2008). Yet, in this study, this aspect of empathy in the therapists' work was reported to be more or less taken for granted and only rarely taken up and problematized. Empathy work, however, addresses itself to a multitude of intertwined emotions that the therapist needs to contain and process. Faced with the demand for measurable outcomes and increasing turnover times, the harbouring vessel of the therapists then soon becomes full. Lack of set time (time to adjust from one task to another) and opportunities to share with colleagues often caused the therapists in this study to become emotionally numb, in turn resulting in yet more compromised-quality treatment (cf. Jönsson 1999, 2009). While the organizational efficiency targets kept going up, the human bodies frequently had a limit for how much they could take before breaking down (cf. Lindgren 1999; Rosa 2014). Although the organizations the therapists worked for sometimes offered them practical help in the form of, for instance, on-the-job supervision to support their emotion work and emotion workload management, this could sometimes only add to their emotion-harbouring burden, when the therapists had to "package" and contain their heavy emotions until the next supervision appointment when these could be dealt with once more. The therapists also reported themselves to sometimes suffer from what can be interpreted as *functional emotional numbness* (resembling Alvesson and Spicer's [2012] 'functional stupidity'), which they saw as one consequence of their changing working conditions.

Major Conclusions

Adequate emotion work is a pre-requisite for successful treatment in psychiatry, and emotions are essential tools that therapists use in their work. In this study, listening to and processing the painful stories of migrant patients was not what taxed the interviewed therapists' emotion work capacity the most. What they considered as most stressful was having to cope with increased performance demands coupled with less time to perform essential work task. Having to compress all the (emotion) work into a limited time, they felt, compromised its quality, with therapists feeling pressured to supply emotion work (empathy) more and faster than they could. Sometimes, this led to functional emotional numbness in them.

Article III

Title: “Migrant Women’s Negotiation of Belonging through Therapeutic Relationships.”

Submitted to the *International Journal of Migration Health and Social Care*.

Authors: Mona Lindqvist and Åsa Wettergren

The article explores migrant women’s experiences and emotions as recipients of psychotherapy in Sweden, their motives for seeking psychiatric care, and their experiences of being treated in psychotherapy. Motivations to migrate, obstacles to migration, and the opportunities entailed by migration all tend to be gender specific (Anderson 2015). While discrimination, exploitation, and violence against them continue to be major identified reasons behind women’s migration, political and sexual identity-related reasons for it are frequently ignored in migration debates (Freeman 2007). In war and conflicts, women are particularly vulnerable to abuse and are therefore taken to be at a greater risk of mental ill-health (The International Committee of the Red Cross 2007).³⁸

In the migrant-receiving countries of the West, talking *about* rather than *with* migrant women is all too common. This is true also of psychiatry, in which Western illness discourses and diagnoses continue to dominate (Rachel et al. 2011; Fassin 2012). Migrant women’s subjective understandings are rarely, if ever, adequately investigated or even listened to (cf. Butler 2002; Ahmed et al. 2003; Erel 2007). This may then lead to objectifying migrant women into a certain clearly demarcated patient group with certain, pre-defined needs.

In this article, the experiences and emotions of twelve migrant women with previous contact with the Swedish psychiatric care system, in particular psychotherapeutic services, are explored. These women’s motives for seeking psychiatric care and their experiences of being treated in psychotherapy are investigated. While psychiatric factors may certainly have played a role in their cases, the study participants themselves attributed the onset, or at least the deterioration, of their mental ill-health to their estrangement and unwanted isolation in their host society (cf. Strijk et al. 2011).

