Struggling for clarity
- cultural context, gender and a concept of depression in general practice

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"To write prescriptions is easy, but to come to an understanding with people is hard"

F. Kafka
Abstract

Many depressed patients attend primary health care, and minority-group patients often see general practitioners for depressive symptoms. The diagnosis and classification criteria of depression and guidelines for management are based on symptoms. However, expressions of depression can vary with culture and gender but the diagnostic tools and guidelines are not adapted to gendered or cultural context and have shown to be poorly applicable in clinical practice. The purpose of this thesis was to analyse how socio-cultural factors— with focus on gender and ethnicity and their intersections—could influence the concept of depression from the perspectives of the patient and patient descriptions, of medical experts as well as general practitioners. By viewing these different perspectives I have tried to illustrate how depressive symptoms are expressed and interpreted in different gendered socio-cultural contexts and how they become a disease entity. Furthermore, I want, in particular, to illustrate a variety of difficulties that GPs may face during the process of care when meeting and treating men and women from different countries showing symptoms which may indicate depression.

Study I. The aim of the study was to explore the reasons for and patterns of attendance among Roma women in primary health care and to shed light on health problems of the Roma. Four Roma women were interviewed in-depth. The data were audiotaped and analysed according to Grounded Theory. The results showed that the daily life of women was characterized by marked hierarchical order and rules formed by gender, age and the collective culture. Young women had most rules to follow and if the rules were broken it was easy to end up outside the collective and display depressive symptoms or pain. The gendered, collective culture could both construct and/or form the concept of illness among the Roma women.

Study II. The aim of the study was to highlight the gendered representations of lay persons’ experiences of depression by drawing on personal stories of depression that appeared in Swedish newspapers. The data were then subjected to a Qualitative Content Analysis. The mediated accounts of depression both upheld and challenged traditional gender stereotypes. The women’s stories were more detailed, relational, emotionally oriented, and embodied. The portrayal of men was less emotional and expressive, reflecting hegemonic patterns of masculinity. The media representations of gendered healthrelated beliefs and behaviours may influence the way patients, physicians and other health care professionals understand and communicate about issues of mental health and depression.

Study III. The aim of the study was to explore how authors of medical articles wrote about different symptoms and expressions of depression in men and woman from various ethnic groups as well as to analyse the meaning of gender and ethnicity for expressions of depression.

Through a search in the medical database PubMed 30 scientific articles were identified and included in the analysis. The result and the discussion section of each article was analysed with Qualitative Content Analysis. The analysis showed that culture and gender formed the expressions of depression, how depression was interpreted and the diagnosis of depression. The analysis of the articles identified a western point of
view, which could lead to “cultural or gender gaps” and which could also influence the diagnosis of depression.

**Study IV.** The aim of the study was to make a qualitative analysis of medical research articles in order to get a broader view of explanations of depression in men and women in various ethnic groups.

Through a search in the medical database PubMed 60 scientific articles were identified and included in the analysis. The result and the discussion section of each article was analysed with Qualitative Content Analysis. The explanations for depression in our study have a strong emphasis on socio-cultural causes with focus on depressed persons from non-western minority groups. Even so, discussion about cultural or gendered explanations for depression was almost missing. We interpreted that the view of minority groups in the articles could be described as a view of “others”. The view of “othering” increases risks for cultural and gender gaps, such as biased scientific knowledge, medicalization of social problems, cultural stereotypes, risk for misdiagnosis of men’s depression, and affects the quality and care of depressed patients.

**Study V.** The aim of the study was to explore and analyse how GPs think and deliberate when seeing and treating patients from foreign countries who display potential depressive symptoms. The data were collected in focus group and individual interviews with GPs in northern Sweden and analysed by Qualitative Content Analysis. The study showed that patients’ early life events of importance were often unknown which blurred the accuracy. Reactions to trauma, cultural frictions and conflicts between the new and old gender norms made the diagnostic process difficult. The patient-doctor encounter comprised misconceptions, and social roles in meetings were sometimes confused. GPs based their judgement mainly on clinical intuition. Tools for management and adequate action were diffuse. There is a need for tools for multicultural, general practice care. It is also essential to be aware of the GPs’ own conceptions to avoid stereotypes and not to under- or overestimate the occurrence of depressive symptoms.

**Conclusion:** The concept of depression is always situated. The gendered socio-cultural norms, beliefs and behaviours can both construct the concept of illness and influence patients’ experiences and expressions of depression as well as form the patient-doctor encounter. The knowledge of medical “experts” is based on a dominating, western view of knowledge, which defines diagnosis and classification criteria of depression as well as guidelines for management. GPs are struggling for clarity between the medical and the clinical practice. The multicultural appearances of depressive symptoms are a challenge for GPs but it is a challenge for society to improve the life circumstances which can lead to a depressed mood and suffering.

**Key words:** Depression, gender, ethnicity, qualitative research, general practice.
List of publications


The papers will be referred to by their Roman numerals I-V.

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To be one of “the others”, GP and a researcher
- a journey

In my early childhood, in the southwestern part of Finland, inhabitants demonstrated when a group of Romanies were allowed to rent one of the houses in the area. The Romanies, “the others”, in the otherwise ethnic homogenous garden suburb, were not accepted. There were diverse rumours about the life of the Romanies and “we” and “they” lived totally apart.

As a GP, a long time afterwards, I met several Finnish-speaking Romany patients. I could understand the Romany patients’ scrutinizing eyes and mistrust in attending the health care centre. Marginalization and discrimination of the Romanies was not only a problem in my home town all those years ago.

I was told that I was entrusted with the task of being a GP for a group of Romanies, not only because of my knowledge of the Finnish language but also because I was one of “the others”, an immigrant.

