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# Normal life crises and insanity—mental illness contextualised

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# Normal life crises and insanity—mental illness contextualised

# Normal livskris och galenskap—psykisk ohälsa kontextualiserad

Karin Ingvarsdotter, Sara Johnsdotter & Margareta Östman



*According to a 2005 survey, the people of Rosengård, a culturally heterogeneous borough of Malmö, Sweden, utilise considerably less mental health services in relation to their estimated needs than the rest of the city's population. A study based on interviews with people living or working in the area revealed several possible reasons. Most important was their perception of what constitutes mental illness. If the cause of one's disturbed mental state is viewed as a normal life crises rather than an illness, one does not seek medical treatment. The aim of this article is to illustrate how under-utilisation of mental health services by an immigrant population can be explained by their different perceptions of what constitutes mental illness. Interventions should add concerns regarding a client's socio-economic and psychosocial needs, rather than solely follow a medical model.*

*Keywords: Mental Illness; Culture; Immigrants*

*Enligt en kartläggning från 2005 utnyttjar befolkningen i Rosengård, en kulturellt heterogen stadsdel i Malmö, avsevärt mindre psykiatrisk vård i relation till uppskattade behov i jämförelse med övrig befolkning i Malmö. Med stöd av data från en intervjustudie bland folk som bor eller arbetar i stadsdelen klargjordes flera möjliga orsaker till den låga konsumtionen. Den främsta orsaken var synen på psykisk ohälsa; om*

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*ett mentalt tillstånd inte uppfattas som en sjukdom utan en normal livskris söker man inte medicinsk behandling för det. Syftet med artikeln är att illustrera hur underkonsumtion av psykiatrisk vård bland invandrare kan förklaras av ett annorlunda synsätt på psykisk ohälsa. Interventioner bör även inkludera människors socioekonomiska och psykosociala värld snarare än att enbart fokusera på deras mentala tillstånd.*

*Nyckelord: Psykisk Ohälsa; Kultur; Invandrare*



## Introduction

According to a 2005 survey, the people of Rosengård, a culturally heterogeneous borough of Malmö, Sweden, utilise considerably less mental health services in relation to their estimated needs than the rest of the city's population (Senior Partners, 2005). Compared with other countries in Europe, North America, and Australia that have large numbers of immigrants, Rosengård is not unique in regards to its low utilisation of mental health services. Several research studies suggest that mental illness is often associated with migration and socio-economic circumstances (Bhugra, 2000, 2003; Cantor-Graae *et al.*, 2003; Cantor-Graae & Selten, 2005). Nevertheless, immigrants have a low utilisation of mental health care (Bhui *et al.*, 2003; Youssef & Deane, 2006; Reitmanova & Gustavsson, 2009). However, such studies are generally based on the supposition that psychiatric diagnoses are universally valid, and they may disregard cultural and social differences that influence the perception of mental illness. In order to find out possible reasons behind the low utilisation of mental health services in Rosengård, an interview study was carried out exploring the views of residents and social workers in the borough.

This article illustrates how underutilisation of mental health services among immigrants may be explained. By investigating different perceptions of mental illness it became clear why a certain population may shun mental health services. Hence, we argue that interventions should add concerns regarding people's socio-economic and psychosocial needs, rather than beginning with the presumption that they are 'sick' and solely need to be treated according to a medical model.