³⁸ www.icrc.org/eng/resources/documents/feature/2007/women-vulnerability-010307;

Through structured open-ended narrative interviews (Andrews et al. 2008), also the migrant women's subjective experiences of their everyday life and their understandings of mental health and ill-health were explored, along with their use of psychiatric services in Sweden. The themes emerging from the interviews revolved around issues such as problems caused by "different" emotional expressions used in interactions with others (e.g., to communicate one's need to relate to someone), a general need for social bonding, and a deep need to feel belongingness in relation to someone or something. The women's feelings of displacement intersected on several levels, arising as they did from lack of relations, the women's need to carry considerable emotional burdens, and discrimination experienced in exile/the host country (cf. Kamali 2008). Although the women did have some social relationships, their earlier relational ruptures had nevertheless left them with a sense of loneliness. Their hopes about their imagined future (see Wettergren 2015) provided them with an important survival mechanism, helping them to endure the often inhumane conditions of existence associated with their migration, the abuse and humiliation they had endured and sometimes still continued to endure. While their flight from their home country had in many ways been difficult to them, also their arrival in the new country brought with it new challenges and outright problems. Nevertheless, as the participants reported, having now arrived in Sweden, they all felt they were openly expected to show happiness and gratitude for being there. Their longing for close emotional relationships had led them to join various associations and organizations. One path for them to negotiate their belonging was, however, also to seek psychiatric care. This meant that the women not only established social bonds with their therapists, but also emotionally invested in their psychiatric care, and did so already before the sessions began (cf. Naldemirci 2013). Yet, even in this psychiatric context, they were exposed to the risk of becoming reduced and shamed as human beings, becoming often victimized, essentialized, and subjected to structural discrimination in the course of the process (cf. Mernissi 1985; Akman 2014).

Major Conclusion

Not only traumas of the past, but also the loss of social bonds and persistent feelings of exclusion, isolation, and estrangement in the host society contributed to both bodily and psychological symptoms prompting the studied migrant women to seek contact with psychiatric care services in Sweden. Access to health care that was granted them as residents of the country allowed them a sense of some degree of formal belonging to the broader society. Besides simply wishing to exercise their formal rights to health care, the women seeking therapy came to it

looking for a deeper sense of belonging. This they pursued by creating a social bond with their therapist. While this strategy often did serve the women's purposes, it also exposed them to forces only reinforcing their feelings of social suffering when the limitations and restrictions inherent in the therapeutic relationship became evident.

Article IV

Title: "Emotional Labour/Emotional Work and Harbouring Strategies by Healthcare Professionals." Submitted to the *Journal of Political Power*.

Authors: Mona Lindqvist and Eva Olsson

The article identifies different strategies through which therapists in psychiatry try to manage the growing demand for emotion work that they today encounter in their work while resisting the increasing productivity and time efficiency expectations that their organizations set on them. While all healthcare work requires emotion work, this is especially true of psychiatry in which emotion work plays a key role (there are very few technical aspects to psychiatric work). At the same time, there are very few opportunities for those working in psychiatry to harbour and share emotions with colleagues – a key requisite for all successful emotion work. The increasing organizational requirements for productivity and efficiency today only further undercut possibilities for (emotion) work, forcing workers in psychiatric to develop and draw upon various strategies if they are to cope with and manage the increasing demands set on them and their work by their organizations.

The article draws upon the emotion management perspective presented by Bolton (2000, 2005), further developed by Olsson (2008). Olsson's examination of 'harbouring work', a strategy by professionals to manage their emotion work and renew their needed emotional energy in teams, illustrates well the need of individual workers in health care to work through their emotions with colleagues. An important finding here is that colleagues, in other words, are often very important for these individuals' ability to solve and endure problems of emotional labour as presented to them by their organization managements. The same has been found to be true of healthcare workers' ability to resist their "greedy organization" (Lindgren 1992; Rasmussen 2004): having an internal team or even an individual team co-member with more emotional energy enables one to better resist poor or damaging working conditions,

compared to proceeding alone. Yet, in contrast to somatic care, for example, emotion work in psychiatry is mostly carried out alone, and there are also fewer practical elements involved in that work to allow one to disguise emotions.

In this article, the ways in which therapists in psychiatry manage emotions at their work is considered, against the background of increasing demands for this type of work and the growing pressures for an ever-increasing pace of the emotion work performed. These ways are identified as more or less conscious strategies of resistance. Qualitative interviews with therapists in psychiatry were used to collect data in three focus groups involving a total of six therapists, along with five additional individual interviews.