Many other immigrant patients, too, have told me that they trust me because of my “otherness”.

My contact with Romany patients showed clearly that contextual factors, such as ethnicity, culture, gender and power relations in society influence the life and health of patients (Helman 2007; Lykke 2002) and was a starting point for my research project. The medical model I had studied did not include this knowledge.

After several years of contact, with help from Bengt Mattsson, I made an interview study among some of the Romany women in order to get a better understanding of their life and health problems.

I started the project with a few interviews but my intention to go further was stopped because of some serious events within the group.

However, more and more patients from other cultures attended the Health Centre. Generally, a depressed mood as a cause for attendance increased (SBU 2004). It was especially difficult to form an opinion of patients from other countries who had symptoms which could indicate depression. I discovered that the skills I relied on in my general practice needed the addition of new skills.

The possibility to collaborate in a research project about depression (Hammarström 2004), offered me an opportunity to obtain wider knowledge about the construction of depression from different perspectives, especially including that of medical experts focusing on ethnicity and gender. The head of the project was Anne Hammarström who became my main tutor. The project included studies about scientific, patient and media perspectives, which are influential factors in the construction of a disorder taking place in clinical practice during a patient-doctor encounter (Helman 2007).
In order to further elucidate the perspective of a doctor in the construction of a concept of depression among patients from different cultures, some GPs were interviewed in focus groups and individually with my other tutor B Mattsson as a moderator.

My experiences of stereotypical thoughts, both my own and patients’ views about Finland for example, have made me more conscious about how easy it is to construct a portrait about “the other” and the “others” which has basic/essential significance in a patient-doctor encounter in health care. Due to social context, such as social class, age, religion, the sameness between individuals from Finland and Sweden can be more than between people in Finland.

The purpose of the description of my journey and my different experiences as an immigrant, GP and researcher has been to demonstrate how my preconceptions have had an impact on my choice of research area and also on the qualitative analysis performed in my thesis (Malterud 2001). My way from Finland almost without any immigrants to a life as an immigrant has, I venture to say, intensified my analysis.
Background

Migration and mental health
Today, many individuals migrate from one place to another and leave one geographical area to stay or settle in another area, voluntarily or under compulsion (WHO 2004). The reasons for migration can be social, political, economical or educational. The total number of migrants is not easy to account for, but according to the UN (2006) there are about 191 million migrants in the world.

Different concepts are used about migrants, often depending on the cause for migration, for example refugees and labour migrants, but in this dissertation I use the term immigrant to mean a person who has left one country and settled in another regardless of the reason (Wachtler 2007).

Immigrants are not a homogenous group but studies have shown that immigrants often have poorer mental health than members of the majority population (WHO 2004). Immigrants are often exposed to threat, violence and severe trauma before migration, which makes the migration process more difficult. Post-migration factors, such as changing cultural and religious attitudes and marginalisation as well as change of economic status can lead to poorer health and increased risk of mental illness (Taloyan et al 2008; WHO 2004).

In social psychology, acculturation is defined as the impact on culture and change of culture, which takes place when different cultural traditions of societies meet (Helman 2007). Both cultures may change but one cultural group often dominates over the other group, which usually means changing the attitudes of an immigrant from an ethnic minority. Cultural adaptation, which can also be formed by gender, age and social context, can be associated with higher risks for mental health problems (Bhugra 2004).

In several western countries, however, it can be difficult for immigrants to join the mainstream community and culture, even if they wish to, because of economic, social and religious or gender discrimination (Viruell-Fuentes 2007). Immigrants can stereotypically be positioned as “the other”. “Othering” is a process which aims to strengthen the normality of the dominated group and keep those separate who are thought to be different from oneself (Grove & Zwi 2005).

Immigrants can be seen as needy and helpless, draining on resources and are rarely portrayed with skills and capacity. Persons or groups to be “othered” can experience this as discrimination (Helman 2007; Grove & Zwi 2005). Discrimination has been shown to have negative consequences for immigrants’ health and meetings with health care (WHO 2001).

Political power and economic wealth are influential factors on health but are often unequally distributed between majority and minority groups in a given society, as well as between men and women (Doyal 1998), which can contribute to poorer mental health of immigrants, especially among immigrant women.
At the same time other factors, for example age and education level, can create differences in life circumstances and health between individuals (Östlin et al. 2006).

In Sweden about 13 percent of the population are immigrants from about 200 countries (Statistics Sweden 2008) and have, on average, poorer health than individuals with a Swedish background (Hjern 2009).

According to a preliminary report from The National Board of Health and Welfare (2009), poorer health in an immigrant group is, to a great extent, due to life circumstances and experienced discrimination and women have poorer health than men. Further, those immigrants who have experienced discrimination reported mental health problems twice as often as other groups (Socialstyrelsen 2009).

Depression is a common diagnosis in primary health care (Chew-Graham et al. 2002), and minority-group patients often see general practitioners for depressive symptoms (Burroughs et al. 2006).

However, GPs are often blamed for not recognizing the depressive symptoms (Blashki et al. 2006). The diagnostic tools and academic education have been criticized as unsuitable in primary care (Hegarty et al. 2009; Kendrick et al. 2009; Gask et al. 2008; Andersson et al. 2002). There is no blood test either to give more clarity (Thomas-MacLean & Stoppard 2005).

When meeting and treating depressed patients it is particularly difficult to diagnose and manage male and female immigrants. The diagnosis of depression is based on symptoms (DSM-IV 2000; ICD-10 1993) but patients’ expressions and illness experiences can vary with culture (Helman 2007; Kirmayer 2006; Bäärnhielm & Ekblad 2000; Löfvander 1997) and gender (Danielsson et al. 2009; Emslie et al. 2007; Marcus et al. 2005; Piccinelli & Simon 2000) and there are often problems in communication (Wachtler 2007).