## Research site and method

### *Sweden—Rosengård*

During the second half of the past century, Sweden became a country with a large immigrant population. Today more than 13% of the nine million inhabitants of Sweden are of non-Swedish origin. If the second generation is included, i.e., people born in Sweden whose two parents were born abroad, this approaches one-fifth of the population (SBC, 2007). Immigration to Sweden has taken place in waves. After the Second World War labour migrants formed the dominant groups. Since the 1980s most immigrants have been refugees or migrants reuniting with family members

already here (SBC, 2007). Both at home and abroad, Sweden is regarded as a role model for other countries as far as in the socio-economic safety net is concerned. In numerous studies the country's welfare system is described as at the forefront with regard to resilience toward globalisation (Lindbom, 2001), in providing new arrivals substantial welfare benefits and in government support aimed at enabling them to achieve economic self-sufficiency (Sainsbury, 2006; Olsen, 2007). Immigrants are guaranteed full access to the Swedish health care system and its social services. In a recent publication by the Swedish Association of Local Authorities and Regions (SALAR *et al.*, 2008), the Swedish health care system is ranked highly by international studies. It has received the highest score for 'generosity' (i.e., who and how many are reached by the health care system) and for 'medical results'. The socio-economic gap between immigrants and native-born Swedes is less than the corresponding situation in other Western countries. With all these positive social indicators it would be reasonable to believe that all residents of Sweden share these resources equally, but apparently this is not so.

The multicultural neighbourhood this study is based upon is called Rosengård and is a borough of Malmö, the third largest city in Sweden. With its 22,000 inhabitants, Rosengård differs from other parts of Malmö in several ways. Its population is culturally heterogeneous; 85% have a foreign background and more than 50 languages are spoken in the area. Social resources in Rosengård are greatly strained and since being built in the 1960s and 1970s it has been a national symbol for certain social problems. Last year it also received attention abroad when Fox News made a controversial feature about immigrants, Muslims, and riots in the area. Every now and then disturbances in Rosengård make the headlines. This part of Malmö has also been the subject of a great deal of research and various intervention projects. There have even been meta-descriptions of Rosengård and its inhabitants (Ristilammi, 1994; Sandström, 2005). The authors of this article have all worked and done research in the area. One of us has lived and conducted fieldwork there for several years, another has participated in a number of local projects, and the third has had clients from the borough as a long-time social worker at a psychiatric unit.



### *Sample and procedure*

Our study was based on interview data obtained from approximately 30 people living or employed in Rosengård. The only inclusion criterion was that informants should reside or work in the borough and be between the ages of 18 and 65. The majority of our informants ranged from 25 to 45. The interview sample was chosen from among people visiting or working at organisations, schools, and public agencies in the area or recommended by other informants. This is often referred to as the snowball or chain referral method and has widely been used, particularly in qualitative sociological research to yield 'a study sample through referrals made among people who share or know of others who possess some characteristics that are of research interest' (Biernacki & Waldorf, 1981). Because the topic of investigation was often

perceived as sensitive by our informants, and also because social standing and power relations could disturb the idea of voluntary participation, caution was exercised when asking informants to name other potential interviewees. The participants came from various ethnic backgrounds and countries of origin including Iraq, Lebanon, Palestine, Afghanistan, Bosnia, Kosovo, Algeria, and Somalia. Prior to the interviews, we did not know whether the participants had had any experience of psychiatric care. In some interviews the fact that the person was suffering from a mental illness came out, but it was not something we actively sought. In addition to the formal interviews, informal and ad hoc conversations and meetings took place. We mention these because to a great extent they broadened impressions and influenced our understanding of situations and contexts.

The locations of the interviews were always chosen by the informant. They took place in people's homes, at their jobs, in schools, at the library, etc. For those who resided in the area, the interviews typically began with an open question such as 'What is mental illness?' or 'What comes to your mind when I say mental illness?' Since this could be a sensitive topic the interview was initiated in an impersonal manner, i.e., no personal questions were asked unless informants wanted to bring up such matters. In the case of those who were employed in Rosengård, we talked about general opinions among their clients, their perceptions as professionals, and their thoughts about the underutilisation of psychiatric health services. The interviews, which lasted between 30 minutes and 2 hours, were conducted in Swedish, tape recorded, then transcribed verbatim. Interpreters were used in half of the interviews. Because the interviewees had various mother tongues, it was not possible to use the same interpreter for all the interviews. The use of an interpreter in cross-cultural qualitative research has received little attention, although it gives rise to several methodological considerations (Temple, 2002; Ingvarsdotter *et al.*, 2010). For example, it might be very difficult for a researcher to assess the qualifications of an interpreter in the case of a minority language for which a certified interpreter cannot be found. In addition, the presence of the interpreter can hinder the informant from talking about personal matters. There can also be meta-communication going on between the informant and the interpreter that the researcher does not know about (Ingvarsdotter *et al.*, 2010).