The healthcare workers in the study who worked alone used different strategies than workers who had a team available to them to provide emotion-work support. Overall, therapists in psychiatry mostly work alone and thus have to carry the major part of their emotional work burden on their own. As a result, they face a need to develop new ways of working with, and harbouring, their emotions, since a team is rarely available. Among such ways, or strategies, in this study was very often withdrawal into privacy to recover emotionally.

In general, the therapists studied felt a need for resistance in order to create space for emotion work manageable on their own over the course of a workday. The resistance by individual therapists tended to remain more hidden and was more often performed in a hidden space, such as when manifested in unusual use of the bathroom at work (cf. Huzell 2005; Karlsson 2008).

Overall, the therapists' resistance to their organizations' increasing demands on them was for the most part carried out in solitude, as a form of covert everyday resistance or "organized misbehaviour" (Ackroyd & Thompson 1999; Karlsson 2008, 2011). The resistance, however, also became a way to manage emotions, since it allowed the resisters a sense of recovery and continuation following emotion work. Singular acts such as beginning to cry, talking to oneself, chatting with friends, having private phone conversations, surfing on the Internet, or just sitting down and doing nothing became harbouring strategies enabling therapists to deal with themselves and their work pressures in the absence of teams acting as buffer groups.

Major Conclusions

The therapists in psychiatry in this study approached their emotional work demands differently depending on how that work was organized and managed in their organization. Since their work was mostly carried out alone, the emotions worked were for the most part also harboured alone, with the resistance strategies resorted to by the therapists, too, developed and pursued alone. The strategies to cope with and manage the demands from the “greedy organization” included everyday resistance and what could be termed as organizational misbehaviour. For the participants in this study the bathroom at work often became a space where they could shield themselves from organizational demands, enabling them to better control, at least for a while, their emotion work and work through their own emotions in order to recover from the accumulated emotional pressures of the workday.

6. Concluding Discussion

The overall aim of this thesis has been to explore and illuminate lived experiences, cultural representations, and organizational conditions that influence the way in which Swedish therapists in psychiatry receive and treat migrant women. This general aim was divided into two part-studies (Parts I and II), each with its own, more specific aim and set of research questions. Of these, the first part-study (Part I) set to examine migrant women’s perceptions of mental (ill-) health as well as their experiences of therapy in Swedish psychiatry, while the second one (Part II) attempted to describe and explain how therapists, in their organizational working conditions, interpret and experience their encounters with migrant women.

Mental health as described by the migrant women in this study showed great conformity with the definition of health and mental health as provided by the WHO. Health, including mental health, for them could, in the manner of WHO, be summarized as a state of overall physical, mental, as well as social well-being. Health and ill-health, in this conception, are then notions that depend on contextual aspects, having less to do with any individual, isolated signs or symptoms of illness.

In the first part-study, it was shown that migrant women experience health and mental health in relation to a sense of belonging. Non-belonging, isolation, and estrangement, for them, indicated non-health, making them feel ill. In their forced displacement (something they always recognized and comprehended), they learnt to manage their everyday lives by constructing for themselves a multiple self, an ‘alien habitus’. This alien habitus enabled them necessary performative acts to secure for themselves a sense of belonging, allowing them to

juggle large numbers of signs and symbols in communicative acts aimed at bonding and belonging.

More concretely, this first part of the study examined narratives presented by twelve migrant women currently living in Sweden. In these narratives, the women described their own, subjective understandings of mental health and ill-health in the context of their everyday lives in the country. The major themes emerging from their narratives centred on descriptions of pain and suffering the women experienced in their social surroundings, some having to do with their earlier, often traumatic experiences in their country of origin but mostly related to their subsequent everyday reality in the new country. Various problems and challenges were described in this regard, which in this research were analysed as instances of structural discrimination. One very common experience here was to feel becoming reduced and labelled when merely asking for help in coping with sadness and grief (see Articles I and III). Despite such experiences, forming, according to the participants themselves, barriers to their inclusion in the broader Swedish society, the migrant women nevertheless described themselves as not giving up, resigning to their fate, and withdrawing, but instead continuing to struggle to achieve their goal, a sense of belonging in the new place. Their agency and resilience in regard to this was partly based on an imagined picture they had of a new life in Sweden, with the “caring” psychiatric services in the country a small yet significant part of that picture. In the women’s narratives, suffering and strength could at times be dynamically connected: as they sometimes described it, their endurance and ability to keep going partly came out of their suffering. Suffering and endurance were thus not each other’s opposites but worked together, a quality the participants attributed to their experience of migration.

