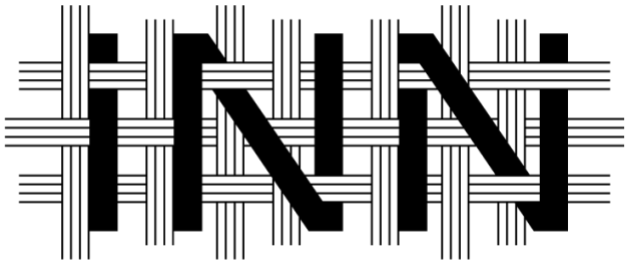

Inland Norway University of Applied Sciences

The Minds That Crossed the Border: Identifying Barriers to Mental Health Help-Seeking in Eritrean Immigrants in Norway

Anastasia Kabatanchi

21 559 words

Master's Program in Public Health Science

Spring 2023

Acknowledgements

This master's thesis marks the end of my two-year education in public health science. I have gained a lot of new knowledge and insight into the processes of public health work, which I'm looking forward to use in practice. There were times when I thought I wouldn't make it, but by God's grace I did, and I'm proud of myself for not giving up.

I want to start by thanking the Eritrean participants who made this study possible. I am grateful for their willingness to share their experiences and insights with me, and without them, my thesis wouldn't have been possible. They truly made a huge contribution to my success, and I can't thank them enough. I also want to thank my supervisor Børge Baklien, for all his encouragement, feedback, advice, and support throughout the process. Thank you for always being available, and for your guidance.

Of course, I couldn't have done this without the support of my family and friends. They were there for me every step of the way, providing me with the motivation and encouragement I need to keep going. I especially want to thank my dad, Valentin T. Kabatanchi, for doing everything he could to help me fulfill my education. He's always been my biggest cheerleader, reminding me of my strength and encouraging me to pursue my dreams. Also, a big thanks to my siblings Telesphore, Therese, Paul, Gilbert, Jane, and Martha for being such an amazing support system.

Finally, I want to thank Martha Kabatanchi for her engagement in my study and for believing in me. She was always there to give me a boost of motivation when I was feeling down, and I'm so grateful for her support.

Oslo, mai 2023

Anastasia Kabatanchi

Table of Contents

Abstract

Immigrants face barriers in seeking and accessing mental health and addiction services. Identifying the barriers that stop mental health help- seeking in Eritrean immigrants is one step to promote mental wellbeing in immigrants. The paper wishes to identify the barriers to seeking mental health care among Eritrean immigrants, through semi-structured, in-depth interviews of 8 participants. Among the 8 participants, only 2 were open to the idea of seeking psychological help, which shows how powerful the obstacles can be. The main findings of the research were that the three main themes “cultural understanding”, “beliefs” and” lack of resources” were in varying degrees found to operate as barriers to mental health help-seeking for Eritrean immigrants in Norway. The expectations of a lack of cultural understanding from health professionals was the most repeated hindrance amongst participants, while beliefs as substitutes for mental health help and a lack of resources within mental health services both shortly followed in repetition. The three main findings were then paired with the three components of the Theory of Planned Behavior ('subjective norms', 'attitudes' and ‘perceived control’), to understand how help-seeking behavior can be encouraged. It does so because the pairings of the three components of the theory and the three main barriers allows one to view the unwillingness to seek help on three different levels; the interpersonal level (subjective norms paired with cultural understanding), the personal level (attitudes paired with beliefs) and the societal level (perceived control and lack of resources).

Abstrakt

Innvandrere møter barrierer når det gjelder å søke og få tilgang til psykisk helsevern. Å identifisere barrierene som hindrer Eritreiske innvandrere i å søke hjelp for psykisk helse er et skritt mot å fremme mentalt velvære blant innvandrere. Oppgaven ønsker å identifisere barrierene for å søke psykisk helsehjelp blant Eritreiske innvandrere, gjennom semi-strukturerte, dybdeintervjuer av 8 deltakere. Blant de 8 deltakerne var det kun 2 som var åpne for ideen om å søke psykisk hjelp, noe som viser hvor sterk hindringene kan være. Hovedfunnene i forskningen var at de tre hovedtemaene "kulturforståelse", "tro" og "mangel på ressurser" ble funnet å operere som barrierer i varierende grad for å søke psykisk helsehjelp for Eritreiske innvandrere i Norge. Forventningene om manglende kulturell forståelse fra helsepersonell var den mest gjentatte hindringen blant deltakerne, mens tro som erstatning for psykisk helsehjelp og mangel på ressurser innen psykiske helsetjenester begge fulgte kort tid etter i gjentakelse. De tre hovedfunnene ble deretter sammenkoblet med de tre komponentene i teorien om planlagt atferd ('subjektive normer', 'holdninger' og 'opplevd kontroll'), for å forstå hvordan hjelpesøkende atferd kan oppmuntres. Dette gjøres fordi sammenkoblingen av de tre komponentene i teorien og de tre hoved barrierene lar en se manglende vilje til å søke hjelp på tre forskjellige nivåer; det mellommenneskelige nivået (subjektive normer koblet med kulturell forståelse), det personlige nivået (holdninger koblet med tro) og det samfunnsmessige nivået (opplevd kontroll og mangel på ressurser).

1 Introduction

Mental health is central to health, and research has shown the vulnerability of immigrants in relation to mental health (Lindert et al., 2009). Mental health is an important aspect of overall health, and it is important to ensure that every individual has access to mental health services. However, for immigrants, there may be unique barriers that prevent them from accessing mental health services. These barriers can include language barriers, cultural differences, and a lack of awareness of available services (Abebe et al., 2017; Byrow et al., 2020; Kour et al., 2021).

This study is therefore going to look at the mental health of immigrants, focusing on Eritrean immigrants living in Norway. Eritrean immigrants are among the largest groups of African immigrants in Norway. While Norway has a relatively small population of Eritrean immigrants, they are one of the fastest growing groups in the country. According to Statistics Norway, there were 19,900 Eritrean immigrants in Norway in 2020 (Statistisk sentralbyrå [SSB], 2022). The purpose of this study is therefore to examine the mental health among Eritrean immigrants in Norway, and to identify the barriers that prevent them from accessing mental health services. The findings of this study will be used to develop suggestions and recommendations for improving and uplifting the barriers to mental health help among this group.

1.1 Background

Norway, like many other European countries, has a growing immigration population. Today, the population of Norwegian immigrants, including those born in Norway to immigrants' parents, constitute approximately 1,025,175 persons or 18,9 % of the total population: 819 356 immigrants and 205 819 Norwegian-born with immigrant parents (SSB, 2022). This percentage consists of people from 214 different countries and independent regions: In total, 492,581 have a European background, of which 105,723 have a background outside the European Union (EU) and European Economic Area (EEA). A total of 342,571 individuals has a background from Asia including Turkey. 144,868 from Africa, 29,515 from South and Central America and 15,640 from North America and Oceania. The largest immigrants' groups from non-western countries are from Somalia, Pakistan, Iraq, Syria, and Eritrea. These

diverse populations have heterogeneous reasons for immigration; labour immigrants account for the largest portion of international immigrants, followed by people who immigrate due to family reunification, refuge and education (SSB, 2022).

In general, the Norwegian population has a good quality of life. However, it is also reported that some immigrants report low quality of life (Hauge et al., 2020; Reneflot et al., 2018). A report on mental health in Norway from 2018 shows that the incidence of mental health issues is higher among individuals from non-western countries than the rest of the Norwegian population; this applies to adults as well as young people with immigrant backgrounds (Reneflot et al., 2018). Internationally, as in Norway, the health status of immigrants differs from the health status of the host population (Abubakar et al., 2018). I will return to the difference in health between immigrants and the host population in the literature review.

1.2 Immigration and Health

As mentioned earlier, there are heterogenous reasons for immigration. Immigration can be seen as a consequence of various social conditions, such as poverty, a difficult labor market, limited opportunities for education, political proliferation, conflicts and war (McAuliffe et al., 2019). Such conditions can contribute to the deterioration of health. Furthermore, immigrants may encounter several social conditions that can have a negative effect on their health in the host country: social, economic, and political conditions can influence immigrants' resources, rights, and security (McAuliffe et al., 2019). Thus, the The health of immigrants is important to consider in a society, both from a human rights perspective and because it affects the host society as a whole (Attanapola, 2013). As previously mentioned, migration is a complex and dynamic process that can affect the health of immigrants, both positively and negatively, depending on a number of conditions associated with individual, social, environmental and health related factors (Abebe, 2010). The health of immigrants has been regarded as a public health challenge in several countries. There is a need of understanding and generating research-based knowledge on immigrant health problems, and healthcare needs are highly relevant for developing preventive interventions, as well as guiding social and policy actions (Abebe, 2010). However, research on immigration health, mental health specifically, has been confronted by several gaps and ambiguities (Abebe et al., 2017; Harris et al., 2021).

1.3 Clarification of key terms and concepts

Mental health and healthcare are complex and multifaceted topics. As such, it is important to have a shared understanding of key terms and concepts that are going to be used in this study, to facilitate clear communication. In this study, I aim to clarify key terms and concepts related to mental health and mental health services among Eritrean immigrants in Norway.

Mental disorder and mental illness

According to the World Health Organization (WHO), mental disorder is a syndrome "characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior" (World Health Organization, 2022). Mental disorders can be caused by a variety of factors, including genetic, environmental, and social factors, and life experiences. Some common types of mental disorders include anxiety, depression, bipolar and post-traumatic stress disorder. Mental illnesses are health conditions involving changed in emotion, thinking or behavior, and are associated with distress and/or problems in social, work or family activities (American Psychiatric Association, 2018). In this study, both terms are used broadly, and is not being limited to a specific diagnosis or set of diagnoses. But rather refers to a wide range of mental health conditions that affect a person's mood, thinking and behavior. This approach is suitable in this context as it allows for a more comprehensive view of mental health needs.

Mental health help-seeking

Help-seeking is a term that is generally used to refer to the behavior of actively seeking help from other people. It is about communicating with other people to obtain help in terms of understanding, advice, treatment, and general support in response to a problem or distressing experience (Rickwood et al., 2005). According to Rickwood et al. (2005), help-seeking is a form of coping that involves seeking support from other people and is therefore often based on social relationships and interpersonal skills. There are various sources of help that can be accessed. However, this study looks at formal help-seeking which is from professional sources of help. That refers to professionals who have a recognized role and appropriate training in providing help and advice, in this case mental health professionals.

Individualism and collectivism

Collectivism and individualism are two terms that describe how a culture values individuality and collectivity. Within individualism, the core unit is the individual; societies exist to promote the well-being of individuals. Individuals are seen as separate from one another and as the basic unit of analysis. Within collectivism, the core unit is the group; societies exist, and individuals must fit into them. Individuals are seen as fundamentally connected and related through relationships and group memberships (Oyserman & Lee, 2008).

Cultural competency

Garneau and Pepin (2015, p. 12) define cultural competence as:

"A complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care".

Cultural competence is a dynamic and ongoing process that involves developing knowledge, skills, and attitudes that enable individuals to engage in effective cross-cultural communication and collaboration (Garneau & Pepin, 2015).

Stigma

Stigma can shortly be defined as "an attribute that is deeply discrediting and proposes that the stigmatized person is reduced from a whole and usual person to a tainted, discounted one " (Goffman, 1986). According to Goffman (1986), stigmatization occurs when an individual is perceived as deviating from the norms, values, or beliefs of the dominant group. This deviation can be related to physical appearance, mental health, social status, or any other characteristic that is perceived as negative or undesirable by the dominant group.

Welfare state

A welfare state is a state that provides a significant level of social security and support to its citizens. It is a system that aims to provide for the basic needs of its citizens, such as healthcare, education, and social assistance. The welfare state is designed to ensure that all

members of society have access to the necessities, regardless of their income or social status (Christensen & Berg, 2023).

1.4 Aim and Research Question

Although Eritrea is among the countries with a large portion of immigrants located in Norway, research on this population is very limited. Based on this, this study is going to look at the mental health of Eritrean immigrants in Norway. The reason behind the choice of population is due to the lack of research and data among this group. I also aim to find out if there's consensus or discrepancies within the research done between my chosen population and other more attended immigrant populations.

The overall aim of this study is to better understand the potential 'ethnic' barriers in preferred help-seeking for mental health problems among Eritrean immigrants living in Norway. My research question is therefore:

"*What are the barriers to mental health help-seeking amongst Eritrean immigrants in Norway?"*

2 Literature Review

The research process started with an initial literature search in three different databases, Oria, Pubmed and Jstor, to get an overview of the literature that is available in connection with the choice of theme. The words that have been used are "immigrants", "mental health", "healthcare"/" health services" and "Norway". Keywords "refugees" and "asylum seekers" have also been used in the search as they are database keywords that also include immigrants. Based on my inclusion criteria, I limited the search to Norwegian or English language, peer-reviewed articles, and academic reports older than 2010 to find the most up-to-date research in the area. In my search, I found a selection of research about experiences with/from minor refugees, this got excluded. The target group is limited to Eritrean immigrants, both genders and aged 18 and over.

During the searching process, I had to constantly go back and forth with the words and combinations in the various databases even though the searches were planned. I used AND between two keywords to get results that referred to both keywords, and OR as a synonym between keywords with the same meaning to get results that include both or one of the words. The search results I got varied in the different databases that were used. In the databases that had more than 500 hits, I only viewed the first 100 titles of the articles because I observed that the matches more likely became irrelevant for the research question. Furthermore, I started selecting articles based on titles and reading abstracts of interest that could be relevant for my research question. 50 articles were chosen based on titles and abstract. Of the 50 articles, there were a total of 16 articles and 3 reports that met the inclusion criteria after full reading.

International studies on this topic shows that the health status of immigrants differs from the health status of the native population (Abubakar et al., 2018; Barstad, 2018; Hendriks, 2015). The health difference lies in the fact that the health of immigrants is often influenced by various aspects such as reasons for, and nature of, migration, origin countries and conditions of the places they came from and traveled through, as well as individuals' initial health condition (Abebe, 2010; Abubakar et al., 2018). Importantly, the health of immigrants is further influenced by the conditions in their new host country, which includes social inequalities, language difficulties, unstable living conditions, discrimination, 'cultural crash' or the ability of health care systems to meet the immigrants' needs (Abubakar et al., 2018; Attanapola, 2013). This can be confirmed with previous research showing that immigrants are

somewhat less satisfied with life, and that they are also more exposed to negative emotional experiences than the majority population (Barstad, 2017).

Norwegian studies have confirmed the international findings. In 2016, Statistics Norway conducted a living conditions survey of people with immigrant background between the ages 16-74, who have lived in Norway for more than 2 years (Barstad, 2018; Straiton et al., 2019). The target population consisted of immigrants with a background from Poland, Turkey, Bosnia and Herzegovina, Kosovo, Eritrea, Somalia, Afghanistan, Sri Lanka, Iraq, Iran, Pakistan, and Vietnam. There were 4,435 participants in total, including 1,049 Norwegian-born with immigrant parents. The survey compares the results to the whole Norwegian population. The results show that six percent of the entire population have mental health problems, the proportion is double so high among immigrants (Straiton et al., 2019). The results also show that the difference in mental health within the immigrant groups and the population in general increases further with age. Among immigrants, the proportion with mental health problems was higher in the oldest age group, compared to the rest of the population where the proportion with mental health problems was higher among adolescent girls and men aged 35-44 (Straiton et al., 2019).

A national study on mental health challenges among young adults with immigrant background from Somalia, Iran, and Pakistan, shows better mental health or a lower risk of mental disorders among this group compared to ethnic Norwegian (Ekeberg & Abebe, 2020). However, the study shows that there are exceptions with post-traumatic stress disorder (PTSD) and schizophrenia. The findings show that the vast majority of the immigrant groups included in the study showed significantly higher odds of receiving a diagnosis of PTSD and schizophrenia compared to ethnic Norwegian (Ekeberg & Abebe, 2020).
The study reflects on possible risk factors for being diagnosed with PTSD and schizophrenia among immigrants after migrating to Norway. Post-migration risk factors are emphasized more than pre-migration, such as having an immigrant status, experience of discrimination and social exclusion, lack of health trust in the healthcare system and difficulties with integration into the new system. The study points out that research in this area is very limited and lacks explanation of these risk factors, and therefore points out the need for these risk factors to be tested more in the future research (Ekeberg & Abebe, 2020).