Ethics approval for the study was given by the Regional Ethical Review Board in Lund (Dnr 101/2006). The interviews were preceded by written and oral information and participants were clearly told of their right to terminate their participation at any time. Informed consent was obtained from each informant.

### *Methodological base and credibility*

The methodological base for the interviews and analysis of the material in this study was inspired by Lincoln and Guba's *Naturalistic Inquiry* (1985) and was a part of a larger research project, making it possible to triangulate sources, methods, and investigators. Various researchers looked into aspects of mental illness in Rosengård,

using different methods and sources. The research group worked with qualitative and quantitative data and met regularly to discuss the study process and outcome. Member checking, described as one of the most crucial techniques for establishing credibility, mainly occurred in an informal way throughout the course of the investigation. The dictum from one interview was repeated to other interviewees for their response. We also discussed the interpretations of interviews with key informants and stakeholders. Moreover, we sought to enhance the credibility of the conclusions drawn from the interviews by presenting direct quotations and making comparisons with prior research.

The goal of generalisation is considered inappropriate for qualitative studies (Lincoln & Guba, 1985). In our inquiry we sought a broad spectrum of opinion, rather than the verification of a given hypothesis. The inclusion of informants from different backgrounds results in obtaining the maximum variation in perspectives on a phenomenon (Miles, 1994). The number of interviews was determined by the criterion of redundancy (Lincoln & Guba, 1985).



## Interview outcome

### *Perceptions of mental illness*

The results of the interviews may be divided into (a) the perceptions of mental illness and (b) how to deal with it.

In several interviews, mental illness was described in terms of sadness, depression, and dejection. These conditions were all said to have explicable underlying causes, such as traumatic experiences or unfortunate life trajectories, and thus they were considered examples of a normal life crisis rather than an illness.

> It is completely normal; it is not an illness. It is quite common to talk about problems you have. You are not supposed to be ashamed for not feeling well.

The above quotation by a man from Iraq clearly illustrates the idea of mental illness as something normal. Another middle-aged Iraqi man explained it thus:

> I think there are things that can affect you if you go through difficult times. There might have been war or other difficult matters. That makes you depressed, and you don't want to be around people.

However, when the so-called normal life crisis is considered to be 'serious' or when neither the person nor his or her relatives are able to handle the situation any longer, a psychiatrist has to be consulted. According to some of our informants, a step toward 'insanity' has been taken and the boundary between normal and abnormal has been crossed.

The close association of the term 'mental' with 'insanity' is seen in the following quotation from an interview with a man about 30 years old from Lebanon:

> Let me be honest: in our native countries, if someone goes to see a psychiatrist or psychologist people talk about him like: 'Look at him, he is mad, poor fellow'. For instance, if there was a man who proposed to my daughter or my sister and you asked around what people know about this person and someone says that he is seeing a psychiatrist or psychologist, you usually would say, 'No, you can't marry my sister.'

Several informants, regardless of whether they came from the Middle East, Afghanistan, or Bosnia, emphasised the feeling of shame and stigma related to mental problems and what they considered insanity. A middle-aged man, originally from Iraq, where he had seen a psychiatrist, explained it this way:

> Often you feel ashamed to consult a psychiatrist. Let me give you an example: I come from Bagdad, Iraq, and for a long time I hesitated about whether I should see a psychiatrist or not. You feel ashamed and you think: 'Why should I do this? Am I insane?' Once I invited the psychiatrist to a dinner party or something like that. I didn't dare to introduce him as a psychiatrist so I told people he was a paediatrician instead. And I think the reason is that people feel ashamed. You don't dare to tell anyone that you need help.