In understanding the dynamics behind endurance and the ability to keep going despite obstacles and let-downs, the concept of resilience provides a useful tool. In this dissertation, this concept has, however, not been used consistently but mostly only alluded to, in particular when discussing the phenomenon and concept of ‘alien habitus’ in Article I, on migrant women’s emotion work in Sweden. The two concepts, resilience and alien habitus, have some features in common worth noting here a little more specifically. Resilience, as proposed by Björnberg (2011), Lenette and collaborators (2013), and Simich and Andermann (2014), is about a capacity to discover new well-being resources, seek support, and negotiate resources through intersubjective action meaningful to oneself in the actual social context. It is

generated at the level of everyday life through social relationships of trust that bestow upon one social recognition and a sense that one's living environment and context can be understood and managed. As the participants in this study explained, they experienced having a multiplicity of beings when acting in their everyday lives, something that I addressed using the term alien habitus (Article I) denoting a complex, dynamic action capability very much akin to resilience. Looked this way, the development of an alien habitus can be seen as a strategy aimed at an on-going *doing* of resilience. Accordingly, also the therapeutic relationship in psychotherapy, in the case of the women in this study who managed to secure such through Swedish psychiatric care services, thus represented for them one part in their overall strategy of resilience. In Article III, this process is analysed more in detail as migrant women's negotiation of belonging in the new country.

In drawing attention to the notion of imagination, Naldemirci (2013) has made an important contribution to the study of migrants' subjective understanding of health and health care in Sweden. As he notes, the imagined availability of health care helped bestow upon his informants a sense of integration and belonging in the new society: "The imagined availability of formal care facilities is where most of my Turkish informants consider themselves to have acquired the basic prerequisites of being modern, well-integrated immigrants in Sweden" (Naldemirci 2013, p. 20). The participants in this study demonstrated similar ability to change their situation through reframing, and not only in regard to access to healthcare, but also in their relationships within the psychiatric healthcare system, drawing upon an imagined picture of therapy and the care it offers. Even when confronted with a harsh reality bringing disappointments, whether through the broader psychiatric discourse or the professional rules governing the therapeutic situation and relationship, they held onto their conviction about the accuracy of this picture. Accessing and utilizing the Swedish healthcare system requires a significant degree of both personal agency and resilience, as demonstrated also by the narratives of the migrant women in this study, and what seemed to have kept them going in doing just that was the hope they drew from this imagined better future (cf. Wettergren 2015).

In psychiatry, however, the multitude of beings denoted by the concept of alien habitus can also be interpreted as a fragmentation of the self, a disorder. Such language and practice of psychiatry imposes a psychiatric discursive order on the Other, thereby depriving the person

from her or his agency and strength in the pursuit of resilience and rather pathologizing her/him. While mental illness indeed exists among migrant women as well, suffering is nevertheless often but an inseparable part of the dynamics of strength in the pursuit of resilience and alien habitus. To experience a sense of being connected, of belonging to a community, is important for health and well-being, with experiences of unwanted isolation and being denied, such as through inability to adequately access healthcare services in Sweden, then only reinforcing one's sense of ill-health and suffering. One suggestion for further study is therefore to examine access to psychiatry as experienced by migrants themselves, not merely as indicated by official statistics or the sheer number of psychiatric clinics located in an area. Overall, in evaluating illnesses and treatment in psychiatry, there is a need to take the *subjective* experience of migrants into consideration far more often and to a much higher degree than what is today allowed within the psychiatric system more and more bent on medicalizing and pathologizing people's suffering.