In this dissertation I attempt to show how contextual factors focusing on ethnicity and gender and their intersections can influence the concept of depression from patients’, medical experts’ and GPs’ perspectives. By studying these different perspectives I have tried to illustrate in what ways the process of care (De Maeseneer et al. 2003), might be formed by sociocultural and gendered context. The view is analysed through a theoretical “lens” of intersectionality.

The concept of intersectionality and gender
Intersectionality is a cultural, theoretical concept which has its origin in the need to illustrate how gender and other sociocultural power dimensions, for example ethnicity, age, social class and sexual preference are bound to each other and construct each other in a dynamic interaction (Lykke 2002; Grenshaw 1994).

The concept of intersectionality was originally formulated, in order to make the relation between gender and ethnicity visible, as a critique of feminism and its “white” hegemony. Feminism was seen by researchers, especially of Afro-American origin in the US, as an idea for white middle-class women,
excluding subordinated women of colour (Grenshaw 1994; Hill Collins 1990; Hooks 1983).

Gender is defined as variability between men and women that is attributable to society and culture (Hamberg 2008) and is seen to have strategic importance as a power differential in the concept of intersectionality (Lykke 2002). Gender includes a wide dimension of power. Women, as a group, are generally subordinated to men and have less political and economic power and opportunities for education (Doyal 1998). Socio-cultural norms regarding men and women and the way to act as men and women, construct, what is seen as masculinities and femininities (Connell 1995) “Doing” masculinities and femininities is an ongoing process in which we all take part (West & Zimmerman 1987) and is formed by intersections between, for example, ethnicity, social class and sexuality (Courtenay 2000).

Research on health and health care of men and women is influenced by gender and ethnicity and their intersections in different ways (Affifi 2007; Kuehner 2003; Patel 2001).

In medicine clinical trials have for a long time had mainly white, middle-aged men as participants, although the results have been generalized as whole populations (Finkler 2004). After many years of critique, it is now more common to include women in research studies and the number of studies about gender and gender-based differences in health have increased (Hammarström 2004). These studies have often focused on hormones and genes or psychological factors but very seldom on global perspectives (cultural, social, political processes) and integrating models of health (Affifi 2007).

To my knowledge, health problems, such as depression, cannot be explained merely by biological, psychological or social factors because they always intersect with each other (Khuener 2003). In this dissertation, however, my focus is on social context, culture and gender and their intersections in constructing the concept of depression, because these entities are obviously present in practice but knowledge about them is deficient.

The theoretical approach in my dissertation is based on a conceptual understanding that scientific knowledge is always “situated” (Haraway 1991). Situated knowledge implies that knowledge must always be interpreted in relation to the society and the context in which it is created (Forssén et al 2009).

Severe life circumstances, such as economic hardship and violence, can lead to depression and can often even be related to unequal power, for example between different ethnic groups or between men and women (Doyal 1998). Social control over “dangerous fertility” of Romany women by sterilization in several European countries (Meekosha 2006) is an example of how gender and ethnicity intersect and can lead to poor mental health.

The social practices of demonstrating masculinities and femininities are associated with different health behaviours and health risks (Mahalik et al 2007; Courtenay 2000). Hegemonic masculinity, the dominant masculine ideas is the
idealised form of masculinity at a given place and time (Connell 1995). Hegemonic masculinity subordinates femininities as well as other masculinities, for example masculinities demonstrated by men from lower status groups, who lack access to cultural or economic resources. This subordination can lead to the use of more physical violence and other kinds of health risks than among majority men (Courtenay 2000).

Most research studies have showed that women suffer twice as much as men from depression (WHO 2001). Different health behaviours based on typically masculine and feminine ideals have been considered as contributing to the gender differences in prevalence rates (Courtenay 2000). According to traditional, stereotypical western norms of masculinities men are independent, strong and do not show weakness whereas emotionality is a typical characteristic for femininities (Connell 1995; Courtenay 2000).

Denial of depressive symptoms is one way to demonstrate hegemonic masculinity and instead of seeking help men can, for example, misuse alcohol in order to alleviate their depressive symptoms by themselves (Noelen-Hoeksema 2004). With the exception of China, men are overrepresented in suicide rates (WHO 2008). In China, especially young women, with many expectations related to norms for culture and gender roles, reproduction and family relations, commit suicide more than men (Parker et al 2001).

The concept of culture and ethnicity
Ethnicity and culture are two complex concepts which are sometimes used as synonyms without a specific definition. However, they are different concepts. In this dissertation I attempt to understand the concept of culture as it is defined by Helman (2007) namely as a cultural “lens” that the members of a particular society share, that tell them how to view and experience the world, how to behave in it, in relation to other people, to their God and to the environment, culture is at the same time a fluid concept. Members of society may share many common values but individual norms and beliefs can vary, for example, with regard to gender, level of education and social class (Helman 2007).

Today, many people are moving from one place to another and traditional boundaries of cultures are changing in a dynamic process (Bhugra 2004). In this shifting context culture involves, besides individual knowledge, also rules, practices and systems of power maintained by the social context (Wachtler 2006).

The concept of ethnicity is defined in this dissertation in line with that of the United Nations (1999) with the understanding that ethnicity includes not only particular cultural attitudes and behaviours, but also the same biological origin and relationships of history, of place of origin and of language (UNECE 1998). However, ethnicity is also an on-going process of our relations taking place in co-operation with each other and is constructed by local and global factors (Helman 2007). Today questions about ethnicity often deal with relations between
groups, especially between majority and minority groups (Eriksen 1999). It is, however, important to bear in mind that when talking about ethnicities, it is not only about different minority groups, because majority groups are as “ethnic” as minority groups (Eriksen 1999). Some researchers see ethnicity as an embellished periphrasis of the concept of race, which maintains fixed conceptions about people and social differences (de los Reyes & Mulinari 2005).