Despite the taboo and stigma associated with mental illness, several informants explained that they themselves perceive it to be something that 'happens to people' and nothing one should be ashamed of. It is, to a certain degree, a matter of what people *believe* other people might think. A 30-year-old woman from Iraq remarked on this in a conversation about mental illness:

> Informant: It refers to things that change your feeling of well-being. It is part of your body, just like the rest of your health—no big difference, no difference at all actually.
> Researcher: Do you mean body and mind, that they are connected?
> Informant: Yes, exactly.
> Researcher: Do you talk about it?
> Informant: For me, yes, we talk about it a lot among my relatives and with my family, but not with everyone. Because people think there is something wrong if you have mental problems. That you are mad, or there is something wrong with you, but that is far from correct.

Our interviews always began with a discussion of mental illness, but the conversations often ended up discussing unemployment, housing conditions, or the structure of society. A young man from Palestine spoke of social problems in Rosengård, where he lived for 13 months and where the rest of his family had been for 5 years. He described the area as being chaotic, and expressed desperation when it came to his housing situation:

> There might be eight or nine people living in a small one-room flat. When my sister wants to change clothes, for example, she has to go to the bathroom because we are so cramped for space. We have looked for apartments all over, but often you have to pay off someone to get a lease on the black market or you have to have contacts.

> That's what it's like. The housing situation isn't good and you just don't feel like doing anything. You don't have time to think about yourself, how you feel, or what kind of health care you need. . . . When I go to visit my friend, who's got a normal place to live in, I feel better. At times like that I don't feel like leaving. Later, when I get back home, I feel mentally weak because of our flat. I get anxious and I don't feel well.

Others have described the unfamiliar social structure in Sweden, the different roles of men and women, and their loss of status as challenging and destructive. A middle-aged man who emigrated from Iraq four years ago stated:

> Among the problems we face is the fact that people were doing well in their home countries.. . . a good job, good income, good—almost everything. But here it is different. We are used to a man supporting the family, making decisions, and being responsible. But here it is almost the opposite. Someone told me that he feels like 90 years old, without any power whatsoever.

The perceptions of people living in Rosengård were familiar to those informants employed in the area. A social worker treating a group of people with post-traumatic stress disorder spoke of a common reaction among his clients when treatment at a Red Cross rehabilitation centre was suggested:

> If you just mention the word mental or psychiatry to a client, you immediately get the response, 'No, I'm not insane'. So when you tell them about the rehabilitation centre at the Red Cross, you have to talk around it and speak of a consultation—you shouldn't really say they are going to meet a psychologist, especially not to people from the Middle East. It doesn't sound good that you are seeing a psychologist, as if you are insane. People get worried and ask 'if I agree to go to the Red Cross, does that mean that I will lose my driver's license? Does it mean I won't be able to get a job in Sweden?'

Also professionals found it difficult to separate the issue of mental illness from other aspects of people's lives. A psychologist working in the area said:

> Symptoms are always symptoms *of something*. They could refer to mental illness, social problems, or both. It can be on several different levels.

In short, the professional of different areas sees the dignity of social problems.