The research done on this area, both internationally and in the Norwegian field, also shows that despite a seemingly higher need, immigrants tend to underuse mental health services (Abebe et al., 2017; Harris et al., 2021; Kour et al., 2021). Findings in a Norwegian study about Syrian utilization of mental health services, indicates that participants consider some formal help-seeking sources, such as general practitioner (GP) and psychologist/psychiatrist, for symptoms of depression (Harris et al., 2021). However, findings also suggest that participants prefer help-seeking from Allah/God or their partner when dealing with mental health problems. Most participants indicated an average of two barriers to seeking help from the GP: language barriers as well as feeling that the GP would not be able to help. This corresponds well to other findings in other Norwegian studies. For instance, findings in another study show that mental health problems are less often raised by immigrants in consultations with GPS (Abebe et al., 2017). Furthermore, results also indicate that the low rate of utilization of mental health services was due to language barriers, but also cultural differences and lack of knowledge about available services. Another systematic review of research about mental health help-seeking among immigrants, found that the salient barriers to help-seeking were cultural barriers, structural barriers, and barriers specific to the immigration experience (Byrow et al., 2020). Lastly, another recent study found some of the same factors as it recognized five main barriers to mental health seeking amongst immigrants in Norway from the perspective of health-professionals: (1) difficulties due to language barriers, (2) difficulties due to lack of culturally competent services, (3) difficulties due to social factors, (4) being curious and flexible improves the user-provider relationship and (5) increasing access to mental health services (Kour et al., 2021). In summary, barriers to accessing mental health services are well documented in the literature and most include cultural barriers, language difficulties, structural barriers as well as perceived stigma and self-help preferences.

The findings thus far help to point out that there is a need for further research in this area. The immigrant definition is comprehensive, and there is therefore a need to conduct research in different types of migrated groups, as their experiences may differ from one another. Although the research presented was informative of the immigrant experience with mental health services, it is limited in that none of them includes Eritrean immigrants in their selection. This is a concern as Eritrean immigrants are amongst the largest growing populations in Norway (SSB, 2022). There is also a need

for further research when it comes to better understanding the barriers linked to immigrants' underuse of mental health services in Norway, so that these can be uplifted, and immigrants can receive the support that they need. Finally, there is need for more research that looks at the culture differences and stigma surrounding mental health problems and the admission to mental health institutions among immigrants.

3 Theoretical framework

This following chapter will focus on the theory of this thesis, which will form the basis for the analysis of the thesis' empirical material, and at the same time contribute to answering the thesis' research question. As the topic of this thesis is about the mental health of Eritrean immigrants and utilization of (mental) healthcare services, it becomes natural here to make use of a theory that includes both individual and environmental factors, and the interaction between these. In addition to including these factors, it is important to make use of a theory that explains behavioral change, as only 2 of the 8 Eritrean participants were open to seek help for their mental health. The statistics is a concerning matter as it illustrates how influential the reviewed hindrances can be. It is also important to find a theory that emphasizes how attitudes affect behavior, as attitudes towards seeking mental health is an underlying barrier for most of the Eritrean participants. The theory that was considered suitable was Azjen and Fishben's Theory of Planned Behaviour (TPB). This model has been widely used to promote a variety of health behaviors, including smoking, exercise, and condom use (Mak & Davis, 2014). It is a useful framework for understanding help-seeking behavior because it can be used to identify factors that influence behavior, such as attitudes, subjective norms, and perceived behavioral control (Mak & Davis, 2014).

3.1 Theory of Planned Behavior

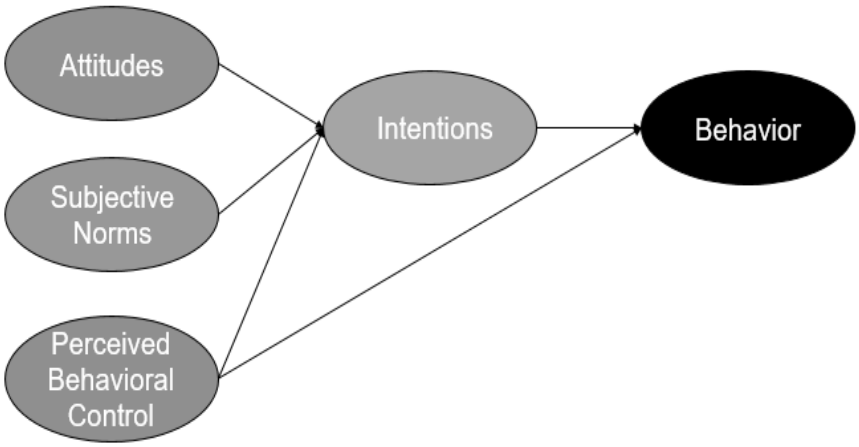

Figure 1. Azjen and Fishben's Theory of Planned Behavior (TPB), 1975

Theory of Planned Behavior (TPB) is a theory within social psychology that describes how people's attitudes, perceptions and intentions can affect their behavior (Myers et al., 2014, p.174). The theory was developed in 1975 by Icek Ajzen and Martin Fishbein and was originally a revision of another theory on reasoned action from the same researchers. The theory states that there are three main components to behavior: attitudes, subjective norms, and perceived control. Attitudes refer to a person's positive or negative evaluation of a specific behavior. Subjective norms refer to a person's perception of what others will think about their behavior. Perceived control refers to a person's belief in how much control they have over a specific attitude. Having a positive attitude, great support from others and a perceived control over the situation raises a greater chance towards behavioral change. To understand how these three factors affect behavior, we can look at an example in which someone is considering seeking help. If they have a positive outlook on the help, they perceive their friends and family to value mental health and they feel they have the means to attain it, the likelihood that they seek the help will increase. Each of the three components increases the chance of eliciting the intent to change behavior; this then tells us that the relationship between the three components is a codependent one, as each of the components greatly contributes to eliciting an intention, and the lack of one of them can hinder it all. Intention is an important factor here as well, as it can be the biggest predictor for behavioral

change. The three components will together determine one's intention to change a behavior, and it is the intention that then will elicit the change.

TPB seems fit because it has received considerable empirical support and has been used to explain a range of behaviors, such as health behavior, environmental behavior, and consumer behavior. For example, it was used to investigate the relationship between attitudes and healthy eating behavior by de Bruijn et al. (2008) and Dunn et al. (2008). De Bruijn et al. found the theory to be a good predictor of the amount of saturated fat an adult consumes (de Bruijn et al., 2008), and Dunn et al. found that although participants held negative attitudes towards fast food, their perceived lack of control over their diet led to the consumption of unhealthy food (Dunn et al., 2008). The research of Dunn et al. supports the claim that the relationship of the three components is quite intertwined since the lack of just one of them can be enough to affect whether behavioral change occurs.

Although TPB has received empirical support, and is popular in areas such as health research, it has been subject to some criticism. Fazio and Olson (2003) biggest criticism is that the theory only considers intentional behavior. The theory tends to assume that we deliberate over the three components (if we want to, what others will think of it and if we can do it) when we behave in particular ways. Instead, Fazio and Olson debate that behavior can be unconscious and spontaneous rather than conscious and carefully thought out (Fazio & Olson, 2003). While this criticism is valid, it can be argued that TPB provides help to bring one's unconscious actions to a more intentional level, exactly by proning people to evaluate their actions by asking the questions of "do I want to?", "what do the others around me think of this?" and "can I?".

These are the three questions that will now be used to try and bring positive behavioral change in Eritrean immigrants to seek professional help when they undergo challenges.

4 Methods

In this chapter, I will begin by explaining the reason for the choice of methods for this study. Thereafter, I am going to look at the methodical point of view for this thesis. Furthermore, I am going to get into the procedure of the entire process, from the preliminary work to data collection and analysis of data material. I will end this chapter by looking at my role as a researcher and getting into research ethics.

4.1 The Choice of Methods

There are two main research strategies: *quantitative* and *qualitative research*. Within methodological issues, many find it helpful to distinguish between these two methods. Qualitative methods emphasize insight, while quantitative research emphasizes overview, or that qualitative research seeks understanding, while quantitative methods seek explanation (Tjora, 2021, p. 35). In other words, quantitative research can be represented as a research strategy that emphasizes quantification in the collection and analysis of data, while qualitative research can be construed as a research strategy that usually emphasizes words rather than statistics and numbers (Bryman, 2016, p. 32). Based on the aim and research question of this thesis, it is sensible in this case to use a qualitative approach as the study is looking to find out about the experiences of Eritrean immigrants, and how it can influence mental health help-seeking when they face challenges. There are different approaches to both quantitative and qualitative research. The most widespread methods of data generation within qualitative research are various forms of interviewing (Tjora, 2021, 127).

I have chosen to use *semi-structured interviews* for data generating in my research. Semi-structured interview is a term that covers a wide range of instances: It typically refers to a context in which the interviewer has a series of questions that are in the general form of an interview guide but is able to vary the sequence of questions (Bryman, 2016, p. 201). Semi-structured interview also allows the interviewer to have some latitude to ask further questions in response to what are seen as significant replies. My main reason for using a semi-structured interview as a method is to get the informants' personal description, experience, and interpretation. Utilizing interviews as a method allows me as a researcher to understand

different aspects of the experiences and perspectives Eritrean immigrants face when seeking mental health help in Norwegian health services.

The choice of methodical point of view has an impact on the selection of data and how data is obtained and created. My methodical point of view is going to be based on *thematic analysis* with inspiration from *phenomenology*. Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data (Braun & Clarke, 2006). A theme is a grouping of data with common similarity. More specifically, each theme is a category, where data with significantly common features are grouped. By grouping the answers into categories in this way, it allows me to create order in the collected data so that it becomes easier to understand and report, while at the same time gives me the opportunity to identify new similarities in them. I will mainly rely on the psychologists Braun and Clarke (2006) relatively detailed step-by-step guide to thematic analysis. However, I will utilize a simplified and adjusted version, which is more suitable for students (Johannessen et al., 2018). This version of the thematic analysis consists of four steps: 1) preparation (provide and get an overview of data). 2) coding (highlight and put words to important points in data). 3) categorization (categorize the coded data into more general themes). 4) reporting (report the themes and their content).

Phenomenology means the study of phenomenon and is about how phenomena appear for each individual from a first-person perspective (Tjora, 2021). In this way, this study can be linked to phenomenology as the aim is to better understand how the Eritrean immigrants experience the challenges, they might face in seeking help for mental health. Phenomenology is based on subjective experience and tries to find one deeper meaning in individuals' experience, this requires the researcher to put their own understanding aside to be able to take in the Eritrean immigrants' *lifeworld*. Husserl defines lifeworld as the sum of physical surroundings and everyday experiences that humans bring with them when they meet the world; the lifeworld both shapes us and is shaped by us (Husserl, 1970). This allows me as a researcher to describe the Eritrean immigrants' subjective experiences that they have, which includes their thoughts, feelings, perceptions, and experiences, as well as their social and cultural background. In connection with this, a methodological approach related to phenomenology will be based on the use of in-depth interviews, where the researcher tries to get participants to put into words how they experience their world, how "things" are and why they are the way they are (Tjora, 2021). As this study looks at mental health of Eritrean

immigrants, and their experiences and understandings surrounding (mental) health services, it is important that their subjective experiences and thoughts are adequately described and further analyzed and interpreted.

4.2 Selection and recruitment

Selection

The recruitment of participants for this study was based on a purposive sampling. This implies that the selection was randomly selected but included participants who have relevant experiences and knowledge connected to the research question or research area (Bryman, 2016). The inclusion criteria for the study are therefore Eritrean immigrants, both genders, aged above 18 and have been living in Norway for more than 3 years. The aim was to recruit 15-20 participants, in the end, 13 people were recruited to participate. 5 participants ended up withdrawing, which left me with a total of 8 participants. In qualitative research, the number of interviews is not the most important factor, but rather the quality of the descriptions obtained (Giorgi, 2009). Malterud et. al. refers to this as "information power". They argue that when the purpose of the study is narrow and the participants are specific to the study's purpose, and the dialogue is strong, fewer participants are needed (Malterud et al., 2016). This was the case for this study as the information gained from all 8 participants were in depth and detailed. Furthermore, as this is a master thesis, it has a smaller time frame than a large-scale project, and pragmatic considerations concerning sample size were therefore made. 2 pilot interviews outside of the 8 selected were carried out before the actual data collection. 1 pilot interview was on Zoom to check the sound and network connection, and 1 was done in person. During data collection, I was aware that unexpected situations may occur before, during and after collecting data, therefore, it was necessary to keep in mind the number of participants and the depth of the interviews to ensure the collection of sufficient data to answer the research question.

Recruitment

Recruitment was carried out via social media platforms Facebook and Instagram by sharing a poster on my page, but also by contacting social media accounts/groups that have a large diverse audience and asked to post information about the project, with attached contact information to the researcher. In this way different social media accounts acted as gatekeepers. A gatekeeper is an essential mediator for accessing participants and may represent a group of individuals who is invaluable for gaining access primarily due to their connections with a research population (Bryman, 2016). The Instagram accounts that were contacted were blackhistorymonth_norway and agenda_x, and the Facebook groups that were contacted were Norwegian Naturals, Av Utlendinger for Utlendinger and Hogskolen i Innlandet, Studiested Elverum. The information poster that was posted on Instagram and Facebook can be viewed in *Appendix A.*

A further strategy for recruitment was through the snowball technique, where currently enrolled participants were asked to recruit further participants (Bryman, 2016). The participants were therefore asked if they knew anyone eligible who would be interested in participating in the study, who were then contacted by the researcher.

Recruitment was limited to Oslo municipality because Oslo is a city of diversity, and because of the study's limited time frame. During recruitment, it was difficult to recruit males and participants generally over 30 years. Men quickly expressed that they were not interested and did not want to answer any questions about mental health. People over 30 often turned down the request by saying that they had a lot to do and did not have time to participate in the study. It was also challenging to recruit participants over 45 years due to language limitations. Recruiting female participants aged under 30, who had resided in Norway for more than 6 years was however comparatively less challenging. The total number of participants enrolled for this study was 8; 6 women and 2 men under the age of 30. Among the volunteers, one was born in Norway, one immigrated in adult years and the rest immigrated to Norway at a school age (5-17). On average it was found that the younger they were, the more openly they talked about their mental health, and that the women were more open and talkative about their mental health than men. Participant's characteristics with pseudonym names can be viewed in table 1.

Table 1.

Research participant characteristics (N=8)

Name	Gender	Age	Age lived in Norway
Semira	Female	21	11 years
Haben	Female	23	Born in Norway
Zula	Female	24	7 years
Jamila	Female	25	12 years
Faven	Female	25	11 years
Zehra	Female	29	11 years
Hayat	Male	27	14 years
Dawit	Male	29	7 years

4.3 Data Collection

4.3.1 Semi-structured interviews

To obtain a holistic perspective of the experiences of Eritrean immigrants' mental health and their utilization of health services, it was significant to use semi-structured interviews. This allows the researcher to have a flexible conversation with follow-up questions to clarify or expand upon the participant's answers (Bryman, 2016). The flexible conversation in semi-structured interviews can result in a deeper understanding of the Eritrean immigrants' experiences and perspectives and allow them to speak more freely and in their own words. For this research, individual interviews were preferred as the purpose was to explore human experiences and as the situation of sharing information depended on the participants feeling of safety (Bryman, 2016). An interview guide was designed to confidently attempt to

gain an overview of the different phases of the interview. The interview guide consisted of open-ended questions because these types of questions motivate detailed responses to the specific themes that would be touched up on during the interview. These themes are divided into three categories: 1) Integration, 3) Mental health, and 4) Potential barriers.