In this dissertation I have chosen to understand the concept of ethnicity according to the definition by Eriksen (1999) and not to use the concept of race, because in the Swedish language and in medicine the word race has often a fixed, biological meaning (Rodell Olgac 2006).

The dominating cultural or ethnic group has both the political and social power, which makes it possible for the majority to define which cultural aspects are of value (Berg 2007). According to Edward Said (1993) the colonial and historical domination by the West has created a hegemony in which western cultures and ethnic origin are regarded as superior to other cultures and has constituted a concept of “us” as Europeans in relation to “them” as non-Europeans. Said describes in his famous work on orientalism how domination by the West has constructed a portrayal of the Orient as exotic, inferior and repressed (Said 1993) and subject to a range of social processes and stereotyping, which can, for example, erode the health care of immigrants from, Southern Asia (Virtuell-Fuentas 2007, Burr 2002). Belonging to another culture can also be seen as the basic cause of mental health problems and includes a risk of culturalization, using “the other” culture and ethnicity as a one-sided explanation of ill health instead of seeing underlying social problems and inequality, and leads to a misdirected diagnosis (Nazroo 1999).

The ethnic group known as the Romanies, or Gypsies, is an example of a minority group which is among Europe’s most marginalised populations (Gahn & Guild 2008; Loewenberg 2006). This is also the case in Sweden, despite legal protection due to their national minority status (Proposition; Nationella minoriteter 1998). The discrimination of the Romanies has occurred in several ways. The Romanies were prohibited from immigrating to Sweden from 1914 to 1954 (Takman 1976). The Institute of Racial Biology was established 1921 and compulsory sterilizations of Romany women took place between 1935-1975 (Montesino Parra 2002).

Even today there is a stereotype portrayal of the Romany population and many Romanies continue to be a target for discrimination and social inequity (Rodell Olgac 2006). Marginalization may underpin health status, help-seeking behaviour and access to resources, and there is very little research about the health of the Romanies (Carcia-Campayo & Alda 2007; Van Cleemput et al 2007).

The domination of the West can also be seen in the field of medical scientific knowledge. The biomedical model, based upon the discovery of specific aetiologies and disease-causing mechanisms developed in Europe in the 19th century,
has been spread to cover much of the world (Jones 2004). Biomedicine and scientific medicine have been seen as universally valid and the cross-cultural spread of biomedicine has been seen as a mark of modernity (van der Geest & Finkler 2004). Medical researchers from high-income countries benefit from better funding and dominate journals and citations (Horton 2003), which have impact on, for example, treatment decisions and the production of knowledge (Helman 2007, Kirmayer 2006). In practice, however, there is a need to differentiate between cultural productions and several studies show local interpretations of diagnosis and treatment even in the West (Finkler 2004).

**The concept of depression**

The concept of depression has many facets and involves historical, socio-cultural, biomedical contexts as well as gender norms. The purpose of this dissertation is not to make an analysis of all these aspects of the concept of depression. My ambition is to analyse the meaning of the gendered socio-cultural context to the concept of depression. My focus of interest is to view how depressive symptoms are expressed and interpreted in different cultures and how they become a disease entity. Furthermore, I should like, in particular, to illustrate a variety of difficulties that GPs may face when meeting and treating patients from different countries who show symptoms which may indicate depression.

*Depression – mood variations within normality, disease and illness*

Depressive disorders have become a common and rapidly growing cause of illness all over the world (WHO 2001). Some authors have called the twenty-first century the “age of depression” (Horwitz & Wakefield 2007). Women are usually reported to have high rates of depressive disorders, about twice the rates for men (Ustun 2000; Marcus et al 2005). The reasons for this gender variation have no uniform explanation in medical research (Piccinelli & Wilkinson 2000).

The term depression is complex and has multifarious meanings. In a former analysis, still used by some clinicians, the concept of depression has three denotations; as a symptom, as a syndrome and as a disease (Pilgrim 2007).

Depression as a symptom implies being low-spirited, being sad or unhappy, the mood is low and it could be temporal or for a short period. The term could be equivalent to “feeling down” which is often used in discussions, texts and articles but it does not imply depression as a disease. It describes an emotion and could mean something within “normal” variations for an individual but can also be fairly strong and hampering (Kleinman 1985).

Depression can also be part of a “depressive syndrome”. In that sense it often occurs together with other mental symptoms such as, anxiety, worries and sleeping disorders. This syndrome can be part of psychiatric illnesses such as psychotic disorders, borderline states, drug-related diseases, in which the symptom depression intersects with other emotional feelings.
Depression – a disease

Depression as a disease, is based on the classification system of ICD-10 (1993) or DSM-IV (2000, 2002). The criteria include affective, cognitive and vegetative, more or less severe, symptoms for at least two weeks previous to diagnosis. There are also several screening and structural interview instruments in order to make diagnosing easier (SBU 2004).

However, development of the criteria of depression as a disease is criticized by several researchers. They argue that the development of the diagnostic process has contributed to the description of depression as a women’s disease, a diagnosis based on Euro-American psychiatric knowledge as well as that the criteria of depression have transformed normal sadness into a depressive disorder.