### *How to deal with different states and conditions*

After discussing their general perceptions of mental health issues, most informants gave their description of how people in Rosengård deal with life crises and 'insanity' instead of seeking psychiatric care. In general, they depend on support from family and social networks. In most communities around the world, the family is regarded as the primary social group (Helman, 2007). The shape and constitution of the family varies between cultures and as does the role the family plays for individuals. Beyond

the urban areas of the industrialised world, the extended multi-generational family is the most common structure. This kind of family often works as a small, self-contained social unit, a miniature community, in which everybody shares resources, helps each other, and works for the common good of the group. In addition to biological relatives and marriage partners, a family can include fictive kin, close friends, and acquaintances. As with societies, the family never exists in a vacuum, but is always part of a larger context, one that is geographical, economical, social, cultural, etc. The context is able to both strengthen and weaken the dynamic of the family to a considerable degree (Helman, 2007). Several informants in Rosengård have emphasised the importance of such a social network. A young girl from Bosnia identified this as one reason why people do not seek mental health services:

> I also think [it is because] the people living there are mostly immigrants and they have each other to talk with. If they have worries or if they long for their home countries, [living in Rosengård] is good for them. I have heard that people do not want to move away from Rosengård because there they have each other and they are close to people from their home countries.

However, even if close relations are considered supportive, they can also be experienced as restrictive. A 30-year-old Muslim woman compares the situation in Rosengård with another borough:

> People care a lot about each other in Rosengård. Also the families are larger. . . . I lived in another borough for a period of time. There people lived very much as individuals; they didn't care about each other. In Rosengård everybody cares about one other—the family. But that can, of course, also be tough, negative. You feel that people try to figure out everything about your life by asking loads of questions [informant laughs], questions you shouldn't ask if you don't know a person very well. Everyone keeps tabs on each other here and I don't really like it that way.

The support from family and social networks may also affect the way a person gets a psychiatric contact. As described initially, a psychiatric diagnosis is associated with 'insanity' and informants feared that those who used to be friends may be lost under such circumstances. As a man from Iraq put it:

> Informant: It is mostly about the fear and the shame. If you hear that a person is seeing a psychiatrist, you think he is crazy or something.
> Researcher: Friends? Or acquaintances? Who is applying the label of 'insanity'?
> Informant: Yes.
> Researcher: Do you talk about it in the family?
> Informant: It is even worse in the family. You are even more afraid that the husband or the wife will find out.

The idea of a social network being supportive is not always recognised by social workers in the area. Some families in Rosengård are described as strongly supportive of one another. At the same time the area has a lot of wounded people and shattered

families. Social workers speak of those who lost their families in war, who left relatives and friends behind, or who for other reasons live without supportive networks. When asking about the importance of this, one social worker said dismissively, 'That's a myth!'

Another main reason cited for not seeking mental health care is the support people receive through religion and faith. The following quotation is taken from an interview with an Iraqi man who was diagnosed with PTSD and who was being treated at a Red Cross rehabilitation centre for victims of war and torture:

> Informant: With regard to religion, it happens sometimes that you read the Quran if you feel mentally ill. Then you get to feel better. There are also religious ceremonies like visiting a dead imam [in a mausoleum] that is a kind of ceremony we've got.
> Researcher: Does it happen that you go to see the imam to talk about your problems?
> Informant: It happens a lot that you go to the imam to get advice or help.

Many other voices cited the importance of faith and religion as a means of support. For some people religious leaders function more or less as therapists, as in one instance one man compared his imam to a psychologist. Others, some of them practicing Muslims, maintain that people do not consult the imam for mental problems and that he only gives counselling for issues pertaining to marriage, relationships or finances. Nonetheless, faith is described as a resource that offers comfort and strength in difficult situations. A Muslim woman with origins in North Africa describes how she perceives the role of her religion:

> Actually I don't think it is very common that you go to see religious leaders if you have mental problems. I think you might see them if you have other kinds of problems—maybe problems with your marriage or something. I remember the time I lived in Stockholm and went to an Islamic school. I recall what the leader was like. When he talked about mentally ill people he spoke badly of them. So I think they themselves are the ones who actually need help. ... that's why I don't think you turn to a religious leader to ask for help. I also think it is very shameful to do it [consult a religious leader in this case]. I don't really think people dare to do it.