The interviews were structured around three phases. The first phase involved transitional questions, where the participants were asked demographic questions such as their age, gender, and how long they have been living in Norway. The transition between introduction and the main part happens in the second phase of the interview. Here, the questions started with "*Can you tell me about …*?" and "*could you describe …*?". These are reflective questions that opened for in-depth answers and encouraged open-ended questions, which created an engaged dialogue between the researcher and partakers. The researcher experienced the conversations as fluid and participants were able to express themselves in greater detail where necessary. Follow-up questions were asked where possible in order to understand the participants' perspectives and experiences on a deeper level. In the last and final phase, participants were given the chance to elaborate on other important things to them that were not covered by the interview guide, and they were also informed about how the material was going to be handled. The interviews were conducted in Norwegian as many of the participants were more comfortable speaking Norwegian than English. The interview guide can be viewed in *Appendix B.*

Majority of the interviews took place digitally via Zoom, where the average time for an interview was about 30 minutes. Out of the 8 interviews that were conducted, only 2 were in-person. Digital interviews were utilized due to participants expressing it was more comfortable for them, and it was easier for them to voice themselves via Zoom than being interviewed in-person. The participants also viewed video call interviews as more flexible and could easily make room for last minute changes. Additionally, video call interviews tend to generate participants that would normally have not participated (Bryman, 2016).

4.3.2 Data Management

The interviews were recorded with the "nettskjema" Dictaphone App, with a mobile phone as recording device. The digital interviews were conducted through a Zoom account that was registered with a HINN/Feide account, and not a personal one. The Dictaphone App forwarded the audio files to the "nettskjema". For ethical and security reasons, it was not possible to play back the recordings directly from the recording device. With this app, the recording of the interviews was encrypted on the phone and sent in securely to "nettskjema". The mobile phone was put on flight mode during the recording to avoid disturbance and complications while recording. Because the network was turned off while recording, the recording was temporarily encrypted on the phone and forwarded to "nettskjema" when the network became available. The recording was not downloaded to any device and was only possible to be listened to through "nettskjema".

After collection of data, the recordings were transcribed and anonymized. The partakers were given a pseudonym so their name can remain anonymous, and transcriptions were done verbatim. Variables that were directly identifiable such as age, education, or workplace were written as categories, to make sure that these are not going to be identified in the transcription. The transcriptions of the interviews were stored on a HINN office 360-onedrive account, which required student ID and password to gain access.

4.3.3 Analysis of Data Material

The data collection was analyzed using a simplified and adjusted version of Braun and Clarkes method of thematic analysis (Johannessen et al., 2018).

The first step consisted of familiarizing oneself with the material; this was the preparation stage where data material was transcribed and read thoroughly through. This allowed me to get a sense of the overall content of the data and the main themes that emerged. Step number two involved generating initial codes using Nvivo. This form of coding involved systematically coding the information into codes and accumulating data relevant to each code. After the coding process was completed, the next step included gathering the initial codes into themes and collating all the relevant data to each theme. This step allowed me to identify the key themes that emerged from the data and to organize the data into a more coherent structure. I ended up with three main themes: "cultural understanding" with sub-themes "stigma" and "collectivism and individualism", "beliefs" with sub-themes "self-help" and

"religion", and "lack of resources" with sub-themes "lack of diversity in health professionals", "interpreter availability" and "financial constraints". The last and final step of the adjusted method of thematic analysis involved writing the report on findings (Johannessen et al., 2018). Appropriate and applicable extracts were selected, the discussion of the analysis was made, which was connected back to the research question and literature review. See table 2 for an overview of themes and categories that appeared during analysis.

Table 2. Overview of themes and categories

Themes	**Sub-themes**
Cultural understanding	Stigma Collectivism and individualism cultures
Beliefs	Self help Religion
Lack of resources	Lack of diversity in mental health professionals Interpreter availability Financial constraints

The analysis was carried out using the program NVivo, which is a tool for coding qualitative data generated from text information. The software program allows for a systematic analysis of the transcribed data, to which I assigned codes to segments of the text, and then assembled these into themes and sub-themes. In qualitative research, inter-rater reliability is important; researchers may assign different meanings and values to themes and codes within the data material (Bryman, 2016).

4.4 Trustworthiness in research

To ensure trustworthiness in research, concepts of *generalizability, validity, reliability, transparency,* and *reflexivity* were utilized.

Generalizability is an important consideration in research, as it refers to the extent to which the findings of the research can be applied to other contexts, groups, or populations beyond the study sample (Tjora, 2021, p. 260). While the sample size was insufficient in this study, the interviews were rich in detail and provided valuable insights into the experiences of Eritrean immigrants in Norway. However, one of the questions that arises from this research is the issue of generalizability. Can the findings of this study be generalized to other Eritrean immigrants in Norway, or to other immigrant groups in Norway? The answer to this question is complex and multifaceted.

On the one hand, the experiences of Eritrean immigrants in Norway are shaped by a variety of factors, including individual circumstances, cultural background, and the broader social and political context. As such, it is unlikely that the experiences of Eritrean immigrants in Norway can be generalized to other immigrant groups in Norway or to Eritrean immigrants living in other countries. On the other hand, there are certain patterns and themes that emerge from the interviews that may be applicable to other immigrant groups or to other contexts. For example, the issue of language barriers is a common challenge faced by many immigrant group (Abebe et al., 2017; Harris et al., 2021; Kour et al., 2021), and the strategies that are later going to be suggested to uplift the barriers may be relevant to other groups as well. Overall, while it is unlikely that the findings of this study can be generalized to other groups or contexts, the insights gained from this study can still be valuable for understanding the experiences of Eritrean immigrants in Norway and for identifying potential strategies for addressing the challenges they face.

Validity refers to the extent to which a research study measures what it intended to measure (Tjora, 2021, p. 260). In this case, the study increased validity by using semi-structured interviews of detailed and nuanced information from participants, which can help ensure that the sample is diverse and inclusive. This also allowed for flexibility in the interview process while still maintaining a consistent structure. Although it can be challenging to ensure validity of the study because of the insufficient sample size, this study used a transparent research

design, including a detailed research plan and consistent methods for data collection and analysis to ensure that the findings are accurate and reflective of the experiences of the group being studied.

Reliability refers to the consistency and stability of research findings over time and across different contexts in which the researcher utilizes methods that are consistent and repeatable, and that produce consistent results (Tjora, 2021, p. 259). However, when using a qualitative research approach with a small sample size, it may be challenging to assess reliability in the traditional sense. In this case, I used a semi-structured interview approach to collect data and used the same interview guide and asked the questions in the same order on all participants. This allowed for a deep and comprehensive exploration of the experiences of the Eritrean immigrants. While this approach may not allow for testing reliability in the traditional sense, it has revealed patterns in the data that can contribute to a greater understanding of the phenomenon being studied. Also, the use of thematic analysis, which is a transparent method for analyzing data that involves identifying patterns and themes across data sets, help to increase the reliability of this study.

Transparency is a key aspect of research that refers to openness and clarity of the research process and findings (Tjora, 2021, p. 264). To increase transparency, this study provides detailed information about the methods and procedures. This includes information such as how the participants were recruited, how the interviews were conducted, and how the data was analyzed. Additionally, by using thematic analysis, it helps to identify patterns and themes in the data, which here increases the transparency of the research. Despite the limited timeframe of this master's thesis, prioritizing transparency in the research process and findings can help to enhance the credibility and trustworthiness of the study, ultimately improving its impact and relevance. By prioritizing transparency, the study can ensure that its results are reliable and accurate, and that its findings can be transferable to other contexts that examine the same issue.

4.5 My role as a researcher

While transparency refers to openness and clarity of the research process and findings, reflexivity is a critical aspect of research, as it involves reflecting on one's own positionality and experience in order to identify potential biases, limitations, and ethical considerations in

the research process (Tjora, 2021, p. 278). As an immigrant conducting research on Eritrean immigrants, I was acutely aware of the importance of reflexivity in ensuring the trustworthiness of this study. Although being an immigrant myself can provide a valuable perspective on the experiences of Eritrean immigrants, I was aware that my own experiences as an immigrant might shape my perspectives and assumptions about the experiences of Eritrean immigrants. However, I was mindful of the potential for my proximity to the topic to limit my reflexivity. Despite this, I found that participants were more willing to open up because of our shared experiences, which allowed me to act as an insider to the topic. While this insider position can be seen as privileged and beneficial for building trust, it can also lead to themes being overlooked or underrepresented. To mitigate this, I employed reflexive techniques during interviews, such as paraphrasing statements and asking clarifying questions such as “did I understand correctly when you said X” or “is it correct that when you say X, you mean Y”, to ensure that I accurately captured participants' perspectives and experiences. Additionally, it is important to acknowledge that another researcher with a different background or perspective may have asked different questions or interpreted the findings differently. This demonstrates that research is always influenced by the researcher's background and perspective, and that it is therefore important to remain reflective of the position as a researcher.

4.6 Ethical Considerations

Informed consent was secured through an informed consent form that the participants received before the interview took place. Participants that had interviews in person received the informed consent before the interview and were given the time they needed to read through and sign. For participants that were interviewed via zoom, the informed consent was sent via student mail which required the researcher to log in with Feide. The participants signed it digitally and resent it via student mail before the interview. The informed consent was in Norwegian as many of the recruits were more fluent in Norwegian than English. An illustration of the informed consent can be viewed in *Appendix C.*

Anonymity and privacy of participants were aspects that were treated with security and respect. When the participants signed the informed consent, it was important that they understood what they were submitting their information to, and that their privacy was going to be taken into consideration. Anonymity was ensured by using pseudonyms during the

transcription process. Additionally, data collection was stored in a OneNote account that was registered with a HINN/Feide account, which is a secure place where only the researcher has access. Recordings and transcriptions are going to be deleted as soon as the thesis has been submitted and marked.

Norsk Senter For Forskningsdata (NSD) is a national center and archive for research data. NSD works to make data about people and society available for research. An application to NSD for this thesis was submitted, and the process of data collection didn't start until the application was approved. Attachment of approved assessment from NSD can be viewed in *Appendix D*.

5 Results

The following chapter will present the results of the interviews that were conducted to answer the research question; *"What are the barriers to mental health help-seeking amongst Eritrean immigrants in Norway?"*. One significant finding is that only 2 of the 8 participants were open to the idea of seeking mental health help when facing challenges. Although I do not have a representative sample and the number may be insufficient, this demonstrates the importance of the study, and how more research on the relationship between immigrants and mental health awareness is needed.

The main findings of the research were that the three main themes "cultural understanding", "beliefs" and" lack of resources" were in varying degrees found to operate as barriers to mental health help-seeking for Eritrean immigrants in Norway. The expectations of a lack of cultural understanding from health professionals was the most repeated hindrance, while beliefs as substitutes for mental health help and a lack of resources within mental health services both shortly following after in numbers. Within the three main themes there were further categories to explore to help understand the issue at hand better, which will be looked at in more detail.

5.1 Cultural understanding

Findings report that the most designated barrier to mental health help-seeking among Eritrean immigrants was the fear of not being understood by Norwegian mental health professionals. As mental health is not something that is talked about in their home country, all of the 8 participants expressed that being met with a cultural misunderstanding and a lack of cultural insight could be one of the biggest factors preventing them from mental health help-seeking when asked about what barrieres they would face if they were to seek mental health help. This common viewpoint was clarified by Jamila (female, 25):

> *"Maybe if it had been someone with the same culture as you, a psychologist with the same culture, maybe. I feel that the psychologist would have understood me better than a Norwegian or someone from another country that did not have the same culture. Because it's not the same thing, it's different cultures. So, I think that [going*

to someone with the same cultural background] would have made it a little bit easier [for me], right?".

Although 5 pointed out that language itself was enough to cause miscommunication, all 8 participants reported that the problem surpassed linguistic barriers, because it is about how the professionals can relate and understand the culture and their experiences and feelings. Zehra (female, 29), remarked that *"it is important that one can relate to you, and sort of know a bit of your history and things like that, it is a lot safer"*. Semira (female, 21) further clarified that even with the language to express herself; she feels that cultural understanding is vital as it is difficult to seek help from someone who does not feel what you feel or can comprehend it and that it is therefore natural that one seeks help from someone with the same characteristics, experiences and understanding as oneself.

"[...] If you have been through a traumatic experience, it can be difficult to tell someone who does not feel the same or can comprehend what you feel. So, I feel that is one of the things that prevents mental health help-seeking. I also think that many people are aware of that. Many people who feel exactly that, that you feel the person you are talking to, may not understand what you have gone through. I therefore believe that it is quite human that we seek out people who have similar characteristics, experiences and understanding as ourselves."

As cultural understanding was recognized as the most repeated obstacle to mental health help-seeking, it was further investigated. The goal with the inspection was to find out what factors contributed to the perceived fear of cultural misunderstandings. The main theme was therefore narrowed down into two sub-themes, which are "hidden stigma" and "collectivism and individualism". The findings within these sub-themes will now be presented.

5.1.1 Stigma

Stigma was considered a vital subtheme to include when talking about cultural understanding because all participants expressed in varying ways that culturally mental health awareness is somewhat of a hidden, oppressed, and undesirable topic in Eritrea. The stigma that comes

with being associated with mental health problems from the culture itself and from other members for one's culture was repeatedly seen as solid reasons to not seek help.

The topic of mental health seemed to be stigmatized in the culture in two ways. One was through the lack of mental health awareness in the Eritrean society. Several participants reported it is not common in their native country to talk about mental health, and many of them were not aware of what it was until they immigrated to Norway, hence it wasn't a topic they thought of or about. This was demonstrated by one participant, Zehra (female, 29), who reported:*"I haven't heard the word mental health [in Eritrea] because it kind of doesn't exist. Surely it does, but it's not to a large extent like it is in Norway."*. Dawit (male, 29) further explains that much of the language around mental health is non-existent in Eritrea: *"Many of the feelings that they talk about here in Norway do not exist in Eritrea. [...] We don't have a word for anxiety, depression [...]"*. The lack of terms could furthermore lead to people struggling with mental health being dismissed and seen as crazy, something Jamila (female, 25) reported:

> *"In Eritrea, like, when you saw people who were kind of crazy, I thought maybe they weren't crazy. So, it could have been so much [mental], right? It could have been that they were depressed, anxious, [perhaps a lot of things] that they didn't get out because you don't believe that there is such a thing as mental health."*

Moreover, the lack of mental health awareness and the stigma that comes with it can lead to Eritrean immigrants struggling with mental health help-seeking when they move to Norway, because it is something that is not common in their native country. Hayat (male, 27) elaborated on his experience, adding that moving to a new country where the culture is different is a challenge, which can affect people mentally. Still, many do not do anything about it because it is not something that was talked about in their home country.

> *"... those who come to Norway, in a way they have experienced a lot on the way to Norway. You also come here to Norway where the weather is completely different, it's cold, it's dark and it's a completely different society. A society that is, in a way, not so open ... it is a lot, and then [you can] automatically [be] affected mentally in a way.*

And then another day goes by where you don't seek help because you think [that] it [will go away] on its own, because maybe you are not used to talk about all that. I was young when I left my country, but there I have not seen a psychologist[...].”

The stigma of mental health problems in the form of lack of mental health awareness in the culture can therefore result in Eritrean immigrants not seeking help because they do not have the firsthand experience with and the language of mental health professions.

The other way that mental health seems to be stigmatized is through fear of the other members of the culture’s reactions to those who face challenges. Since mental health is not talked about in Eritrea, it affects the way people who experience mental disorders are viewed and treated. Some participants express that because of the stigma associated with mental health struggles, it is difficult to open up to someone from their home country, and in result the lack of support in the social environment makes it even harder to seek mental health help. Semira (female, 21) explained:

“[...] The Eritrean environment, it's very taboo and it's very shameful to talk about mental disorders or seeking help. [...] Because it is so taboo, I think it would have been, if I had been depressed and had to seek help, I think it would have been very much like that "oh people will find out. To feel like you have to hide it. [...] As soon as you seek help, it will... you will be branded then. You are labeled as "sick", you are labeled as such. So, I think that stops... I think that would have been an obstacle for me then if I had intended to seek help.”