Laura Hirshbein (2006) has written a historical review about how depression emerged from a mass of different symptoms among hospitalized patients in America as a specific disease category between DSM-1 (1952) and DSM-111 (1980). The diagnosis of depression with concrete criteria in response to new anti-depressant medication has been developed in a mainly female population. The fact that there were more women than men in trials was not commented on but was taken as evidence that depression was more prevalent in women than in men and has led to further assumptions that depression was a female disease.

Depression as a disease was earlier divided according to the origin of the depression into an endogenous and a reactive depression. The endogenous depression was viewed as a disease with psychopathological and etiological principles about genesis, treatment and symptoms. The reactive depression was viewed instead as a reaction to some kind of severe life events or trauma (Carney et al 1965).

Researchers Allan Horwitz and Jerome Wakefield (2007) argue in an overview of medical history that the change of diagnostic criteria into depression (DSM-III 1980) has contributed to transforming normal sorrow into a depressive disorder. These authors state that for thousands of years it has been understood that symptoms must be interpreted in the actual context that patients are living in. It is natural for people to become sad after a great variety of losses and trauma and many people who develop symptoms after a loss, even when they meet DSM criteria for depression, are not disordered (Horowitz & Wakefield 2007). The new, decontextualized diagnosis criteria (1980) based only on symptoms, without an earlier distinction between disordered sadness without cause and normal sadness with cause, can be seen, according to Horwitz and Wakefield, as responsible for a huge transformation of sadness as a normal human emotion to clinical depression.

The criteria of depression is also criticized as being a “culture-bound” classificatory system dominated by Euro-American psychiatric knowledge and evidence standards excluding local knowledge and alternative frames of systems and meaning. (Helman 2007; Kirmayer 2006; Kleinman 1985).
Much of the research has been controlled by pharmaceutical companies, which has been criticised as suppressing negative findings (Kirsch et al 2008). When the unpublished trial data were included in the meta-analysis of antidepressant medications in the US, the benefits fell below the accepted criteria for clinical significance for patients at moderate levels of initial depression (Kirch et al 2008).

**Depression – an illness**

In a patient–doctor encounter illness represents the patients’ perspectives regarding the concept of a disorder and includes what patients relate about their symptoms and the meaning given to them (Kleinman 1988). The concept of illness, besides individual factors, is influenced by the socio-cultural context and gender in an ongoing process (Okello & Ekblad 2006; Danielsson & Johansson 2005; Karasz 2004).

The historical context and the gendered, religious and cultural orientation of the particular society has an impact on how illness complaints are expressed, whether expressions of a depressed mood are regarded as an illness or as a normal state and on how stigmatizing the illness can be, or if an individual seeks help or not (Johannisson 2009; Helman 2007).

Somatic symptoms, such as pain, are stated as the most common clinical expressions of emotional distress worldwide (Bhugra 2004; Kirmayer & Young 1998). Somatisation, i.e. that a depressed mood is mainly expressed in the form of physical symptoms, can even be seen to be a concept that reflects the individual, body-mind dualism of western biomedical practice (Kirmayer & Young 1998). In other traditions of medicine, such as Chinese or Ayurvedic traditional medicine, there is no sharp distinction between the “mental” and the “physical” and people understand the concept of distress by interconnecting somatic and emotional symptoms with a social context (Helman 2007).

For example, neurasthenia in China includes a subtext of unexpressed emotions, linking distress to social environment and imbalance of yin (dark, moist, watery and female) and yang (hot, dry, fiery and male) and specific organs in the body. Neurasthenia is understood both by patients and doctors from the same cultural background (Lin 1983).

Explanations of health and illness can often be crucial for a patient’s understanding of their illness and for a successful patient–doctor communication (Kleinman 1985). The scientific explanations of depression and patients’ understanding of depression can differ from each other and are formed by historical, cultural or gender context (Johannisson 2009; Johansson et al 2009; Helman 2007).

In the past a depressed mood was, even in western countries, in accordance with other traditions of medicine, included in different syndromes, such as neurasthenia or hysteria. Womens’ depression was explained as a pathology of sexual organs and sexuality (Busfield 1996). The aetiology of mens’ neurasthenia was dependent on social class. Abuse and extravagant sexuality were thought to
cause neurasthenia among working class men, whereas overwork was related to neurasthenia for middle-class men (Johannisson 2001).

Today, in medical research depression is said to have a bio-psycho-social origin (Piccinelli & Wilkinson 2000), although studies combining these differentials are rare (Johansson et al 2009; Kirmayer 2006) and the causes of depression are not taken into account when diagnosing depression (Horwitz & Wakefield 2007).

Depression – a sickness
Depression is one of the world’s most common disorders (WHO 2001) and is estimated to be an increasing ill-health issue (Murray & Lopez 1997) and immigrants have been seen to have more mental health problems, for example depression, than Swedish born individuals (Socialstyrelsen 2009).

Despite individual suffering and the increased risks of other somatic diseases the disease of depression causes deficit working capacity and, in high income countries, increasing costs for treatment whereas in low income countries there are very few possibilities of getting treatment for serious cases of depression (WHO 2008).

It is difficult to estimate how many people living in Sweden do actually suffer from depression. However, the diagnosis of depression was a leading cause of sick leave in Sweden 2008 according to the statistics from Försäkringskassan (69.5 % females and 30.5 % males). Under the same period 737,705 persons got a prescription for antidepressive medicines (Statistics; Apoteket, 2008).

In recent times a professional, discussion by Nordic GPs has been started about the need for reflexion on medical practice and on the limits between normal suffering and the diagnosis of depression as well as risks for medicalization of a depressed mood (Hovelius & Andersson 2009). At the same time there is a medial debate about two books that have attracted much attention, emphasizing how the concept of depression has been formed by the historical, gendered and socio-cultural context (Johannisson 2009) and the history of the treatment of depression in between “pills and talk” and the role of the medical companies (Carlberg 2008).