In focusing on the notions of alien habitus and of belonging, this study has attempted to contribute to just such a broader understanding of the phenomenon of resilience that is needed to better incorporate the subjective dimension of health and illness in the analysis. In its case, the question here was, in the first place, about the imagined meanings of access to health care, including also the therapeutic relationship. Among the participants in this study, the all-important sense of belonging could become "real" through one's relationship with a therapist. This sense, quite emotional in nature, could then also in turn contribute to one's coping ability and further resilience, by creating hope for a future belonging and inclusion in the host society. Such findings are of interest to research on the mental health of migrant women, as the notions of resilience, alien habitus, and belonging all provide for a much larger picture of health than what the focus on particular symptoms of mental illness like permanent fear and worrying will allow.

The second part of this study examined therapists' interpretations and understandings regarding their encounters with migrant patients in psychiatry, including their understandings of how able to offer a good reception and treatment for migrants they felt themselves to be in their prevailing psychiatric context. As a therapist working with migrants myself, my position in this examination was somewhat unique, enabling me to rather accurately identify what was described to me and what was there behind the words used that would have otherwise

remained concealed. It also enabled me to more readily and perhaps also more clearly express myself to the study participants. As noted earlier, working in psychiatry involves emotion work that requires time and reflection, although it is often not the patients' stories of their harrowing life experiences that create the biggest need for this emotion work (to manage the strain and stress from listening to them) but, rather, the tight organizational structures and demands that leave therapists with little room for thinking and reflection as part of their emotion work, while still requiring them to be emotionally available for patients in therapeutic relationships.

The intense emotion work performed by therapists in psychiatry has been compared to heavy manual labour (Hochschild 2003; Olsson 2008). This work, moreover, as was the case also in this study, tends to be carried out in organizations that place increasing efficiency demands on their workers, forcing them to cut back on the time available for each treatment. (Here the "efficiency", to underscore, does not denote a more focused, respectful reception of each patient, but, rather, faster turnover times and overall greater organizational productivity.) There is thus a clear risk that the therapists expected to help people with pain and suffering themselves become exhausted and ill, having to do their "emotional heavy lifting" (as one participant expressed it) in conditions not supportive of, or even feasible for, the task.

The marketing principles of the NPM put psychiatric staffs in an awkward position by forcing them to show (in principle unquantifiable) empathy and compassion towards another human being while at the same time keeping track of every minute spent in the process, so as to dispense just the right amount of empathy to each patient and not waste any time in the "unproductive" labour of trying to relate to one's patients, however unfamiliar to one culturally or socially, as best one can. Where production is expected to continuously increase, the suffering patient is made into a market entity that needs to be merely "managed", and that at an ever-increasing pace, moreover. As a result of all this acceleration and increasing pressure, therapists then need to either find or themselves develop strategies that can help them to avoid becoming drained of all their emotional energy.

In this study, the interviewed therapists reported that they often felt even deeply for their migrant patients, but due to the accelerating pace of their work and the high turnover of patients they had to manage they sometimes found themselves unable to relate to these at all, feeling themselves to be at risk of becoming emotionally numb. This left them feeling bad for

their patients (not being able to provide these with sufficiently good-quality therapy) and bad for themselves (taking their signs of emotional numbness to speak of possible burnout and illness). To manage their working conditions and cope with the increasingly pronounced productivity demands from their organization, the therapists resorted to resisting these demands in their everyday routine through organizational misbehaviour. In other words, they looked for and also found solutions on their own through which to deal with and slow down, in however minor ways, the accelerating work pace they were faced with, without causing the management to interfere.

What all this implies is that the therapists in this study were not just passively adapting to the demands of the large organization of psychiatry, but actively resisted the on-going commodification of emotion work in ways they found possible for them and convenient enough for their everyday working life. Through this resistance, they looked to gain emotional energy to help them counteract emotional numbing and burnout. This, in turn, they expected to enable them to also enjoy more their work with their patients, instead of merely struggling through the day, besides, importantly, providing migrants seeking help from psychiatry with a more proper reception and treatment.