In alignment with Semira’s viewpoint, 5 participants exclusively expressed that they had experienced that people who struggled with mental health were treated differently, which could also make it more challenging to talk about the topic out of fear of people’s judgements. People’s reactions included cruel comments, being laughed at, seen as crazy, isolated from the other members of society and for the men especially, being seen as weak. Several of the participants reported they would entirely avoid help-seeking because of such judgments, whilst Zula (female, 24) said she would keep it a secret from the other members of society if

they seeked help: "*If, for example, I had gone to a psychologist or therapy, I would have kept it a secret* ". Hayat (male, 27) illustrated this fear of judgment from other members of his culture:

> *"If I say, for example, that I struggle with such things, they may either laugh at me or perhaps view me as a very weak person. It is because [talking about your mental health problems] is not in our culture. [...] They [hold it within themselves] if they have anxiety or any difficulties."*

In addition to fearing judgments from extended members of society, several feared the reactions from their respective families. Some of the participants shared that they feared judgment from their family. Faven [female, 25] shared that *"even my family would maybe look at me [...] in a different way than they do now [...]. So yes, there are certainly some obstacles there".* The fear involved social exclusion by the family, as Faven (female, 25) explained:

> *"[...]And the family would rather, if [their child] is struggling with some mental health, or there is something with the child, the family [hides] … the children in the background. They are completely excluded from everything [socially], they should not be shown, no one should know about it, [and it is kind of] kept [private]."*

In summary, stigma was considered a vital subtheme to include when talking about cultural understanding because all participants expressed in varying ways that mental health is *culturally* an oppressed topic in Eritrea, and thus the stigma can be seen as a barrier to mental health help-seeking. Stigma in the form of lack of mental health awareness can make it difficult to seek out help because of lack of the experience with and the language of mental health professionals. Stigma was also talked about in the form of fear of judgments from both extended members of one's culture and from one's own family. This included fears of being laughed at, called crazy, viewed as weak and social exclusion. These were repeatedly seen as solid reasons to not seek help. This section focused on how stigma can on an individual level

affect one's intention to seek help. The next section will further look at how larger, cultural differences affect mental health help-seeking.

5.1.2 Collectivism and individualism

Findings show that there are differences in how mental health is regarded in the two cultures the participants are a part of, and these differences affect help-seeking. Participants identified Norway as a more individualistic culture, and Eritrea as a collectivistic one, as Dawit (male, 29) put it: *"[...] In Norway, people are individualistic. They are very little social and have different family values and family structure compared to the society I grew up in".*
Four of the eight participants, Dawit, Zehra, Semira and Faven, recognized Norway as an individualistic society that puts more emphasis on the self-development and personal freedom of the individual than they do the collective. Individualism was then seen as one of the reasons as to why Norwegians have a bigger focus and vocabulary around mental health than Eritreans. Zehra (female, 29) put it like this:

> *"Norway is very concerned about mental health, and such compared to where I am from. In a way, I haven't heard the word "mental health" until I sort of moved to Norway. I think the reason for that is that people in Eritrea are more concerned with other things, while people here in Norway are concerned with how you feel on the inside and such."*

In addition to seeing Norway as an individualistic country who put a bigger emphasis on mental health awareness than Eritrea, some of the participants feared that this cultural gap could cause misunderstandings when approaching a mental health professional. Semira (female, 21) explained that:

> *"Going to a psychologist is a Norwegian thing [to do], an ethnic Norwegian thing. Many hold back and say ok if I tell a person about how I feel about my culture or the traumas I have and such, then they won't be able to understand."*

Faven (female, 25) shared the same view and further explained that the reason why this gap between the two cultures could result in cultural misunderstandings when approaching a mental health professional is that Norwegian psychologist might be prone to downplay the role that the collective plays for Eritrean individuals, as they might not be fully able to relate to it.

> *"... in Norway, it is completely normal for young people, or people in general, to decide on their own lives when they reach a certain age. They can go do what makes them happy and they can explore the world. For me, however, it's a little different. For example, we might think more about "oh, I don't want to lose my family", "I don't want to go against my family in this and that way". I think it would be easier for me to seek help from a psychologist who has a foreign background, who would have understood why I can't go against my family in a certain way, I can't live without my family somehow. So, no, I don't think I would have been 100% understood and given the help I need [from a psychologist with a Norwegian background]."*

Furthermore, as the definition of collectivism clarifies, a major characteristic of a collectivistic society is that society is prioritized over the individual, the interests of the collective prevail over the interests of the individual. This view on collectivism was shared among several of the participants, who talked about having to suppress their own feelings and struggles to keep the harmony with the collective. One participant, Faven [female, 25] was hesitant to seek mental health out of the fear of going against family values: *"We might think more about "oh, I don't want to lose my family", "I don't want to go against my family".* Another participant put her parent's feelings before her own; Haben (female, 23) had the view that some parents has been through so much worse than her and therefore the children's mental problems are nothing in comparison, and that she is not sure how her parents might react to her openness around her mental health:

> *"Our parents have had it much worse than us. Our mental and psychological problems are nothing compared ... I myself have struggled to tell my parents ... things about my mental health because I have been like that ... no ... they have experienced*

worse things, I don't know how to express myself, don't know how they're going to react."

In short summary, the findings show that half of the participants identified cultural differences in the form of individualism in Norway and collectivism in Eritrea. It was recognized that collectivism affects them in the sense of having to suppress their mental health challenges because they put their families first. Some of participants further explained that this cultural gap can generally negatively affect help-seeking as they fear that the individualistic Norwegian mental health professional will not fully grasp their collectivism.

5.2 Beliefs

As we have looked at cultural understanding and how its sub-themes "stigma" and "collectivism and individualism" can prevent some of the participants from seeking help, this following section will focus on the replacements for the help, which is beliefs.

Findings show that when it came to which source of help participants would prefer when seeking mental health help, most preferred finding solutions on their own or through their religion, then seeking professional help. Beliefs were found to replace mental health help in 6 of the 8 participants, with 2 participants being the only ones open to seek mental health professionals when facing challenges. Jamila (female, 25) voiced that she doesn't find any issue in seeking professional help: "*I'm a Christian [...] and I kind of pray to God, but I don't see it as a problem to go to a psychologist.".* So did Hayat (male, 27) when asked if he would seek help if facing challenges*: "Yes, absolutely, because I understand it, kinda".*
When it comes to the 6 hesitant participants, they held the belief that they would rather try other methods before seeking a mental health professional. However, there was variation in whether they would find solutions on their own or through their religions.

5.2.1 Self-help

The participants would rather try to work on the mental issues on their own, through methods such as reflecting on their own, seeking support from their environment or reading self-help

books. Zehra (female, 29), for instance, voiced that she is a person that tackles and works through her challenges by herself; "*I feel like I'm kind of good at dealing with [on my own] in the beginning, and work on it and move on from it.".* Zula could relate to Zehra in dealing with the issues on her own; *"I would rather sit at home and let it pass than seek help."*
In accordance with Zehra and Zula, Faven (female, 25) too reported that she was more open to the idea of self-help rather than seeking professional help and included an openness to self-help materials as sources of help:

> *"Maybe I would listen to more podcasts, read books or self-help and things like that before I go [seek mental health help]. I don't even know what it is to struggle mentally, maybe it's normal for me to be a little anxious here and there, because at home I've learned that things like that happen somehow, you shouldn't talk about it, it's not like that important, they [shall] pass. [...] [But] no, I don't think I'd [seek mental health help] ... as it's not that important [for me]."*

Amongst participants who promoted self-help, it also included support from their social network as a form for self-help. Zehra (female, 29) believes that talking things out and sharing with others helps a lot and works as a replacement for therapy: *"I also think it might help to talk a lot. I also share a lot. So maybe that's why I don't need a psychologist."*
Similarly, Dawit (male, 29) reported that he found much support from the people around him, but made the note that such help depends on the openness of the social system:

> *"If I encounter a challenge I can talk to a colleague or those who are close to me and so on. But it says a lot how your network or circle is, right? So, my friends and my family are more open, so I know if I talk to them there will be no judgment, so I can just talk to them."*

5.2.2 Religion

Some of the participants reported that they would rather seek God than mental health professionals. Haben (female, 23) reported that she seeks God when facing mental challenges: *"My faith has always been God, that is what has helped me.".* In alignment with this view,

Semira (female, 21) shared that earlier she would consider seeking professional help, but that has changed after she became religious:

> *"I think now I would not have considered a psychologist. Earlier in life, I have considered it. Or I have recommended it to people around me. But because I'm so religious, it wouldn't be my first choice for solving things."*

In summary, beliefs were found to replace mental health help in 6 of the 8 participants, with 2 participants being the only ones open to seek mental health professionals when facing challenges. However, there was variation to be found, in whether the 6 hesitant participants found solutions on their own or through their religions. The hesitant participants would rather try to work on the mental issues on their own, through methods such as reflecting on their own, seeking support from their environment, reading self-help books or would rather seek help from God than mental health professionals. Based on these findings, beliefs were found to be a significant preventing factor in seeking help.

5.3 Lack of resources

While the last section looked at how beliefs could replace professional help, this section focuses more on how physical and materialistic resources hinder help-seeking. Resources were found to be lacking in the form of 1) lack of diversity amongst mental health professionals, 2) linguistic barriers to communication and 3) financial constraints.

5.3.1 Lack of diversity in mental health professionals

Lack of diversity in mental health professionals was credited as a significant prevention of mental health help-seeking. The participants remarked that they feared that an ethnic Norwegian psychologist would not be able to fully understand their experiences as an Eritrean immigrant. As Semira (female, 21) put it: "*People hold back and say 'ok if I go tell a person how I feel about my culture or what kind of trauma I've had [...], he's not going to understand'."* 4 out of the 6 participants made the point that there is a need for more diversity in the sense of having more people with a multicultural background within the mental health

field. Semira said: *"You have to be able to offer as much diversity as possible."*. Jamila (female, 25) agreed; *"I wish there was more diversity in psychologists, so it would have been easier."*. In accordance with Semira and Jamila, Dawit (male, 29) said that mental health professionals having the same values and cultural background would definitely help the case of seeking help.

> *"It can help a lot if there are more cultural ... er... more ethnicities, and then it becomes diverse. If there is more diversity there, it helps, because then you can seek help from the person you think "he can help me", right? Who have the same values, who have the same cultural background and so on."*

Out of the 6 participants who brought up the point of a lack of diversity within the mental health service, 3 of them also included that Norwegian psychologists could try to gain more cultural insight so they can be able to offer better help. Zula (female, 24) reflected that Norwegian psychologists should not only work from their own cultural perspective, but try to broaden their view and look at the person as a whole:

> *"People are different, but what I think would have been better is to just take a look at the background and grasp or understand the person. Not from the Norwegian perspective, but generally as a human being. Or they can have people with a multicultural background who work within the mental health care system."*

Faven (female, 25) shared the same view as Zula, and suggested that Norwegian psychologists should be taught more about how to start or open conversations about mental health with Eritrean immigrants.

> *"I think those with a more minority background would have understood better. I think so. But at the same time ethnic Norwegian psychologists, if they had had some understanding about how to open or start that topic at all, it might have made me as an Eritrean background think 'oh, he or she the psychologist knows something about it, maybe she can understand me, I want to talk about it'".*

In accordance with Zula and Faven, Semira (female, 21) remarked that the Norwegian educational system was including more materials about cultural understanding than earlier, but that as of today Norwegian psychologists lack the proper training in being able to offer Eritrean immigrants the best help:

> *"[If a Norwegian psychologist would give proper help] No, I actually don't think so. I feel in some situations of course, but most of the time I don't believe so. Unless they had been trained for it. Now there has been more in studies, when I look at, for example, in social work and the like, these various studies have got more curriculum on how to deal with foreign children and foreign traumas. But as of today, I don't think they could have understood and been able to offer me the best possible help."*

In summary, the participants reported a lack of diversity within the health system, with 3 of them also including that Norwegian psychologists should be giving more educational training to gain more cultural insight to be able to offer Eritrean immigrants better help. For these reasons, lack of resources in the form of a lack of diversity within the mental health field was found to be a great obstacle for help-seeking. The following section reviews another resource, interpreter availability.

5.3.2 Linguistic barriers

Findings show that although all 8 participants had good Norwegian skills, and they viewed linguistic expression as a barrier to mental health help-seeking. Zehra (female, 29), for instance, identifies language as the biggest barrier: *"I think the biggest [barrier] would probably be language since there aren't that many people who speak Tigrinya."*. Participants reported that the barrier is not in the form of the professionals not understanding what they are saying, but more in the way they express themselves. Like Semira (female, 25) said: *"I think that language is a big obstacle because it limits you in expressing yourself."* Zula (female, 24) agrees with Semira, and further explains that it is difficult as a bilingual to express yourself in a language other than your native language.

"Language is something that worries me in my encounter with [mental] healthcare. Yes, maybe I've come a long way with language and with integration, but when I'm really frustrated, for example, I want to express myself in my native language because that's when I express myself better. It's like when there's complete chaos in your head, then only your native language comes out, because it's the one that describes your whole personality. So, at home when I'm frustrated, I can't describe my feelings in Norwegian. Not because I can't, but only because there are other languages, and Norwegian is probably the fourth language I know."

This is also something that Zehra (female, 29) agreed on. She further explained that language is a hindrance for quite a few people, especially when you don't have the words to formulate and express yourself in a foreign language:

"I think language could end up hindering quite a few people. If you somehow can't master the language, then it can be very difficult because it somehow prevents you from doing a lot. For example, what I thought could be the problem was what if he [the psychologist] doesn't understand what I mean, or how to formulate it, or how to put it into words. If you don't know words then it becomes very, very difficult."

Whilst some of the participants viewed linguistic expression as a challenge, most of participants made the point that there is a general need for interpreters who speak their native language, Tigrinya, in the Norwegian mental healthcare system. As Jamila (female, 25) reported: *"Perhaps an interpreter would have been significant for those who have lived in Norway for only a few years and have limited language."* Some Eritrean immigrants might have difficulties expressing themselves in a different language than their mother tongue, which can lead to misunderstandings. However, this is an issue that according to Semira, Zula and Dawit can be avoided by implementing more translators and interpreters that speak Tigrinya.

"I think that [language] is a big obstacle because it limits you in expressing yourself. So, I also think that, for example, you can be misunderstood very easily. Yes, language is a big barrier. But if [the Norwegian mental health system] could sort of offer help

to have [Tigrinya] interpreters, for example, because now it's like we have so many multicultural people in Norway that someone is in these fields." (Semira, female, 21)

Zula (female, 24) further explained that language and expression can be difficult for those who are well integrated in the Norwegian culture, so it is expected to be twice as difficult for those who are not as integrated. She however recognizes that more interpreters in the health system comes with expenses:

"At least I want to make it a little easier with interpreters and such. Because I know it is already so difficult for those who know the language and are well integrated. It also becomes doubly difficult for those who are not so integrated and do not have the language. I wish they could inform and make it easier with an interpreter available so that it doesn't become so expensive, because it's already quite expensive without an interpreter then."

Whilst Zula recognized the economic challenges of gaining more interpreters in the mental health field, Dawit (male, 29) included another challenge, which was that having translators from the same culture can be limiting for one's openness during sections. However, he suggested a solution to the problem, which was that it should be anonymous so that the one who seeks help feels secure and comfortable enough to be able to open up without the fear of judgment:

"There may be some challenges, but there are solutions. The best possible solution is to find an interpreter who can translate from Tigrinya into Norwegian, right? … But it can cause challenges for those who seek help to get a translator who is from Eritrea because it could limit them to talk openly about their problems… It can help a lot if there is an interpreter system [which is anonymous] so that you don't have to present who you are, so that you feel more secure and comfortable when talking about your challenges and problems."

In summary, the participants viewed linguistic expression as a barrier to mental health help-seeking, and most of the participants made the point that there is a general need for

interpreters who speak their native language in the Norwegian mental healthcare system. One of the participants recognized the financial challenges that comes with applying more translators, and one of them mentioned that having a translator who shares one's culture can limit openness and therefore some form of anonymity should be considered during sessions. The following, last section will look further into findings around financial constraints.