GPs’ dilemmas in caring for the depressed patient
Primary care differs from specialist psychiatric care (Mattsson et al 2002). Problems in the primary care setting are often presented on the crossroads between somatic, psychological and social symptom presentations and it is often difficult to apply genuine psychiatric diagnostic systems in primary care, especially that of depression without contextual factors (Kendrick et al 2009; Cole et al 2008; Gask et al 2008; Chew-Graham et al 2002). There are further difficulties when meeting patients from different countries (Helman 2007; Kirmayer 2006).
Non-verbal or verbal expressions of suffering, which can be shaped by culture and gender can be difficult to interpret and language difficulties can be negatively related to the quality of doctor-patient communication (Schmid Mast 2007; Ferguson & Candib 2002).

In a study from Switzerland, Schmid Mast et al (2007) found that patient satisfaction was related to female gender stereotypical nonverbal behaviour (e.g. more looking at the patient, softer voice, less interpersonal distance) for female physicians and patient satisfaction was especially high if male physicians showed male gender stereotypical behaviour (e.g. more interpersonal distance, louder voice, more expansiveness).

Consultation research has shown that there is an asymmetry in power in the patient-physician relationship (Pendleton et al 1984). Power can be recognized, for example, as a question of medical expertise, as social status but also as a question of gender. Women physicians have expert and social status power but female gender can imply a status conflict by challenging existing power relations between men and women (Johansson 1998). Immigrant status can combine the already present power differential and contribute to poorer care (Wachtler 2006). At the same time patients acceptance of power differences can differ due to cultural or religious norms, for example (Meeuwesen et al 2006).

Patient-centredness is crucial in western medicine (Pendleton et al 1984) but there are cultural differences in the patients‘ need for participation, although all patients will be heard and understood (Schouten et al 2007). In a Swedish study, GPs interviewed by Wachtler reported that they used the same, patient-centred method with immigrant patients as that with native-born Swedes but focused on similarities between themselves and the patients but avoided cultural differences, which could lead to poorer communication and health care (Wachtler 2006).
The aim of the thesis

The general aim
The purpose of this thesis was to analyse how socio-cultural factors- with focus on gender and ethnicity and their intersections- could influence the concept of depression from the perspectives of the patient and patient descriptions, of medical experts as well as general practitioners. By viewing these different perspectives I have tried to illustrate how depressive symptoms are expressed and interpreted in different gendered socio-cultural contexts and how they become a disease entity. Furthermore, I want, in particular, to illustrate a variety of difficulties that GPs may face during the process of care when meeting and treating men and women from different countries showing symptoms which may indicate depression.

The specific aims were:
Study I – to explore the reasons for and patterns of attendance among gypsy women in primary health care and to shed light on health problems of gypsies.

Study II – to highlight the gendered representations of lay persons’ experiences of depression by drawing on personal stories of depression that appeared in Swedish newspapers.

Study III – to explore how authors of medical articles wrote about different symptoms and expressions of depression in men and women from various ethnic groups as well as to analyse the meaning of gender and ethnicity for expressions of depression.

Study IV – to make a qualitative analysis of medical research articles in order to get a broader view on explanations of depression in men and women in various ethnic groups.

Study V – to explore and analyse how GPs think and deliberate when seeing and treating patients from foreign countries and who display potential depressive features.
Methods

Participants, material and procedures

Study I

Four Romany women, my own patients, who attended Mariehem Health Centre in Umeå most frequently during a two-year period were invited to an in-depth interview. All the women agreed to participate but did not always attend when planned.

The women were 31, 32, 33 and 40 years old, had been or were born in Finland and all came from different core families. They had lived in Sweden for 5-20 years and had moved several times. They had attended the health centre 3-13 times during a two year period before the interviews were conducted.

The process of making appointments for interviews lasted for almost a period of one year, because of local events in the Romany group, which prevented some of the women from going out.

The aim of the interviews was to let the participant explain her situation in her own words. Open questions concerning the women’s life situation, health, illness, thoughts about causes of illness and attendance at the health centre were asked (Malterud 1990). Interviews took place at the health centre and were conducted in Finnish by AL, and lasted for about 1-2.5 hours. Interviews were audiotaped and transcribed verbatim.

Study II

The study included articles about depressive illness retrieved from three Swedish newspapers with a high daily circulation: Aftonbladet (circulation 452300), Göteborgsposten (248800) and Svenska dagbladet (180 800). A database search of the Swedish full-text newspaper database Mediearkivet was performed for the period 1st January to 31st December 2002 with the descriptor “Depr*”. The search resulted in a total of 1.151 articles. All of these articles were read through and those in which an individual described his or her own experiences of depression, or where the author named or referred to a particular person’s experiences were chosen for this study. A total of 26 articles met these criteria. The material included 14 personal stories, four celebrity stories, eight letters to the editor. Three of the articles contained two different accounts. As a result the study included 29 different individuals’ stories of depression. Twenty-one of these individuals were women, and eight were men. One of the letters to the editor included a mother’s experience of a daughter’s depression and another letter a son’s experience of a father’s depression.

Study III

The study material included 30 scientific studies and review articles which were identified in a search of the medical database PubMed. The following search
words were used in “all field” search: “depression”, “gender” AND “ethnicity”. The search was limited to the English language and to the time period 1994-2004. The search was performed in May 2005. In total 331 abstracts were identified, which were carefully examined. Out of these 331 abstracts, 30 articles with focus on symptoms of depression were included in this study. Studies focusing solely on depression rates, explanations, other psychiatric diagnosis or chronic illnesses, pharmaceutical treatments, or studies in which depression was only mentioned as a secondary illness were excluded.