In conclusion, this study then contributes to research in several different ways. Firstly, it adds to and expands on existing migration research by focusing on the motives, agency, and resilience of migrant women as well as their subjective understandings of mental health, none of which has been given much attention in the literature thus far. Secondly, it helps to push research on health care and migration further through its investigation of the highly under-researched area of the therapeutic relationship between migrant women patients and healthcare professionals in psychiatry. Thirdly, it contributes to the development and improvement of health care in Sweden, by advocating a more comprehensive understanding of health. Fourthly, it contributes to the development and improvement of, more specifically, psychiatry in Sweden, by presenting new knowledge about migrant women's subjective understandings of (ill) health and their motives for seeking psychiatric help. Finally, it also adds to prior research on healthcare workers' emotion work, by providing new knowledge about the specific work conditions in which therapists working in large organizations today more and more often find themselves practicing their profession.

Helping Suffering Migrants in Sweden: Present and Future Directions

Besides being a mere academic exercise producing abstract, theoretical arguments related to the themes of migrants, mental health, and the reception of patients in psychiatry, a fundamental aim of this dissertation research has been to, from a more pragmatic perspective, contribute new knowledge with practical implications. A leading question informing its delineation of the problem area has been: How can circumstances of the kind described in this dissertation be, first, more clearly acknowledged and, then, improved, and not only for migrants in Sweden (and beyond), but also for those helping them in psychiatry along with the psychiatric organization on the whole?

In this regard, it seems clear, first of all, that smaller municipalities and communities are better positioned to engage in a productive reflection on, and to respond to, the healthcare needs of migrants. In them, healthcare organizations tend to be smaller in scale, with the different departments making up the organization situated more closely to one another (both physically and organizationally), which enables them to more readily and effectively take on the task. At the same time, healthcare organizations all tend to be slow (despite their demands for higher work pace for their staffs) when it comes to making operative decisions really mattering for their ability to more broadly meet the needs of those seeking help from them. This much is made evident, for example, by the fact that in many migrant-receiving municipalities it has been volunteers from the local community who have responded to the migrants' more specific needs, or at least to a far greater extent than the representatives of the official healthcare system in place, psychiatry included. Nevertheless, in this also the element of luck tends to play a role, with some migrants in the country receiving notable help from individual actors in the local community whilst others have been met only with responses showing indifference at best and a discriminatory, even openly hostile attitude at worst.

By law, health care in Sweden is to be offered equally to all individuals residing in the country. Yet, migrants have often been effectively excluded from the scope of health, in particular psychiatric health, services by, among other things, explaining that they cannot be treated owing to their lack of fit with the (diagnostic) criteria in use in the highly specialized clinics coming to question (cf. Kirmayer et al. 2011). As I see it, however, the issue here is rather about structural discrimination, though not necessarily or always on racial grounds: what we see in these cases is more likely acts of othering the persons seeking help. This is

accomplished by appealing to very narrow Western/Swedish/local definitions of mental ill-health in complete disregard to how, for instance, the WHO has defined good health (including good mental health; see Ch. 1) and how migrants themselves subjectively understand and express their (typically social) suffering.

At the same time, some migrants have nevertheless succeeded in their quest to secure for themselves therapeutic help from professionals in psychiatry, as many of the participants in this study had, too, although, as it seems, probably more thanks to their persistence and endurance than any openness of the system to their needs. When this has happened, what kind of help have the migrant women then sought for their needs, and what kind of needs did they actually have? Based on the narratives provided by the participants in this study, migrant women mostly suffer from a lack of social bonds and belonging. To the extent that this indeed is so, and that lacking social bonds and a lacking sense of belonging can both act as a major cause of mental health problems, the answer to their needs is then not a mere increase in the number of psychiatric care facilities ready to receive migrant women with mental issues; rather, the goal must be to oppose and counteract any tendencies towards pathologizing and medicalizing people's social suffering.

Currently, no person seeking help from psychiatry in Sweden can proceed to treatment without first being issued an official diagnosis. However, even with that done, therapy services offered in psychiatry in the country are not readily accessible, or even visible, to migrants. Migrant participants in this study reported having learned about these being offered in their home community mostly from their own networks, meaning other migrants telling them about this opportunity to connect with the mainstream society through a living Swedish person, a therapist in psychiatry. As I see it, by the way, it must also say something also of the quality of the treatment offered if the word is out there in the migrant community that a therapeutic relationship is likely worth trying.