5.3.3 Financial constraints

Findings show that prohibitive costs were a barrier in mental health help-seeking. Haben (female, 23) commented: *"And if you are struggling financially, for example, it is a bit more difficult in a way [to seek help]."* Jamila and Faven agreed with Haben that finances can be a hindrance. Jamila (female, 25) commented that she thinks people would want to seek professional help, but because of the prohibitive costs, they end up resorting to solving the problems themselves:

> *"If I'm being completely honest, maybe it if it'd been cheaper. Yes, because I think many people want to talk to a psychologist but when they see that it is so expensive, they choose to just deal with their own problems on their own."*

Faven (female, 25) also added to this view of finance being a burden that she does not have as much money as ethnic Norwegian children nor the privilege of getting financial help from her parents since they had to start from scratch when they immigrated:

> *"Yes, I wish it was a little cheaper because it is very, very expensive. I have looked up the price if you are going to seek help, it is very expensive. And I don't have as much money as ethnic Norwegian children do. Because they might get help from their parents financially and things like that, because their parents are from here and started life a long time ago, but my parents had to come here and start from scratch, so I don't get any financial help there. So, I would like the government to facilitate it or create something that can make it easier to seek help."*

In addition to financial expenses being a barrier to mental health help-seeking, several of the participants voiced that there are some limitations for Eritrean newcomers in the mental healthcare system. These limitations are in the form of lack of mental health courses for immigrants, lack of therapy offered upon arrival to Norway, and generally limited options for Eritrean immigrants. Zula (female, 24) reported that there are some lacking resources for Eritrean newcomers in the mental healthcare system. She expressed that as a new immigrant she didn't feel as if the mental healthcare system was sufficiently available for her, and that the offer was more sufficient for those who were already in the system:

> *"When I think about it now, in general, they have such a good system. But for me when I was a new immigrant, especially now that I am so familiar with the system, I feel that they did not have such a good offer when it came to new arrivals. I'd say they were or are more focused on those who are already in the system."*

Some of the participants offered suggestions as to how to handle the lacking mental health offers for newcomers. Faven (female, 25) voiced that it could be helpful if the Norwegian mental health service could arrange mental health courses that teaches Eritrean immigrants about what mental health is and how it occurs as many Eritrean immigrants have not come across it prior immigration:

> *"The Norwegian mental health service could arrange or conduct courses to teach Eritrean immigrants about what mental health is, and what causes it. Because not many people have come across it. And when I go to a new GP, it is most likely because it's something physical. I never think about telling my GP what I'm struggling with mentally because it's nothing to talk about."*

In accordance with Faven, Hayat (male, 27) suggested that some form of mandatory, imposed therapy or follow-up from psychologists can be useful for newcomers, who face mental challenges on their way to a new country:

"I think that having not forced but imposed [therapy] can be helpful. It's like okay, you know what, you've come to Norway so you should at least have some follow-up with a psychologist. And it may also be nice to say that it is completely normal that you receive help in some way. For we know that when you have crossed so many countries, experienced a lot on your way and must learn everything in the new country, it can [mentally] affect you. I think it should be mandatory to be offered some sort of therapy when you arrive. And it should be reassuring that when you are struggling with some thoughts, no matter what it is, a psychologist is available."

In summary, the financial expenses were a barrier in mental health help-seeking. One of the participants explained that she does not necessarily have as much money as ethnic Norwegian children nor the privilege of getting financial help from her parents. In addition to financial expenses being a barrier to mental health help-seeking, several of the participants voiced that there are limitations for Eritrean newcomers in the mental healthcare system, in the form of lack of mental health courses for immigrants, lack of therapy offers upon arrival to Norway and generally limited options for Eritrean immigrants. Some of the participants offered suggestions as to how to handle the lacking mental health offers for newcomers, such as mental health courses, imposed therapy and follow-ups by psychologists. Financial constraints were therefore found to be a hindrance in mental health help-seeking.

6 Discussion

This study seeks to identify the barriers to mental health help-seeking for Eritrean immigrants in Norway. To do so, the discussion around the findings will be based on the TPB-model, because it can be used to study what inspires changes in behavior. The discussion will be based on pairing the three main findings (cultural understanding, beliefs, and lack of resources) with the three components of the TPB-model (subjective norms, attitudes, and perceived control). The purpose of this is to understand how help-seeking behavior can be positively changed. This is because it allows one to view help-seeking behavior on three different levels; the interpersonal level (subjective norms paired with cultural understanding), the personal level (attitudes paired with beliefs) and the societal level (perceived control and lack of resources). Accordingly, the following discussion will be parted into three sections; Firstly, subjective norms will be discussed, and will be paired up with the data findings around 'cultural understanding'. Secondly, attitudes are going to be discussed, and these are linked to the data findings around 'beliefs'. Finally, perceived behavior control is going to be discussed, and this is linked to a lack of resources. By uncovering these areas, the hope is that they can contribute to an understanding of what can create an intention to change help-seeking behavior in Eritrean immigrants.

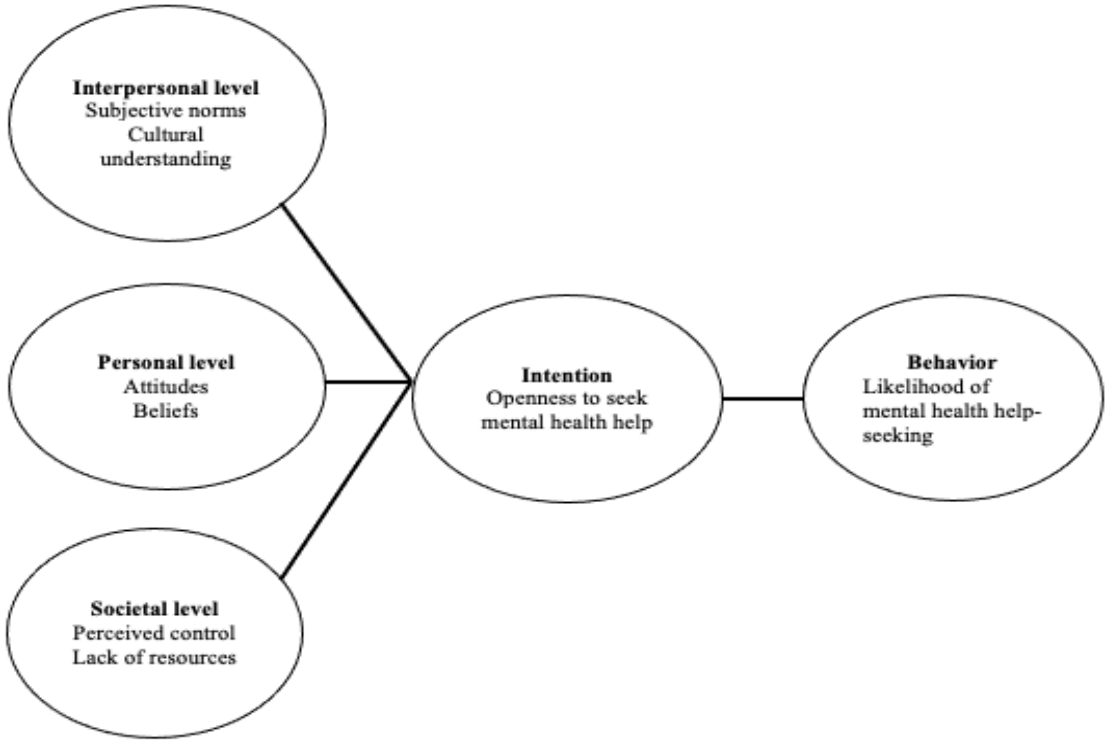

Figure 2. Conceptual model of the current study based on Azjen and Fishbein's Theory of Planned behavior

6.1 Subjective Norms and Cultural Understanding

To begin with, the discussion will explore the influence of interpersonal relations on mental health help-seeking among Eritrean immigrants, through examining the role of subjective norms. TPB defines subjective norms as a person's perception of significant others' opinions on their behavior, which can influence the intention to change their behavior (Myers et al., 2014, p. 173-174). To understand the role of subjective norms on help-seeking, this section will look at the findings around one of the main hindrances 'cultural understanding', with further inspections on the roles of its subsets of 'stigma' and 'collectivism and individualism'. The theme of subjective norms is paired with the findings under 'cultural understanding' because of their similarity in emphasizing the power of one's social network to influence help-seeking behavior.

6.1.1 Cultural Competency

'Cultural understanding' was in the findings recognized as the most repeated obstacle to mental health help-seeking. Cultural understanding in this context refers to the level of cultural awareness and knowledge amongst mental health professionals. Findings of this study report that the most designated barrier to mental health help-seeking among Eritrean participants, was the fear of not being understood by Norwegian mental health professionals. All participants expressed that being met with a lack of cultural insight could be one of the biggest factors preventing them from mental health help-seeking. Most importantly, the problem surpassed linguistic barriers because it is about how the professionals can relate to and understand the immigrants' culture, their experiences, and their feelings.

The finding that the general practitioner would not be able to help because they do not understand the Eritrean immigrants cultural background correlates with other Norwegian findings (Harris et al., 2021; Abebe et al., 2017; Kour, 2021). For instance, Harries et al. (2021) found difficulties due to the lack of culturally competent services to be one of two barriers, alongside language barriers. Kour et al. (2021) have explored the issue of help-

seeking in Norwegian immigrants from a health professionals' perspective. They found that most of the health professionals identified the lack of cultural component services in treatment as a potential barrier to mental help-seeking. This in turn causes misunderstandings of what was socially and culturally acceptable behavior. Furthermore, the health professional felt helpless in not knowing how to approach these patients in treatment, difficulty in developing a trusting relationship because the cultural expectations of the patients were left unmet, and a tendency for the patients to discontinue treatment because of the unmet need. These findings support that lack of cultural competency from health professionals is a reality for immigrants (Abebe et al., 2017; Harris et al., 2021; Kour et al., 2021). It also shows that the consequences of cultural misunderstandings are many, varying from the expectations to be met with a lack of cultural knowledge from a health professional to the actual reality of having the unmet expectations demotivate immigrants to complete treatment. More research is however needed to give the full picture of this significant hindrance, both from the immigrants and health professional's side.

There have been suggestions offered as to how to handle the issue of a lack of cultural understanding from health professionals, both from the participants of this study as well as Norwegian health professionals (Kour et al. 2021). Two suggestions that have been mentioned by participants in both studies were addressing the lack of diversity in health professionals and increasing cultural competence in Norwegian health professionals, which I will now look at.

The lack of diversity is a concern because of the fear that Norwegian mental health professionals would not be able to relate to how they struggle, as much as somebody who shares some of the same background, values and views would. In accordance with most of the participants of this study, Kour et al. (2021) also found there are very few immigrant health professionals in Norwegian health services. Moreover, they reported that immigrant patients often ask for health professionals of immigrant origin and that it could cause difficulties when they do not get access to these. It illustrates that immigrants prefer somebody from their own culture when addressing mental health services, because they wish to be understood. Thus, increasing diversity through acquiring more psychologists and other health workers with multicultural backgrounds will have several advantages. Firstly, it might reduce immigrants' fear of not being related to. Secondly, promote immigrants' mental health awareness, thirdly,

reduce the stigma surrounding mental health in the population and lastly, practitioners with diverse cultural backgrounds could increase cultural competence among health workers. This, in turn, might offer guidance to ethnic Norwegian health workers in how to approach patients with another background than their own.

There are however some challenges to implementing more diversity in Norwegian health care. One challenge is that increasing diversity is a complex issue that requires efforts and cooperation on several plans (Ewoh, 2013). For example, it can involve requiring politicians to promote diversity at the system level, to the individual level where immigrants participate in higher education. This can lead to complications and conflicts of interest, and one should look at ways to avoid these. Another challenge is that increasing diversity is more of a long-term goal than it is a short-term goal, which means there are higher chances of implementation challenges, such as policy changes, lack of cooperation, conflict of interests and availability of resources, can lower efforts or completely end the implementations (Campos & Reich, 2019).

It is important to figure out ways to sustain the long-term goal. One last challenge is one of financial means, as a long-term goal like this can be costly. One should have to look at ways for the goal to be cost-efficient, meaning having the maximum effect with the lowest costs, at whatever point this is possible without reducing the quality of the implication.

Increasing cultural competency in Norwegian health workers was another suggestion that is to be found both in this study as well as the study by Kour et al. (2021). It illustrates that Norwegian psychologists should try to gain more cultural insight so they can be able to offer better help. In this study, several emphasized that Norwegian psychologists should be taught more about how to start or open conversations about mental health with Eritrean immigrants.

In accordance with my findings, the Norwegian educational system should include more curricula on how to deal with foreign children and foreign traumas. When Norwegian psychologists lack the proper training, it becomes difficult to offer Eritrean immigrants the best help. Similarly, Kour et al. (2021) reported that health workers talked about the lack of

available resources such as official courses, training, or guidelines on cultural sensitivity in treatment programs. Increasing cultural knowledge among ethnic Norwegian health professionals is an important point as the lack of educational materials in treatment programs limits Norwegian health workers from acquiring more knowledge and skills in cultural competence. Thereby, it also limits the relationship they can have with patients from other cultural backgrounds. Thus, increasing cultural competence can increase knowledge about cultural differences, such as addressing differences between collectivism and individualism and the differing views on mental health. It can also involve taking courses about adversities that immigrants face, such as wars and fleeing abroad, and the consequences that these experiences might have on their mental health. Additionally, educating individuals more about how the traumas and trauma symptoms that are significant for immigrants, such as the increased risk for PTSD and depression, might affect and express itself in individuals (Teodorescu et al., 2012). Increasing cultural competence is important, as participants of this study did not view the language itself to be the challenge, but their adversities being understood by the health professionals were.

Based on my interpretation of the findings, I will now outline two strategies for enhancing cultural competence among health workers: One is a short-term goal and the other is a long-term goal. There are advantages to the proposal of increasing cultural knowledge in health professionals. The first one is that doing so will directly tackle the fear of many immigrants and help build trust among immigrant patients and their practitioners. The second advantage is that the suggestion is quite generalizable, as the majority of psychologists in Norway are of ethnic origins and there is a lack of diversity in health professionals. Providing courses to enhance the cultural competence of Norwegian health professionals who are already employed presents a more practical and expeditious solution than attempting to increase diversity among health professionals. This is since the ratio between ethnically Norwegian health professionals and those of other backgrounds is still skewed (Kour et al., 2021). This means that it would take more time and financial resources to completely balance it out. Increasing the cultural competencies of the health professionals can also be more cost-effective from a financial viewpoint than promoting diversity in health professionals. The former goal is short-term, involving the provision of more reading material and teaching courses for Norwegian health professionals. The latter goal is more long-term, focusing on encouraging more immigrants to participate in health- and higher education. The latter, long-

term goal includes efforts on both sides; the educational system must make ways to motivate, encourage and include immigrants in their programs, and the immigrants will have to engage in health and/or higher education. One last advantage is that increasing competency will not only be limited to Norwegian health workers; adding more curriculum on cultural differences in the education system can also guide and inform upcoming health workers of all backgrounds in how to engage with people with another cultural background than their own.

A disadvantage to increasing cultural competency in Norwegian health workers is that the outcome of implementing this relies on health workers efforts and willingness to learn new material and put it into practice, and it might be a challenge to implement systems that are there to ensure that the practitioner is motivated to try on their growing cultural competency. Another challenge might be to figure out ways for the health workers to acquire new knowledge about other cultures without making them feel inadequate; as I understand, this can for example be simple tactics such as giving them the space to make mistakes and praising their efforts. A third disadvantage of increasing cultural competency is the financial costs of including more curriculum on foreign traumas and teaching new courses to both educational workers, students, and health professionals. Regardless of which of the options is improved upon, whether it is increasing diversity or increasing cultural competence in Norwegian health workers, they both will cost to implement. However, increasing competency in health workers is a more specific short-term goal, and therefore appears to be more cost-efficient than the long-term, complex goal of increasing diversity within mental health professionals.