In some interviews informants mentioned the impact of spirits and demonic possession was communicated. According to the Islamic cosmology, angels constitute a link between Allah and human beings. The angels were created from light; they are immortal and sexless and operate as messengers of Allah. Somewhere in the realm between the angels and humans are the invisible and intelligent spirits, the djinns. They were created from fire and have the ability to reveal themselves in many different shapes. Like humans, they can be either good or bad, helpful or harmful (Esposito, 1998; Al-Krenawi & Graham, 2000). Opinions about whether the djinns exist, their nature, or their possible influence on humans varied a lot among informants. Some

opposed the belief that djinns can affect humans; others, like a man from Afghanistan, told rich stories about people close to him who had been possessed by spirits:

> Informant: Yes, it is common. She [the informant's wife], for example, had problems in Pakistan. She came here and they examined her. She was sent to the Emergency Room and they did an ECG and everything, but still they couldn't find what was wrong with her. She wakes up during the night and her heart is beating, as if she is terrified of something. Then you think: the doctor cannot help, doctors in Europe do not help, so maybe you turn to someone else. First you go to see a mullah or an imam.
> Researcher: How is she now?
> Informant: Same thing, one day well, one day not.
> Researcher: What does the mullah do if you go there for treatment?
> Informant: I cannot say exactly what they do but they have a special kind of knowledge that they have achieved, I don't know what it is myself. They write verses from the Quran and hang it around the neck and things like that, but it isn't known really.

A man from Iraq, who also shared his experiences of people he knew who had been possessed by djinns, was more familiar with procedures to exorcise them:

> Informant: Often we seek help from religious leaders or someone. Morocco is more advanced in these sorts of things.
> Researcher: Do you know if there is someone in Rosengård offering this service?
> Informant: We have been looking for these kinds of learned guys and we found a couple. But then the patient ran off when he understood that someone was coming to help him—he ran and hid. They use amulets, incantations, and things like that. Some people use a special kind of stone, a Sulemani stone.

Other informants, including an imam working in Rosengård, explained possession by spirits as fairly common and indicated that there are many men who perform exorcisms in Malmö.

## Discussion

This study was aimed at finding possible reasons for the low utilisation of mental health services in a multicultural neighbourhood of a Swedish city by exploring how people perceive mental illness. The empirical data has shown that there are multiple explanations on various levels. Despite different welfare and immigration policies, the findings of our study are consistent with results from similar studies in other countries. For example, shame and stigma, have been highlighted as the main reason for low utilisation of mental health services in case studies of Asians in Canada and Australia (Kirmayer *et al.,* 1996; Wynaden *et al.,* 2005), Latinos in the United States (Kouyoumdjian *et al.*, 2003), and Arabs and Egyptians in Australia (Youssef & Deane, 2006; Endrawes *et al.,* 2007). Inhabitants of Rosengård do not seem to constitute an exception. Shame and stigma are frequently associated with the perception of mental illness as 'insanity'.

Conditions must often be seen as very serious before they are considered anything other than a normal life crisis. The way people are supported by their family, their social network, and their faith in taking care of such crises and 'insanity' is described in other studies worldwide (Kleinman, 1991; Kokanovic *et al.*, 2009). El-Islam (1982, 2008) has investigated the role of the family among Arabs in cases where a member suffers from mental illness. He argues that the extended family and the therapeutic milieu it may involve generate a better prognosis compared to institutionalisation.