Twenty-three of the articles were published by authors working in western countries (USA, UK, Canada, Germany, Switzerland and Denmark). Five of the articles were published in collaboration between authors in western countries and authors in other countries (India, Japan, Singapore) and two by authors wholly in other countries (Korea, Argentina). In the included articles depression was diagnosed according to DSM-III, DSM-IV or ICD-10.

Study IV
The articles in this study were identified in a PubMed search in the same way as in study III. Out of the original 331 abstracts, 60 abstracts with focus on reasons for depression in men and/or women in various ethnic groups were chosen for this study. Exclusion criteria were articles with focus only on depression rates, symptoms, other psychiatric diagnosis or chronic illnesses, pharmaceutical treatments or studies in which depression was only mentioned as a secondary illness were excluded.

Nine of the articles were published in countries, such as Brazil, Hong Kong, India, Iran, Israel and Pakistan. Four of the articles were published in collaboration with authors from western countries and authors in other countries (the Arab Emirates, Brazil, Chile, India, Zimbabwe) and all the other articles were published in western countries.

Seven of the articles focused both on symptoms and expressions and were also included in study III.

Study V
All GPs, including trainees, working at two Primary Health Centres with many immigrants living in the catchment area in Umeå were invited to focus-group interviews. Focus groups have been seen as a suitable way to receive information from many informants in interaction about a specific topic (Warr 2005).

Fourteen GPs were interviewed in two focus-group interviews. One of the GPs who could not participate for practical reasons was later individually interviewed. Furthermore, one of the GPs who attended a group interview and expressed special experiences of another culture, was also individually interviewed. Seven of the doctors were women and eight were men. Four doctors were born and grew up outside Sweden.
Both the individual and group interviews lasted 1-1.5 hours and were audiotaped. BM acted as moderator and AL was observer. The individual interviews were conducted by AL. The opening question of all interviews was: please tell us about your thoughts and reflections when seeing a patient from a foreign culture and who presents possible depressive symptoms?

**Analysis**

Qualitative research methods can serve as a bridge between theoretical and practical knowledge and are suitable ways to study individual experiences as well as health and disease of human beings in their socio-cultural environment. A qualitative approach can contribute to a broader understanding of medical science (Malterud 2001).

Two different qualitative methods, Grounded Theory and Qualitative Content Analysis, are used in this thesis. Grounded theory was initially developed by two sociologists Glaser and Strauss (1967) and was modified later (Strauss & Corbin 1990). One of the basic ideas is that analysis of the transcript interviews is conducted parallel to the interview process and can give ideas for refinement of further interview questions (paper I).

Qualitative Content Analysis gives an opportunity to make an analysis of different kinds of data material, such as interviews written texts or observations. The research material can be analysed on different levels, both close to the text but also on an analytic level (Graneheim & Lundman 2004) (papers II, III, IV, V).

The medical community often regards qualitative methods as subjective. Reflexivity, sharing preconceptions and accounting for and evaluating the effects of the positioned researcher at every stage of the research process, are important tools to maintain this “qualitative objectivity” (Kokanovic et al 2009; Malterud 2001).

**Study I**

The data analysis of the study was based on Grounded Theory (GT).

In this study each interview was analysed preliminarily at once, which led to a greater focus on the everyday life of the women rather than on their health, because it was more and more obvious after each interview that the social context of the women’s life was important for their health.

All interviews were afterwards read several times and scrutinized with open coding line by line. Then, these codes were compared and discussed together with a co-author (BM) and different codes were linked together to categories. The categories were examined and concepts summarizing the material were searched for and data were re-read by using selective coding e.g concerning relationships. Data analysis, and observations were discussed together to validate the interview data.
**Studies II, III, IV, V**

The material from Swedish newspapers, medical research reports and interviews with GPs were analysed by Qualitative Content Analysis.

All text was first read through several times to get an overview of the content and obtain a sense of the whole. The whole text (papers II and IV) respectively the whole section of the results and the discussion (papers III and IV) were then explored for meaning units consisting of words, sentences and paragraphs that contained aspects related to each other through their content and context. The meaning units were coded and thereafter the codes were summarized and sorted into subcategories and abstracted into main categories.

To improve the credibility of the study, a second investigator (EJ) study II, (AH) studies III, IV and (BM) study V also coded, discussed and compared the codes and the subcategories as well as the categories with the main author. Only minor discrepancies were found between the researchers. After coding, all the codes, subcategories and categories were discussed and revised by all the authors of the articles.

The underlying meaning throughout the meaning units, codes and subcategories was interpreted during the process and was formulated into four (in study II) and three (V) themes, threads of meaning throughout the subcategories.

The analysis of study III and IV resulted in three (III) and six (VI) main categories in a process of more text near analysis.
**Results**

**Study I**
The analysis of interviews and observations in clinical practice resulted in three categories, “daily life of the Romany women”, “women’s health” and “attending the health centre” and were all formed by the collective, gendered pattern of life.

The daily life of women was characterized by a marked hierarchical order and rules. Young women had most rules to follow and if the rules were broken it was easy to end up outside the collective and display symptoms.

“Women’s health” was characterized by a collective attitude to health and illness. The women seldom attended the health centre alone but paid a visit together with relatives or friends and presented often similar symptoms, such as pain, headaches and depression. They were often given the same diagnosis and treatment.

The women attended when they were upset by something that had happened in the Romany collective, for example contraventions of collective rules or after troublesome contacts with authorities, which often caused tension, pain and depression resulting in the immediate visit.

The hierarchical order and rules with gender and age as decisive themes together with collective punishment were powerful factors to promote ill health, pain and depression.