On another note, it should be mentioned that the discussion surrounding cultural competency is not to be limited to just include health professionals, but also immigrants. The responsibility of cultural competency will remain unbalanced if solely rests on the health professionals. In my view, efforts should be made to increase mental health awareness among immigrants, so they can better understand the language surrounding mental health and meet the health professionals halfway. This belief is based on the statements of some of the Eritrean immigrants of this study, who reported that they do not come from a culture that has a vocabulary around mental health, and even some had not heard the word mental health before arriving in Norway. Language around mental health is almost non-existent in Eritrea, it is, therefore, important to make efforts to raise mental health awareness in immigrants in

Norway. The goal is that accessing health services becomes a neutral experience for them. Some suggestions as to how to raise mental health awareness can be having more focus on mental health in introduction programs, having classes that are led by or include a health professional or setting up a program that offers free mental health help to new incomers. As with increasing diversity and cultural competency among health professionals, the disadvantage of this proposal is largely to do with financial costs. The outcome however could be beneficial, as it would allow immigrants to gain the language to be able to interact with health professionals and thus meet them halfway in the helping.

Lastly, regarding the TPB model, it appeared sensible to link cultural understanding to the component of subjective norms. The participants of this study all expect that significant others, here being Norwegian health workers, will not be able to fully understand them and this demotivates them from seeking help for their mental health. According to the theory, a supportive perception of subjective norms is one of the three components needed to elicit a behavior. However, the negative assessment of subjective norms instead leaves the immigrants demotivated to engage in help-seeking behavior. The subjective norm is therefore not in the usual form of fearing that significant others will not approve of a certain behavior, but instead manifests in the form that significant others will not be able to understand certain behaviors. This tells us that one of the components of TPB is not fulfilled, because the subjective norms of the Eritrean immigrants appear to be that significant others will not understand their experiences. This subjective norm needs to be challenged in order to normalize mental health seeking behavior in immigrants.

However, the suggestions as to how to handle cultural incompetence, such as increasing diversity and cultural competency in the health field and increasing mental health awareness among immigrants, come with financial and social challenges. While this section focused more on cultural understanding and the focus was mainly on the health professionals, the next section will look closer at the perspective of the Eritrean immigrants and further look at how subjective norms in its original meaning affect them through the sub-theme of stigma and social setting.

6.1.2 Stigma, Self and Social Setting

The theme of stigma was considered vital to include when discussing cultural understanding because all participants expressed in different ways that mental health awareness is viewed as a taboo and a suppressed and undesirable topic in Eritrea. Stigma is a negative belief or attitude towards a particular group or behavior and can be seen as a form of subjective norms in the sense that subjective norms are beliefs about what others think and do regarding a particular behavior or issue (Goffman, 1986). As we have seen when it comes to mental health, subjective norms can play a significant role in shaping Eritrean immigrants' attitudes and behaviors. However, as the findings show, Eritrean immigrants believe that seeking help is stigmatized in their community, and they are less likely to seek help, even if they are struggling. And if they sought help, they would most likely keep it a secret.

These findings are consistent with other studies that have identified fear of stigma as a barrier to seeking mental health help among immigrants (Bismar & Wang, 2021; Mantovani et al., 2017). The study by Mantovani et. al (2017) explored the relationship between stigma and mental health help-seeking for mental illness among African descended faith communities in the United Kingdom. The researchers found that stigma associated with mental illness is a significant barrier to help-seeking. Specifically, participants reported feeling ashamed, embarrassed, and stigmatized by mental illness, and were often hesitant to seek help due to fears of being labeled as “crazy” or “mad”. The researchers suggest that subjective norms, the perceived social pressure to seek or not seek help, play a role in the stigma associated with mental illness in these communities. This corresponds with the findings in a Canadian study about mental illness stigma and help-seeking attitudes of students with immigrant parents (Bismar & Wang, 2021). The researchers found that students with immigrant parents reported higher levels of mental illness stigma than students without immigrant parents. One of the major findings was that immigrant students expressed fear of being stigmatized by their society if they sought help for mental challenges. The students felt that seeking help for mental illness was seen as a sign of weakness or lack of resilience in their culture and were therefore less likely to seek mental health help and less likely to believe that seeking help is effective.

Based on the findings of this study and the studies presented above, stigma, subjective norms and cultural beliefs can play a significant role in shaping attitudes toward mental health help-seeking in immigrant communities. Presented findings and research has shown that stigma surrounding mental health illness can be particularly strong in some immigrant communities, including the Eritrean community, where mental health challenges are viewed as taboo, a weakness, or a personal failing. This stigma makes it challenging for Eritrean immigrants to seek help for mental health issues, which can aggravate mental health issues, leading to more severe challenges, which can affect their quality of life overall. Here, stigma contributes to forming negative subjective norms towards mental health, and thus plays a role in shaping negative attitudes towards mental health in the Eritrean community. In the Eritrean culture, there is a strong emphasis on conformity and social harmony, which makes it difficult for Eritrean individuals to seek mental health help as it goes against the norms of their community. This leads to individuals experiencing pressure to maintain a facade of strength and resilience, even if they are struggling mentally.
Evidently, stigma is heavily influenced by one's social setting. This can cause challenges for immigrants as the distinctive part of the immigrant's experience is that they belong to more than one social group.

To better understand how being a part of two cultures can reduce the intention to seek help, one can make use of George Mead's theory of social self (Mead, 1934). According to Mead's theory, individuals develop a sense of self through interactions with others and by taking on the perspectives of others. This includes not only the people they interact with directly but also the broader social and cultural context in which they live. However, this can cause a lack of social harmony for multicultural immigrants, as they are engaging in two cultures with seemingly opposite sets of values. Participants themselves view their origin culture to be more collectivistic, meaning it prioritizes relations over the individual, whilst they view Norway to be more of an individualistic culture that prioritizes the individual over the collective group. Half of the participants of this study recognized Norway as an individualistic society that puts more emphasis on the self-development and personal freedom of the individual than they do on the collective. This split in values alone is enough to cause confusion in immigrants and thus reduce the intention to seek help, as they move from a culture that tells them to put others before themselves to arrive in a culture that tells them to prioritize themselves (and their mental health) above others. This can lead to some

immigrants with collectivistic backgrounds feeling selfish to seek help, and some end up suppressing their struggles to keep harmony with the collective. This major cultural difference between collectivism in one's minority culture and individualism in the majority culture can cause misunderstandings in interactions with the majority culture as it does not have as much of a collectivistic standpoint as the immigrants. This cultural difference needs to be addressed somehow, to reduce confusion and raise the intention to seek mental help in immigrants. Misunderstandings might be avoided by the earlier suggestions of raising diversity and cultural competency in the mental health field and raising mental health awareness in immigrants.

Furthermore, it is evident that the stigma in the minority culture has more influence than the openness to mental health in the majority culture, as half of the participants reported they would entirely avoid help-seeking because of judgements from other members of their community. For Eritrean immigrants, the experience of stigma around mental health help-seeking in their community can shape their subjective norms around seeking help, which in turn affects their sense of self. As mental health issues are not something that is talked about in their native country, it makes it even more difficult and challenging when they arrive in the host country, as mental health is something that is highly prioritized in the new society. As a result, they might feel conflicted when it comes to seeking mental help, as their subjective norms in their community look at mental health illness as something taboo, whilst the host country has a more positive attitude towards mental health and utilization of mental health services. Thus, despite that the host country has a positive attitude towards mental health, Eritrean immigrants are still likely to not seek help because of a sense of pressure to conform to the norms and expectations of their culture. This is a hindrance from their community that needs to be targeted so that it becomes less stigmatizing to seek mental help. Therefore, reducing the stigma that is associated with mental health help-seeking among Eritrean immigrants, it requires a comprehensive approach that considers the multicultural context in which these individuals exist.

There are several suggestions on how to reduce stigma. One suggestion for this approach is to promote positive attitudes toward mental health seeking through social influence and persuasion. Social influence can be achieved through the use of opinion leaders, who are individuals that have a high level of influence within their social group (Flodgren et al.,

2019). Opinion leaders can play a role in reducing stigma towards mental health help-seeking and promote positive attitudes by raising awareness about mental health and the benefits of seeking help. By leveraging their influence and social networks, opinion leaders can help bring more mental health awareness to the community and encourage others to seek help when needed. Opinion leaders might be more effective if they are of the same cultural background as the target group, as it was made evident by participants of this study that it is easier to interact with people they can relate to. This can ultimately lead to a more supportive and accepting environment for those struggling with mental health issues.

Another way to reduce mental health stigma can be through the use of campaigns (here referring to advertising through mass media, social media or social contact events) that have persuasive, encouraging or educational content (Henderson et al., 2017; Rüsch et al., 2005; Sampogna et al., 2017). This can be used to change the attitudes and beliefs of individuals towards mental health seeking. It can be achieved by using messages that promote the benefits of seeking mental health help and reduce the perceived stigma to accessing mental health services. Although campaigns have shown improvements in reduced stigma, it is still debated what techniques and components make them the most effective (Evans-Lacko et al., 2010; Vyncke & Van Gorp, 2020; Wong et al., 2021). More research is needed to detect what components of campaigns decrease mental health stigma, especially in immigrant groups (Wong et al, 2021). Another suggestion can be through interventions that target the social norms that shape positive attitudes towards mental health help-seeking. Such interventions can be 1) social marketing campaigns that promote positive attitudes towards mental health and encourage help-seeking behaviors, 2) community-based interventions that involve working with community leaders and organizations to promote positive attitudes towards mental health and reduce stigma, and 3) interventions that involve peer support and education such as peer counseling and support groups (Schuster et al., 2016; Withall et al., 2012). Such interventions can be designed to specifically address the social norms that perpetuate negative attitudes towards mental health and promote more positive attitudes. By shifting these norms, interventions can help to create a more supportive and accepting environment for Eritrean immigrants who struggle with mental health issues. The issues with the proposals are similar to those of increasing cultural competency; mainly to do with financial and longevity efforts. The pay-off, however, from a political stance, will be that the promotion of mental wellness

through openness to seek help will lead to well-functioning, healthy, contributing societal members.

Regarding the TPB model, Eritrean immigrants may be influenced by social norms that stigmatize mental health help-seeking, leading to a hesitation to seek help for mental challenges. This tells us that the subjective norm component of TPB is also not fulfilled here, as subjective norms of the Eritrean community appear to be that mental help-seeking is viewed as taboo, which hinders the members of the community to seek mental help. Mead's theory of self emphasizes the importance of conformity in one's social network, but the multicultural Eritrean immigrants experience a gap between the stigma and collectivism in their own community, and an openness to mental health help-seeking and individualism in the host country. Closing this gap is important to promote mental wellness in immigrants. To encourage immigrants to be willing to seek help requires a comprehensive approach that includes increasing awareness and education, and challenging stigmatizing beliefs and attitudes in the Eritrean community. This can be achieved through suggestions such as social influence through opinion leaders, persuasive messages, and interventions. Although these suggestions are costly, they will help promote positive attitudes towards mental health seeking, which again might change behavioral intentions and promote mental health help-seeking behavior among Eritrean immigrants.
While this section looked at how interpersonal relations in the form of subjective norms can affect mental health help-seeking, the following section will explore how participant's own personal attitudes affect mental health help-seeking.

6.2 Attitudes and Beliefs

As it has now been discussed how interpersonal relations might prevent Eritrean immigrants from seeking help through factors such as "cultural understanding", "stigma" and "collectivism and individualism", this following section will discuss the personal level in which attitudes and beliefs hinder help-seeking. Here, the discussion will examine the role that attitudes have on mental health help-seeking. TPB defines attitudes as an individual's positive or negative evaluation of a particular behavior, in which a positive attitude raises the intention to engage in a behavior (Myers et al., 2014, p. 173-174). To understand the role of attitudes on help-seeking among Eritrean immigrants, this section will look at the findings

around ‘beliefs and its sub-themes ‘self-help’ and ‘religion’. The TPB component of attitudes is paired with the findings under ‘beliefs’ because both themes emphasize the ability of one’s perception in hindering behavior for seeking mental help.

Interpretations of the findings reveal a negative attitude in Eritrean immigrants towards mental help-seeking. Most participants preferred finding solutions on their own or through their religion than seeking professional help (Abraham et al., 2018). Beliefs were found to replace mental health help in 6 of the 8 participants, with 2 participants being the only ones open to seeking mental health help when facing challenges. Clarifications as to why they preferred self-help and religion over seeking professional help were found mainly to be because of stigma and fearing the reactions of other members of their culture and believing they won’t be fully understood by the health professionals because of cultural differences. The negative attitude is not only then influenced by their social systems, but also a lack of faith in the help itself as they believe it won’t be of any use if the health workers won’t be able to relate to them. A third reason behind the negative attitude is one that was more implied than it was directly said; several participants held the view that openness with mental health is a Norwegian and individualistic trait, and they did not associate it with their cultural identity. In doing so they hold the attitude that seeking help is not a behavior of their kind to engage in.

How might the issue of negative beliefs be handled? Earlier suggestions such as increasing diversity and cultural competency in the mental health field might address the lack of faith in the health system. However, attitudes are strong and set beliefs that can take time to change. They are often withheld through confirmation bias; a cognitive bias in which one favors information that confirms one’s existing beliefs (Myers et al., 2014, p. 112). To fight against confirmation bias, it will be important to showcase counter arguments in the larger society. The main priorities for attitude change should be to normalize seeking help for immigrants to decrease stigma and increase cultural competency in health professionals and showcasing to fight the immigrants’ distrust in the help. This can be done through strategies such as campaigns, posters and brochures that offer reminders or positive feedback (such as “thank you for making use of our mental health services”). Campaigns, posters and brochures have been found to be effective in decreasing stigma and promoting positive health behavior (Ngigi & Busolo, 2018).

In addition, many of the participants wanting to see more diversity in the mental health field and having workers that can relate to their experiences. Therefore, it will, as already mentioned, be important that the strategies make use of opinion leaders and role models of multicultural backgrounds to signify that help can be given by and to immigrants. Whilst these strategies have the benefit of challenging the beliefs of immigrants, they are limited in that attitudes and personal values are quite set and can be hard to influence (Maio et al., 2019). Thus, the impact of changing beliefs relies on how strong the belief is in each individual, that there needs to be an individual intrinsic motivation to engage in the call-to-actions of the strategies (Schultz, 2014), and that changing attitudes is a long-term and thus financially costly goal.

In regards to the TPB model, attitudes, subjective norms, and perceived behavioral control are all significant predictors of behavior, but attitudes are however more often difficult to affect due to their deep-seated nature and complexity (Maio et al., 2019). This is because attitudes are formed through a variety of factors, including past experiences, cultural beliefs, and social norms, and therefore may be more resistant to change as a result. Additionally, since attitudes may involve multiple beliefs or values, changing one aspect of an attitude may therefore not necessarily lead to a change in behavior. Based on the findings, attitudes towards mental health help-seeking have a significant impact on Eritrean immigrants' willingness to access mental health services. This is because mental illness is often viewed as a personal weakness or a moral failing rather than a medical condition in the Eritrean culture. This stigma creates a strong attitude in Eritrean immigrants, which prevents individuals from seeking help when facing mental challenges. Overall, attitudes and beliefs can be difficult to change, and may require significant effort and time to modify unlike subjective norms and perceived behavioral control, as they are influenced by factors such as social pressure or perceived ability to perform a behavior.

The next section will further look at how perceived behavioral control on the societal level can hinder help seeking among Eritrean immigrants.

6.3 Perceived Behavioral Control and Lack of Resources

While the last section looked at how attitudes and beliefs could replace professional help, this section discusses how physical and materialistic resources hinder help-seeking and increases the lack of perceived behavioral control (TPB). Perceived behavioral control on the societal level in this context refers to the collective sense of agency and autonomy that Eritrean immigrants may feel regarding the resources available to them to seek help in their host country. Resources were found to be lacking in the form of 1) lack of diversity amongst mental health professionals, 2) linguistic barriers to communication, and 3) financial constraints. The hindrances that Eritrean immigrants may face in the utilization of mental health services can contribute to a sense of helplessness and lack of control at the societal level. This can in return lead to feelings of frustration and disempowerment, which can make it challenging for Eritrean immigrants to seek the help that they require.