The idea of the extended family as a resource for mentally ill people appears in several studies (Kleinman 1991). Most cited is the World Health Organisation's (WHO) longitudinal multinational schizophrenia study, whose major finding was that patients suffering from schizophrenia in developing countries had a much longer recovery than their equivalents in developed countries (Sartorious *et al.*, 1986). However, the anthropologist Byron Good (1997) argues that theories concerning the role of the family are still inadequately explored and require additional research from different perspectives and levels to present a better picture of how family relations are related to mental illness. Also, the meaning and measurement of 'social support' has been questioned. Jacobson (1987) has shown that this concept has largely been established on culturally based assumptions and expectations. Finally, faith and religion are often described as having a crucial impact for people suffering from various health problems (Helman 2007). Both Al-Krenawi and Graham (2000) and El-Islam (1982, 2008) suggest that religion, whether it is Christianity, the Druze sect, or Islam, plays a major role for Arabs in their encounters with adversity including mental health problems. They also find that it is not unusual among Muslims to have a notion of mental disorder as something supernatural, such as possession by spirits. Regarding the religious and spiritual dimension in the encounter with a client, social work could learn from experiences in other disciplines (Al-Krenawi & Graham, 2000; Leavey & King, 2007; Johnsdotter *et al.*, forthcoming). For example Rousseau *et al.* have, through several cases in the work of the Transcultural Child Psychiatry Team in Montreal, illustrated how 'acknowledgement by the team of the potential value to the patient and family of considering more than one cultural world allows the family to draw on both traditional and host community knowledge to deal with the crises at hand' (2005, p. 306).

The belief in spirit possession, the importance of a social network, and the aspect of shame and stigma associated with mental illness are considerations that can be crucial in meeting with clients. To overcome barriers between immigrants and the welfare system, and to meet the mental health care needs of a migrant population, culturally sensitive services have often been recommended (Al-Krenawi & Graham, 2000; Kouyoumdjian *et al.*, 2003; Endrawes *et al.*, 2007; Reitmanova & Gustavsson, 2009). Such services could include recruiting personnel of various ethnical backgrounds, providing interpreters and cultural brokers, distributing information in minority languages, and educating staff to be culturally aware.

However, some central factors should be taken into consideration. First, there is a risk of essentialising 'culture' and reducing it to stereotypical patterns of specific ethnicity, nationality, or language. In the encounter with a client, professionals often associate culture with something deviate and they may forget that they themselves take part in their own culture-specific context. Moreover, one must not lose sight of the fact that identity processes vary considerably in the dynamic interaction between immigrants and host societies (Eastmond, 1998). Consequently, there is no way to know a priori what role 'culture' has for a certain individual.

Second, too large a role may be attributed to culture in situations where such aspects de facto have no bearing and where socio-economical factors may be of greater significance. Kleinman and Benson (2006) illustrate this in the case of a Mexican family in the United States. The mother had died of AIDS, leaving a four-year-old son who was HIV-positive. The boy, who had to see the doctor regularly, did not come as frequently as recommended, at which point a social anthropologist was consulted in order to determine what *cultural* factors caused his father not to bring his son to the scheduled appointments. The consultant found that there were no cultural issues at all. The father was working two jobs to support his family and simply did not have time to bring the boy. In short, there is a risk of essentialising cultural aspects and over-emphasising them at the expense of socio-economic factors.

A third problem in implementing a culture sensitive approach is that culture-specific services are often undertaken on a micro-level; that is, they are often restricted only to the meeting with the client. On the institutional level, however, the system may remain closed to cultural variations (Watters, 2001). No matter how important and valuable, a culture-sensitive approach in face-to-face contact with clients is of little use, as demonstrated in our study, if those clients do not appear in the first place.

### *Normal life crises and social work*

We have seen that what constitutes mental illness may be a question of definition. It seems as if there is a discrepancy between the classification system used in the Swedish health care system, which is predominantly based on a biological or pathological, medical explanatory model (Kleinman, 1980), in contrast to folk perceptions among residents of Rosengård. Our informants tended to classify different mental states as 'normal life crises' rather than medical conditions. The debate over where to draw the line between normal and abnormal, health and illness, is a historical and interdisciplinary one. In the last few decades psychiatrists, anthropologists, and scholars in the field of social work have argued that Western societies are becoming more and more medicalised (Kleinman, 1991; Good, 1997; Horwitz, 2007) and that in today's society more attention is given to individuals' vulnerability than to their resilience. Derek Summerfield observes that the focus is placed on discovering or inventing new medical diagnoses, not without influence

from the pharmaceutical industry, and that more and more diagnoses 'invite people to see a widening range of experiences in life as inherently risky and liable to make them ill. This involves a blurring between unpleasant but everyday mental states and those suggesting a clinical syndrome' (2004, p. 21). So the question is whether people in Rosengård really have 'too' low a utilisation of psychiatric care or whether the rest of the city is over-utilising?