Yet, treating as many patients a day as possible can hardly lead to quality (emotion) work. In fact, there seem to be two versions of the meaning of quality at play here: one that is the official, organizational version of quality and centres on high patient turnover rates at clinics, and another, completely different version of it that centres on the experience of being seen and recognized in a relationship. It was the latter version that also the participants in this study adhered to when talking about their experiences of receiving psychiatric treatment in

Sweden. Sadly enough, then, the psychiatric care system in the country seems to be heading in the opposite direction compared to them, only strengthening its resolve to keep on dividing people according to a diagnostic system where the human being and her contextual suffering vanishes behind the omnipresent labelling of symptoms.

All this implies an urgent need for further research not only on migrants and mental health, but also, and very much so, on what is of importance in psychiatric treatment from the perspective of both the patients and the therapists. In regard to this, there will be an obvious need to learn also from patients, and not just by taking notes on the results of some shallow anonymous survey asking patients for their opinions. If the goal is psychiatry that works for all people, in order to learn more and be able to change things for the better we must first engage in some serious research on the subject but also take practical action on the issues. Future research must tackle the various barriers in health care and psychiatry that prevent migrants from getting help. While structural discrimination no doubt plays a major role here, there are also other factors, as indicated by the participants in this study, such as, to give but one example, the tendency to display “wrong” symptoms by talking about physical pain in psychiatry.

Wisened by my own research experience, I would, finally, also like to add a bit more personal observation, namely, that research needs to be much more “on the nerve” on what is going on. Towards that end, Back and Puwar (2012) have called for the employment of “live methods” whereby various kinds of means and methods are used in parallel by both the researcher and those being researched. In such a setup, the division between the researcher and the researched becomes blurred, with the outcome of research always a joint outcome. In it, furthermore, there is also a message contained for policy makers distanced from practice, one that I myself am only too keen to share, too: cease production of yet more beautiful but practically unusable documents to implement in the everyday practice of our clinics; if your policy documents are to be useful and, beyond that, even beneficial, they need to be produced by the users and providers of care coming together around such live methods.

As for any more concrete suggestions for how to improve the working conditions of professionals practicing in psychiatric organizations, one way, to begin with, might be to also officially recognize the correspondence of emotion work and physical labour, and not only in the domains of health care and psychiatry, but also so as to promote a better appreciation of

emotional demands at the workplace in general. Due to its heavy nature, emotion work needs to be considered on par with physical labour, especially when evaluating the effects of wear and tear on workers and developing emotional ergonomics at the workplace. That this has remained a neglected area is likely due to the fact that those working in psychiatry are predominantly women. It seems, consequently, that, when looking at the domain from a broader perspective, what we see at play in it is not only a traditional view of the “migrant woman” but also a traditional and gendered view of those working in health care, one which presents emotion work as just a natural part of what women should do anyway.

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Speaking about social suffering?

Previous research shows that migrant women suffer from elevated mental ill-health. Yet conceptualizations of health and ill-health have mostly been provided by medical organisations. This thesis builds on and contributes to the body of knowledge on how migrant women and therapists within psychiatric care perceive migration and (mental) health.

The overall aim of the thesis is to illuminate migrant women's lived experience and organisational conditions that influence the therapists in Swedish psychiatry. The very meeting between the migrant woman and the therapist thus takes center stage. Empirically, the thesis is based on interviews with migrant women and therapists in psychiatry. The analysis reveals that the women are primarily searching for a way to belong in the host society. Through therapy, then, the women are trying to achieve a sense of belonging. However, the work pace in psychiatry is increasing and the therapists are struggling to provide the patients with the help they need. In order to manage the heavy emotion work, the therapists oppose the accelerating work pace by performing resistance in their work. Balancing between the social suffering of the migrant women and the working conditions of the therapists, this thesis exposes shortcomings in psychiatric care.

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