Another study that has identified several hindrances to the utilization of health services among immigrants and refugees, including Eritrean immigrants, came to the same conclusions as this one. The identified hindrances included linguistic barriers, financial constraints, and a lack of diversity among healthcare providers (Pavli & Maltezou, 2017). The authors found that these barriers can make it challenging for immigrants to prioritize their mental health needs, as they feel that they need to focus on their financial situation first. Additionally, linguistic barriers can make it difficult to communicate their mental health needs to health professionals, which can further prevent them from seeking help. Finally, a lack of diversity in health professionals can make it difficult for immigrants to find providers who can understand their cultural background and experiences, which can prevent them from seeking help. The common barriers identified in this study and the mentioned one have a common restraint, finances. All the barriers are somehow influenced by financial constraints. This can however be viewed from two perspectives; the Eritrean immigrants and their need to access affordable healthcare services, and the larger, societal perspective of a welfare state that must distribute their resources on several groups. This will now be examined more closely.

From a personal level, Eritrean immigrants view financial constraints as a significant barrier to mental help-seeking. One participant explained she doesn’t have as much money and

financial support from parents as compared to ethnic Norwegian children. Although the Norwegian healthcare system doesn't require health insurance to treat patients, it still requires that patients must pay a certain price for their treatments. Because Eritrean immigrants experience financial difficulties which hinder their ability to seek help, this can lead to a sense of hopelessness. This lack of perceived behavioral control over their financial situation can make it more challenging for the immigrants to prioritize their mental health needs, as they may feel that they need to focus on their financial situation first. This can lead to untreated mental health conditions, which can have negative consequences not only for the Eritrean immigrants, but also for the society as a whole. For example, untreated mental health conditions can lead to increased healthcare utilization, decreased productivity, and increased social welfare costs (Greenberg et al., 2015). To prevent these issues, it is important to offer Eritrean immigrants the best possible service, so they feel comfortable seeking help. According to the Eritrean participants, the barriers can be uplifted by for example increasing interpreter availability in their native language, Tigrinya. However, because of the mental illness stigma in the Eritrean community, it was suggested that the interpreter should be anonymous so that the one who seeks help feels secure and comfortable enough to express her or his feelings without the fear of judgment. Furthermore, it was suggested to raise diversity and health competency in the mental health field and raise mental awareness in Eritrean immigrants. However, these approaches require financial investment from the welfare state, which makes it more difficult to facilitate the best possible assistance for Eritrean immigrants.

On the other hand, the welfare state is supposed to provide for the basic needs of its citizens, to ensure that all citizens have access to the resources they need to live (Christensen & Berg, 2023). The welfare state can prevent financial constraints in immigrants and promote perceived control by reducing costs where it's possible, providing some free forms of mental help and investing more in social benefits and support programs that help immigrants integrate into society, find employment, and education and training opportunities. In exchange, such implications can lead to the immigrants contributing to the economy and society through their skills, knowledge, and cultural diversity. This can help reduce economic inequality and promote social mobility, which can lead to a greater sense of control and well-being among immigrants. A study done by Algan and colleagues (2010), found that welfare state policies that promote social integration and well-being among immigrants can lead to

positive economic and social outcomes for both immigrants and society as a whole. Additionally, the study found that immigrants who received social benefits and support were more likely to find employment and experience upward social mobility, which led to increased economic productivity and growth. The authors noted that social integration and inclusion can lead to greater social cohesion, trust, and well-being among members of society, which can further promote positive social outcomes (Algan et al., 2010). This can in this case contribute to accessibility of mental health services and promote the immigrant's willingness to seek help.

While it is important to consider the potential benefits of welfare state policies that promote social integration and well-being among Eritrean immigrants, there are also concerns about the potential costs and unintended consequences of such policies. For example, when immigrants are provided with social benefits, such as financial support, housing, or healthcare, they may be less motivated to find work and integrate into the host society; this is because they may rely on these social benefits instead of seeking employment and assimilating into the culture (Borjas, 2017). Also, welfare state policies can lead to an increase in taxes and public spending, which can have negative effects on economic growth and competitiveness (Alesina & Glaeser, 2004). However, it can again be argued that the benefits might outweigh the drawbacks as investing in immigrants' mental health will promote well-functioning, healthy societal members that contribute back to welfare. Although the financial challenges are recognized, the TPB model implies that working on increasing access to resources will directly increase perceived control in the Eritrean immigrants, and thus raise the intention to seek help for their mental challenges.

6.4 Practical implications

The TPB-model provides a theoretical framework for understanding the complex interplay of factors that shape mental health seeking behavior. However, to be effective, it is important to translate this theoretical understanding into practical interventions that can address the specific barriers to care that the Eritrean immigrants face. The analysis of the data concludes that none of the components of the TPB-model are fulfilled from the perspective of the immigrants. They were found to lack fulfillment of the subjective norms' component, as they feared not being understood by the health professionals because of their experiences and culture, and because of the stigma associated with mental health in their native country. The attitude component was also not fulfilled, as findings revealed a negative attitude in the immigrants towards seeking help and a preference to engage in self-help or finding solutions through their religion rather than seeking professional help. Lastly, the study found that lack of resources was a significant barrier to seeking mental health help, which in turn hindered the fulfillment of the perceived behavioral control component of the Eritrean immigrants.

Given that Eritrean immigrants lack all components of the TPB-model the effort to behavioral change should be immense. Regarding practical implications, one can argue that the practicality of the unfulfilled components are of various degrees. Attitudes are often difficult to change due to their personal, deep-seated nature and complexity. Although information strategies such as campaigns and posters with reminders, words of encouragement or opinion leaders could help fight the negative attitudes, it could still be challenging to shift immigrants' deepest attitudes towards mental health help-seeking. Subjective norms could be faced through education by raising diversity and cultural competence in health workers and reducing the stigma through raising mental health awareness in immigrants. However, the change is limited as the subjective norms reflect beliefs and values within a community and changing the viewpoint on mental health in the Eritrean community can be challenging as it is already steadfast that seeking mental health help is taboo and makes a person weak. In addition to that, much of the responsibility of increasing mental health awareness in this group relies on the interpersonal relationship of the people in the community and how much they encourage each other to engage in health-seeking behavior.

However, out of the three components, perceived behavioral control represents the most attainable area for intervention, as it pertains to societal changes. On a societal level, participants expressed barriers to seek help in the form of linguistic barriers, financial constraints, and lack of diversity among healthcare providers. These barriers can be uplifted by for example increasing interpreter availability in Eritrean immigrants' native language, raising diversity and health competency in the mental health field, and raising mental awareness in Eritrean immigrants through providing educational courses and more interactions with health workers, especially for newcomers. This can increase the perceived behavioral control in Eritrean immigrants. However, all these barriers have one main challenge: financial contribution from the welfare state. Although there are concerns about the potential costs and unintended consequences of investing in interventions that can uplift the barriers, the benefits outweigh the disadvantages; improved mental health outcomes among Eritrean immigrants may facilitate their integration into society, increase employment opportunities, and foster the development of healthy and productive members who can contribute to society. This, in return, may result in immigrants paying back the financial costs that have been invested in interventions through their contributions to society.

6.5 Limitations

There are both strengths and limitations to the present study. The special contribution of the study is that it identified barriers to mental health help-seeking in immigrants and got the data directly from an affected and overlooked group in Norwegian research, Eritreans. The use of semi-structured interviews allowed for a deeper exploration into the personal experiences and perspectives of Eritrean immigrants. The findings of the study provide useful information that can contribute to understanding the health behaviors of immigrants and be guides for how to offer the best possible mental health help for minorities.

The study, however, has several limitations. One of the more concerning limitations is that it only focuses on the experiences of the immigrants, and thus excludes other relevant perspectives in the mental health field, such as health professionals, politicians, and administrators. While the insight gained here and the suggestions made to promote help-seeking in immigrants might contribute to the discussion of health behaviors of immigrants, one should keep in mind that it does not paint the entire picture; Encouraging help-seeking in

immigrants is a complex task that relies on the collaboration of several entities. There is a need for more research from different perspectives to get a fuller picture of help-seeking behaviors of immigrants, and better address hindrances in implications from the different parties.

Another weakness of the study is that it only focuses on identifying the barriers to mental health, but it is equally important to have research on motivators for mental-health help-seeking as this can provide concrete guidance to goal-oriented interventions that promote mental wellbeing in immigrants. Thirdly, the study is limited due its sample. The external validity of the study is limited because of the small sample size of 8 participants. Although the enriched data explores the theme on a deeper level, it can be questioned how generalizable the experiences of the 8 participants are, and if they reflect the larger population. The population mostly consists of women in their twenties, and only two male participants who are also in their twenties. It was a challenge to find older participants as well as male participants, and the abstinence of them can create a skewed and incomplete picture of the issue at hand. Therefore, future research exploring the help-seeking behaviors of immigrants in Norway should include bigger, diverse samples. Lastly, due to time constraints it was not possible to compare gender or age differences, or other differences such as income or level of integration. Such differences can be useful data when trying to identify barriers as well as motivators to help-seeking in immigrants, and thus further research is encouraged to include them.

7 Conclusion

This study sought out to answer the research question: "*What are the barriers to mental health help-seeking amongst Eritrean immigrants in Norway?"*. To answer the research question, the findings of the study were categorized into three main categories: "cultural understanding", "beliefs", and "lack of resources". These categories were in varying degrees found to impede mental health help-seeking among Eritrean immigrants in Norway. The findings were discussed using the Theory of Planned Behavior, which posits that the intention to a behavior is influenced by supportive subjective norms in the significant others, a positive attitude from the individual and a perceived control over the behavior. The three main barriers were paired with the three components of the Theory of Planned Behavior ('subjective norms', 'attitudes' and 'perceived control'), in order to understand how help-seeking behavior can be encouraged. Eritrean immigrants were found to have the perspective that all the elements in the TPB-model were lacking, and this could explain the lack of intention to seek help. They were found to lack fulfillment of subjective norms, as they feared health professionals would lack cultural understanding and because of the stigma in their community. Their attitude towards help-seeking was found to be negative, and influenced by self-help, religion, and stigma. Finally, the lack of resources in the form of language barriers, lack of diversity and financial constraints on societal level was a significant barrier that impeded the fulfillment of the perceived behavioral control component. Given that all components of the TPB-model were lacking, the efforts to behavioral change should be immense. Nonetheless, perceived behavioral control represents the most feasible area for intervention, as it pertains to societal changes and less personal and interpersonal changes. Although interventions can be costly, investing in Eritrean immigrants' mental health would lead to healthy and productive community members who can contribute to society, which can benefit the immigrants and the community as a whole. Overall, this study provides important insights into the challenges Eritrean immigrants encounter when seeking mental health help and can inform future efforts to improve mental health outcomes for this population. With more research in this area, it is possible to develop effective interventions that can help Eritrean immigrants and other immigrant groups to overcome the barriers they face when seeking mental health help.

References

Abebe, D. S. (2010). *Public health challenges of immigrants in Norway: A research review*. Folkehelseinstituttet. https://www.fhi.no/publ/2010/public-health-challenges-of-immigrants-in-norway-a-research-review/

Abebe, D. S., Lien, L., & Elstad, J. I. (2017). Immigrants' utilization of specialist mental healthcare according to age, country of origin, and migration history: A nation-wide register study in Norway. *Social Psychiatry and Psychiatric Epidemiology*, *52*(6), 679–687. https://doi.org/10.1007/s00127-017-1381-1

Abraham, R., Lien, L., & Hanssen, I. (2018). Coping, resilience and posttraumatic growth among Eritrean female refugees living in Norwegian asylum reception centres: A qualitative study. *International Journal of Social Psychiatry*, *64*(4), 359–366. https://doi.org/10.1177/0020764018765237

Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., Dhavan, P., Fouad, F. M., Groce, N., Guo, Y., Hargreaves, S., Knipper, M., Miranda, J. J., Madise, N., Kumar, B., Mosca, D., McGovern, T., Rubenstein, L., Sammonds, P., … Zhou, S. (2018). The UCL–Lancet Commission on Migration and Health: The health of a world on the move. *The Lancet*, *392*(10164), 2606–2654. https://doi.org/10.1016/S0140-6736(18)32114-7

Alesina, A., & Glaeser, E. L. (2004). *Fighting poverty in the US and Europe: A world of difference*. Oxford University Press.

Algan, Y., Dustmann, C., Glitz, A., & Manning, A. (2010). The Economic Situation of First and Second-Generation Immigrants in France, Germany and the United Kingdom. *The Economic Journal*, *120*(542), F4–F30. https://www.jstor.org/stable/27765750

American Psychiatric Association. (2018). *What is Mental Illness?* https://www.psychiatry.org:443/patients-families/what-is-mental-illness

Attanapola, C. T. (2013). *Migration and Health: A literature review of the health of immigrant populations in Norway*. NTNU Samfunnsforskning AS. https://ntnuopen.ntnu.no/ntnu-xmlui/handle/11250/2372560

Barstad, A. (2017). Innvandring, innvandrere og livskvalitet. En litteraturstudie. In *51 s.* Statistisk sentralbyrå. https://ssb.brage.unit.no/ssb-xmlui/handle/11250/2487101

Barstad, A. (2018). Livskvalitet blant innvandrere. En analyse basert på Levekårsundersøkelsen blant personer med innvandrerbakgrunn 2016. In *50 s.* Statistisk sentralbyrå. https://ssb.brage.unit.no/ssb-xmlui/handle/11250/2572308

Bismar, D., & Wang, C. D. (2021). Mental Illness Stigma and Help-Seeking Attitudes of Students With Immigrant Parents. *Journal of College Counseling*, *24*(2), 146–161. https://doi.org/10.1002/jocc.12182

Borjas, G. J. (2017). *The Earnings of Undocumented Immigrants* (Working Paper No. 23236). National Bureau of Economic Research. https://doi.org/10.3386/w23236

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bryman, A. (2016). *Social research methods* (Fifth Edition). Oxford University Press.

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

Campos, P. A., & Reich, M. R. (2019). Political Analysis for Health Policy Implementation. *Health Systems & Reform*, *5*(3), 224–235. https://doi.org/10.1080/23288604.2019.1625251

Christensen, J., & Berg, O. T. (2023). Velferdsstat. In *Store norske leksikon*. https://snl.no/velferdsstat

de Bruijn, G.-J., Kroeze, W., Oenema, A., & Brug, J. (2008). Saturated fat consumption and the Theory of Planned Behaviour: Exploring additive and interactive effects of habit strength. *Appetite, 51*(2), 318–323. https://doi.org/10.1016/j.appet.2008.03.012

Dunn, K. I., Mohr, P. B., Wilson, C. J., & Wittert, G. A. (2008). Beliefs about fast food in Australia: A qualitative analysis. *Appetite, 51*(2), 331–334. https://doi.org/10.1016/j.appet.2008.03.003

Ekeberg, K. A., & Abebe, D. S. (2020). Mental disorders among young adults of immigrant background: A nationwide register study in Norway. *Social Psychiatry and Psychiatric Epidemiology*, *56*(6), 953–962. https://doi.org/10.1007/s00127-020-01980-z

Evans-Lacko, S., London, J., Little, K., Henderson, C., & Thornicroft, G. (2010). Evaluation of a brief anti-stigma campaign in Cambridge: Do short-term campaigns work? *BMC Public Health*, *10*(1), 339. https://doi.org/10.1186/1471-2458-10-339

Ewoh, A. I. E. (2013). Managing and Valuing Diversity: Challenges to Public Managers in the 21st Century. *Public Personnel Management*, *42*(2), 107–122. https://doi.org/10.1177/0091026013487048

Fazio, R. H., & Olson, M. A. (2003). Implicit measures in social cognition. research: Their meaning and use. *Annual Review of Psychology, 54*, 297–327. https://doi.org/10.1146/annurev.psych.54.101601.145225

Flodgren, G., O'Brien, M. A., Parmelli, E., & Grimshaw, J. M. (2019). Local opinion leaders: Effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, *2019*(6). https://doi.org/10.1002/14651858.cd000125.pub5

Garneau, A. B., & Pepin, J. (2015). Cultural Competence: A Constructivist Definition. *Journal of Transcultural Nursing*, *26*(1), 9–15. https://doi.org/10.1177/1043659614541294

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Duquesne University Press.