The issue of utilisation has got to do with how people's needs are estimated (Watters, 2001). In the interviews, problems of higher, more immediate priority than mental well-being—mainly of a social character—were put forward as reasons why people do not avail themselves of public health care services. Informants admitted feeling depressed from time to time and that their state of mind was sometimes a problem. However, living with eight people in a one-room flat, or the fact that all of one's prior education and skills seem to be worthless, were experienced as more pressing concerns than their mental health, and more urgently in need solution.

In Sweden and the Western world in general, there has been a deinstitutionalisation process going on in psychiatry since the 1970s. Parallel to this, other structural changes have taken place. The largest outcome in Sweden was a mental health reform that came into effect in 1995. It aimed at making support and care for people suffering from mental illness more community based. It also focused on clarifying the different responsibilities of municipal social and psychiatry services (Markström, 2003). The new approach was to be client-focused and holistic; the needs and requirements of the individual are supposed to determine such support, and close interaction and cooperation between the advocacy services are to be practised. The reform has been subject to heavy public debate and more than a decade later only a few municipalities in Sweden have fully put the reform into practice or changed their structure of how to support people with mental illness (Gotmark *et al.*, 2006; Markström *et al.*, 2009). However, the group targeted by the mental health reform is those with severe mental illness, i.e., the people our informants would describe as 'mad'. There is no provision for putting the needs and requirements of an individual with a 'normal life crisis' in focus. One barrier to getting sufficient treatment and support might thus be the widespread distinction in Western countries between health and social care.

As Wakefield has pointed out, symptoms that 'can be caused by internal dysfunctions can also be caused by normal responses to social problems' (1997, p. 338), which seemed to be the case for several of our informants. Our study has shown that 'normal life crises' are not regarded as medical states and we, therefore, suggest a relocation of resources from the health care sector to the domain of social work. Today the service structure in Western societies focuses to a great degree on determining whether problems are of a social, economic, or medical nature and then measures are adjusted accordingly (Watters, 2001). As we have seen in our study there are no such clear distinctions among those we interviewed in Rosengård. Thus, mental health services need to go beyond the clinical model and acknowledge problems as expressed by people themselves. Since many immigrants do not view

themselves as suffering from illness but from a range of social and economic adversities, the social work sector needs to be enlarged.

A further advantage of establishing a service system with a more holistic approach would be to reduce the stigma surrounding mental illness. As Kvaternik and Grebenc (2009) recommend, social work should focus on interventions that resolve problematic situations for their clients and not on classifying problems. For this study we did not deliberately select informants who were or had been in psychiatric treatment. Our aim, rather than to evaluate current services, was to study general perceptions of mental illness within an immigrant population through interviews with residents and professionals working in the area. This approach made us question the Western classification system of mental disorders as well as current western structures where social and medical services too often are compartmentalised.



## Conclusion

The underutilisation of mental health services by immigrants in our study was due to multiple issues, among other things fear of shame and stigma and the existence of support by religion and social networks. In addition, certain cultural-specific perceptions guided strategies and decision-making; if a mental state is not regarded as an illness, one does not seek medical treatment for it. The western mental health service system does not easily accommodate cultural variations. A broader, more inclusive approach to a culturally diverse clientele would heighten the effectiveness of clinical social workers in serving the socio-economic and psychosocial needs of immigrant communities. Hence extensive collaboration between social and medical services is needed to meet mental health needs in multicultural settings.

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