Goffman, E. (1986). *Stigma: Notes on the management of spoiled identity* (1. Touchstone ed). Simon & Schuster.

Greenberg, P. E., Fournier, A.-A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015). The Economic Burden of Adults With Major Depressive Disorder in the United States (2005 and 2010). *The Journal of Clinical Psychiatry, 76*(2), 5356. https://doi.org/10.4088/JCP.14m09298

Harris, S. M., Sandal, G. M., Bye, H. H., Palinkas, L. A., & Binder, P.-E. (2021). Integration Is Correlated With Mental Health Help-Seeking From the General Practitioner: Syrian Refugees' Preferences and Perceived Barriers. *Frontiers in Public Health, 9*. https://www.frontiersin.org/articles/10.3389/fpubh.2021.777582

Hauge, L. J., Eilertsen, M., Gustavson, K., Aarø, L. E., & Røysamb, E. (2020). Fra nord til sør: Livskvalitet i Norge 2019. In *154*. Folkehelseinstituttet, Område for Psykisk og fysisk helse. https://fhi.brage.unit.no/fhi-xmlui/handle/11250/2838086

Henderson, C., Robinson, E., Evans-Lacko, S., & Thornicroft, G. (2017). Relationships between anti-stigma programme awareness, disclosure comfort and intended help-seeking regarding a mental health problem. *The British Journal of Psychiatry, 211*(5), 316–322. https://doi.org/10.1192/bjp.bp.116.195867

Hendriks, M. (2015). The happiness of international migrants: A review of research findings. *Migration Studies, 3*(3), 343–369. https://doi.org/10.1093/migration/mnu053

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy*. Northwestern University Press.

Johannessen, L. E. F., Rafoss, T. W., & Rasmussen, E. B. (2018). *Hvordan bruke teori? Nyttige verktøy i kvalitativ analyse* (1. utgave). Universitetsforlaget.

Kour, P., Lien, L., Kumar, B., Nordaunet, O. M., Biong, S., & Pettersen, H. (2021). Health Professionals' Experiences with Treatment Engagement Among Immigrants with Co-occurring Substance Use- and Mental Health Disorders in Norway. *Substance Abuse: Research and Treatment*, *15*, 11782218211028668. https://doi.org/10.1177/11782218211028667

Lindert, J., Ehrenstein, O. S. von, Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees – A systematic review and meta-analysis. *Social Science & Medicine*, *69*(2), 246–257. https://doi.org/10.1016/j.socscimed.2009.04.032

Maio, G. R., Haddock, G., & Verplanken, B. (2019). *The psychology of attitudes & attitude change* (3rd edition). SAGE.

Mak, H. W., & Davis, J. M. (2014). The application of the theory of planned behavior to help-seeking intention in a Chinese society. *Social Psychiatry and Psychiatric Epidemiology*, *49*(9), 1501–1515. https://doi.org/10.1007/s00127-013-0792-x

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, *20*(3), 373–384. https://doi.org/10.1111/hex.12464

McAuliffe, M., Khadria, B., & Bauloz, C. (2019). *World migration report 2020*. IOM. https://worldmigrationreport.iom.int/

Mead, G. H. (1934). *Mind, self, and society: From the standpoint of a social behaviorist*. University of Chicago Press.

Myers, D., Abell, & Sani, F. (2014). *Social psychology* (2nd edition). McGraw-Hill Education.

Ngigi, S., & Busolo, D. N. (2018). Behaviour Change Communication in Health Promotion: Appropriate Practices and Promising Approaches. *International Journal of Innovative Research and Development*. https://doi.org/10.24940/ijird/2018/v7/i9/SEP18027

Oyserman, D., & Lee, S. W. S. (2008). Does culture influence what and how we think? Effects of priming individualism and collectivism. *Psychological Bulletin*, *134*(2), 311. https://doi.org/10.1037/0033-2909.134.2.311

Pavli, A., & Maltezou, H. (2017). Health problems of newly arrived migrants and refugees in Europe. *Journal of Travel Medicine*, *24*(4), tax016. https://doi.org/10.1093/jtm/tax016

Reneflot, A., Aarø, L. E., Aase, H., Reichborn-Kjennerud, T., Tambs, K., & Øverland, S. N. (2018). Psykisk helse i Norge. In *178*. Folkehelseinstituttet, Område for psykisk og fysisk helse. https://fhi.brage.unit.no/fhi-xmlui/handle/11250/2984478

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health*, *4*(3), 218–251. https://doi.org/10.5172/jamh.4.3.218

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, *20*(8), 529–539. https://doi.org/10.1016/j.eurpsy.2005.04.004

Sampogna, G., Bakolis, I., Evans-Lacko, S., Robinson, E., Thornicroft, G., & Henderson, C. (2017). The Impact of Social Marketing Campaigns on Reducing Mental Health Stigma: Results From the 2009–2014 Time to Change Programme. *European Psychiatry*, *40*, 116–122. https://doi.org/10.1016/j.eurpsy.2016.08.008

Schultz, P. W. (2014). Strategies for promoting proenvironmental behavior: Lots of tools but few instructions. *European Psychologist, 19*, 107–117. https://doi.org/10.1027/1016-9040/a000163

Schuster, L., Kubacki, K., & Rundle-Thiele, S. (2016). Community-based social marketing: Effects on social norms. *Journal of Social Marketing*, *6*(2), 193–210. https://doi.org/10.1108/JSOCM-06-2015-0036

Statistisk sentralbyrå. (2022). *Fakta om innvandring*. SSB. https://www.ssb.no/innvandring-og-innvandrere/faktaside/innvandring

Straiton, M. L., Øien-Ødegaard, C., Aambø, A. K., Holmboe, O., Johansen, R., Grewal, N. K., & Indseth, T. (2019). *Helse blant innvandrere i Norge. Levekårsundersøkelsen blant innvandrere 2016*. Folkehelseinstituttet, område for helsetjenester. https://fhi.brage.unit.no/fhi-xmlui/handle/11250/2632079

Teodorescu, D.-S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology*, *53*(4), 316–332. https://doi.org/10.1111/j.1467-9450.2012.00954.x

Tjora, A. (2021). *Kvalitative forskningsmetoder i praksis* (4. utgave). Gyldendal Akademisk.

Vyncke, B., & Van Gorp, B. (2020). Using counterframing strategies to enhance anti-stigma campaigns related to mental illness. *Social Science & Medicine (1982)*, *258*, 113090. https://doi.org/10.1016/j.socscimed.2020.113090

Withall, J., Jago, R., & Fox, K. R. (2012). The effect a of community-based social marketing campaign on recruitment and retention of low-income groups into physical activity programmes—A controlled before-and-after study. *BMC Public Health*, *12*(1), 836. https://doi.org/10.1186/1471-2458-12-836

Wong, E. C., Collins, R. L., McBain, R. K., Breslau, J., Burnam, M. A., Cefalu, M. S., & Roth, E. (2021). Racial-Ethnic Differences in Mental Health Stigma and Changes Over the Course of a Statewide Campaign. *Psychiatric Services*, *72*(5), 514–520. https://doi.org/10.1176/appi.ps.201900630

World Health Organization. (2022). *Mental disorders*. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

Appendix A: Recruitment poster

Inland Norway University of Applied Sciences

Appendix B: Interview guide

Intro:

Takk for at du deltar i studiet mitt, det betyr mye for meg og masteroppgaven min. Jeg vil åpne dette intervjuet med å introdusere mitt forskningsspørsmål som er: *Hvilke faktorer virker som barrierer for å søke om psykisk hjelp blant eritreiske innvandrere i Norge?* Dette intervjuet kommer til å være anonymt (ikke identifisert ved navn) av etiske grunner.

Overgangsspørsmål	- Hvordan har du det i dag? - Hvor gammel er du? - Hvor lenge har du bodd i Norge?
Integrasjon	- Hvor godt integrert i det norske samfunnet vil du si du er? - Hva er din relasjon/generelle inntrykk av psykisk helsevern i Norge? - Hvor godt kjent er du med det norske pskyiske helsevesen? - Hvilke forventninger har du til psykisk helsevesenet? - Opplever du tydelige forskjeller på synet på mental helse i de to kulturene du er en del av?
Psykisk helse	- Kan jeg få spørre hvordan din mental velvære var før du flytta til Norge og hvordan den er i dag? - Hadde du vurdert å søke psykisk helsehjelp dersom du hadde opplevd psykiske utfordringer?
Potensielle barrierer	- Hva slags barrierer som eritreisk innvandrer bosatt i Norge vil du

	møte når du søker psykisk helsehjelp? - Er språket noe som bekymrer deg for ditt møte med helsevesenet? - Er din tro? - Er din kultur? - Føler du at norske psykologer hadde forstått dine erfaringer og utfordringer for å kunne tilby deg best mulig hjelp? - I ditt perspektiv, hva kan bidra til å forbedre disse barrierene?

Avslutning:

Det var alle spørsmålene jeg hadde. Tusen takk for at du tok deg tid til å snakke i dag, og for å gi meg muligheten til å intervjue deg. Før vi avslutter dette intervjuet, er det noe du vil legge til som ikke ble nevnt eller dekket? Hvordan opplevde du dette intervjuet? Er det noe mer angående prosjektet mitt du ønsker å vite?

Appendix C: Consent form

Vil du delta i forskningsprosjektet
" Psykisk helse og opplevde barrierer for å søke psykisk helsehjelp blant Eritreiske innvandrer"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å finne hvilke faktorer som virker som barrierer for å søke hjelp til psykiske helseproblemer blant eritreiske innvandrere i Norge. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Dette er en masteroppgave og all datainnsamling skal kun benyttes til denne oppgavens formål.

Innvandreres helse har blitt sett på som en folkehelseutfordring i flere land, noe som øker behov for å forstå og frembringe forskningsbasert kunnskap om innvandreres helseproblemer. Eritrea er blant landene med en stor andel innvandrere som er lokalisert i Norge, tiltros for dette er forskningen på denne populasjonen svært begrenset. På bakgrunn av dette ønsker denne studien å se på den psykiske helsen til eritreiske innvandrere i Norge.

Problemstilling som skal analyseres er; Hva er faktorer som fungerer som barrierer for å søke psykisk helsehjelp blant eritreiske innvandrere i Norge?

Hvem er ansvarlig for forskningsprosjektet?

Høyskolen i Innlandet, studiested Elverum er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?

Du får spørsmål om deltakelse for å være med på å øke oppmerksomheten om psykisk helse i din etniskgruppe, og identifisere mulige barrierer for hjelpsøking. Utvalget for dette prosjektet er basert på et målrettet utvalg. Dette innebærer at utvalget ikke er tilfeldig valgt, men inkluderer deltakere som har relevanserfaringer og kunnskap knyttet til forskningsspørsmålet.

Hva innebærer det for deg å delta?

Det vil bli gjennomført semi-strukturert intervjuer i henhold til min problemstilling om faktorer som fungerer som barrierer for å søke psykisk helsehjelp blant eritreiske innvandrere i Norge. Mitt forskningsspørsmål er styrende for intervjuet og spørsmål i min intervjuguide vil være åpne spørsmål. Varighetstid for intervjuet er beregnet på 1 time. Intervjuet er anonymt og vil bli tatt opp med «nettskjema» Diktafon-appen med mobiltelefon som opptaksenhet. Diktafon-appen skal videresende lydfilene til «nettskjema». Av etiske og sikkerhetsmessige årsaker har jeg kun tilgang til opptakene gjennom «nettskjema», hvor jeg bruker min student ID for å få tilgang.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Du kan si nei dersom du ikke ønsker å delta. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket. Det er kun jeg og min veileder som vil ha tilgang til materialet. Jeg er underlagt taushetsplikt, og alt materiale vil bli behandlet konfidensielt. Data som er transkribert og analysert vil bli

oppbevart på passord beskyttet PC hvor det er kun jeg som har tilgang. All informasjon som blir samlet inn vil bli makulert etter bruk og godkjenning av masteroppgaven. Deltakernes identitet vil bli anonymisert gjennom hele prosessen, og vil ikke kunne gjenkjennes i publikasjonen. Prosjektet skal etter planen avsluttes 19.05.2023. Etter godkjenning av prosjektet vil all innsamlet materiale makuleres.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Høyskolen i Innlandet, studiested Elverum har Personverntjenester vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene

å få rettet opplysninger om deg som er feil eller misvisende

å få slettet personopplysninger om deg

å sende klage til Datatilsynet om behandlingen av dine personopplysninger

Hvis du har spørsmål til studien, eller ønsker å vite mer om eller benytte deg av dine rettigheter, ta kontakt med:

Anastasia Kabatanchi

Masterstudent i Folkehelse ved Høyskolen I Innlandet, studiested Elverum

Telefon: +47 903 64 506

Epost: 257341@stud.inn.no

Veileder

Børge Baklien

Førsteamanuensis ved Høyskolen i Innlandet, studiested Elverum

Fakultet for Helse- og sosialvitenskap

Telefon: +47 624 30 055

Epost: Borge.baklien@inn.no

Hvis du har spørsmål knyttet til Personverntjenester sin vurdering av prosjektet, kan du ta kontakt med:

Personverntjenester på epost (personverntjenester@sikt.no) eller på telefon: 53 21 15 00.

Med vennlig hilsen

Anastasia Kabatanchi

Appendix D: NSD assessment

Sikt

Meldeskjema / Mental helse blant Eritreiske innvandrere / Vurdering

Vurdering av behandling av personopplysninger

Referansenummer
630653

Vurderingstype
Standard

Dato
13.12.2022

Prosjekttittel
Mental helse blant Eritreiske innvandrere

Behandlingsansvarlig institusjon
Høgskolen i Innlandet / Fakultet for helse- og sosialvitenskap / Institutt for folkehelse og idrettsvitenskap

Prosjektansvarlig
Børge Baklien

Student
Anastasia Kabatanchi

Prosjektperiode
02.01.2023 - 19.05.2023

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 19.05.2023.

Meldeskjema

Kommentar
OM VURDERINGEN
Personverntjenester har en avtale med institusjonen du forsker eller studerer ved. Denne avtalen innebærer at vi skal gi deg råd slik at behandlingen av personopplysninger i prosjektet ditt er lovlig etter personvernregelverket.

Personverntjenester har nå vurdert den planlagte behandlingen av personopplysninger. Vår vurdering er at behandlingen er lovlig, hvis den gjennomføres slik den er beskrevet i meldeskjemaet med dialog og vedlegg.

VIKTIG INFORMASJON TIL DEG
Du må lagre, sende og sikre dataene i tråd med retningslinjene til din institusjon. Dette betyr at du må bruke leverandører for spørreskjema, skylagring, videosamtale o.l. som institusjonen din har avtale med. Vi gir generelle råd rundt dette, men det er institusjonens egne retningslinjer for informasjonssikkerhet som gjelder.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige personopplysninger og særlige kategorier av personopplysninger om etnisitet, religion og helse frem til 19.05.2023.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 a.

Behandlingen av særlige kategorier av personopplysninger er basert på uttrykkelig samtykke fra den registrerte, jf. personvernforordningen art. 6 nr. 1 a og art. 9 nr. 2 a.

PERSONVERNPRINSIPPER
Personverntjenester vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen:

- om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet.

DE REGISTRERTES RETTIGHETER
Vi vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18) og dataportabilitet (art. 20).

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
Personverntjenester legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

For å forsikre dere om at kravene oppfylles, må prosjektansvarlig følge interne retningslinjer/rådføre dere med behandlingsansvarlig institusjon.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til oss ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilken type endringer det er nødvendig å melde:
https://www.nsd.no/personverntjenester/fylle-ut-meldeskjema-for-personopplysninger/melde-endringer-i-meldeskjema

Du må vente på svar fra oss før endringen gjennomføres.

OPPFØLGING AV PROSJEKTET
Vi vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!