**Study II**
The analysis of personal accounts of illness in three Swedish newspapers focusing on the gendered representation of lay persons’ experiences of depression resulted in four themes; “a successful façade”, “a cracking façade”, “losing and regaining control” and “explaining the illness”.

Both the men and women were described as high performers in relation to both work and education and had close relationships with their relatives; a “successful façade”.

Women described an “insidious onset” of depression which led to “inner darkness” or “feeling lost” that revealed cracks in the façade. Women conveyed how their bodies mirrored their feelings. Experiences of shame and guilt related to fear of others’ attitudes toward mental illness, fear of societal harassment and women could feel that they were bad mothers.

Multiple explanations (work overload, stress, cracking relations, reproduction, specific hormones, other physical illnesses, specific personality) were presented as explanations of women’s depression. However, women regained control of their lives by actively seeking medical and psychological help on their own, trying to change their lives and talk about their condition with others, which challenged the stereotypical norms of women as passive.
The men were portrayed as paying less attention to their feelings. Most of the portrayed men had experienced a sudden, unexpected onset of depression. The movement-related metaphors were related to falling, “one’s existence sinking down”, and to bodies that refused to function and the only reason for depression seemed to be work and stress-related factors. The men could, however, feel confused, vulnerable and insecure and were described as being passive and relying on friends or relatives for help, which challenged the culturally dominant constructions of masculinities about men as active and independent.

The traditional gendered stereotypes about femininities and masculinities seemed to form men’s and women’s’ expressions and explanations of depression in the Swedish context. But in managing depression neither men nor women seemed to follow stereotypical gendered norms.

**Study III**

The analysis of medical research publications concerning the expressions of depression in men and women from various ethnic groups resulted in three categories; “illness complaints”, “the meaning of illness” and “depression diagnosis” and illustrate how gender and socio-cultural context formed symptoms of a depressed mood, the diagnosis of depression and help-seeking.

The term depression did not exist in several non-European languages but there were cultural expressions, for example “thinking too much” and “nerves” which were seen both as local illness categories and as cultural explanations for depression.

Depression was quite often communicated by bodily symptoms worldwide but the area of the body that was emphasized could differ by culture. In western countries there were gender differences in expressions of depressive emotions. Emotional symptoms and crying were seen to be more frequent among women than men, but men “needed more alcohol”, which could be seen to follow the traditional western norms of femininities and masculinities.

Expressions of emotional distress were also formed by cultural context. For example, verbal expressions were not sanctioned in some Asian cultures.

The attitudes and norms about normality and abnormality could also be seen to differ by culture. The cultural norms and ideas about illness of families in different societies had an impact if a depressed mood was seen as a normal reaction to severe problems or a medical disease and the cause for seeking professional help. In collective cultures, such as in some countries in Asia and Africa, mental illness was viewed as a collective loss of face for the family and a cause of family shame and depressed persons would seek help first when the family decided if help-seeking was needed.

The health-care professionals’ own cultural norms and stereotypes could also be seen to influence the process of diagnosing, which could be biased when meeting patients with other cultural norms than one’s own.
RESULTS

In summary, articles often used issues and the diagnosis criteria of depression based on a universal, western point of view, which could lead to "cultural and gender gaps" which in turn influence the diagnosis of depression.

**Study IV**
The analysis of explanations of expression in medical texts focusing on ethnicity and gender resulted in six categories, “hidden depression”, “changing conditions”, “lacking resources”, “cracking relations” and “intersecting norms” which included socio-cultural explanations of depression and the view of one’s own normality in relation to non-western others.

Explanations of depression differed by cultural context. Depression as a term does not exist everywhere. For example, neurasthenia in several Asian countries included symptoms of a depressed mood, which were related to the physical body and the social environment and could with western criteria be diagnosed as depression.

The political changes, for example after the collapse of communism in Latvia, the westernization of psychiatric knowledge rapidly changed the diagnostic category of neurasthenia to a new diagnosis category of depression. This change occurred with the help of information campaigns by pharmaceutical companies. The change shifted the causes of depression from society to an individual and was a starting point for treatment with medication.

Poverty, low education and unemployment were presented as causes for depression especially among women from minority groups. Negative social relations were described in non-western countries, such as conflicts with partners, arranged marriages, deaths due to infections and premature deaths as well as difficulties post-partum, and were presented as explanations of depression. Women were more exposed than men. In some cultures the pressure upon women to bear sons could lead to marital disharmony, violence and depression if the newborn baby was a girl.

There were no gender differences in depression in the religious group of Orthodox Jews in the US and the UK. The absence of gender difference was explained by higher tolerance and rates of depression and lower rates of in the use of alcohol among male Jews. Male Jews had a lower use of alcohol than other religious groups, especially Protestant males, or persons with no religious affiliation. The norms of gender, culture and religion can be seen to explain what men do and the absent gender differences in the groups of Orthodox Jews.

**Study V**
Three themes were identified in the analysis of interviews with GPs “realizing the background”, “struggling for clarity” and “optimizing management” which described several difficulties in communication, diagnosing and management of depression also tools for adequate action and management were lacking.
The GPs graded the patients as clearly unhappy or sad, which was regarded as a normal response to their previous history, gendered life stressors and the exile status of the patients.

Patients’ earlier history remained, however, mainly unknown to the GPs and many possible decisive factors were not touched upon. The GPs felt that they were uninformed about foreign cultural and religious norms and much of the knowledge came from media and occasional narratives implying a risk for stereotypes and generalizations.

The patient-doctor encounter comprised misconceptions. Misunderstandings in verbal and non-verbal communications were frequently reported by the GPs. Patients from countries other than Sweden could be unfamiliar with a patient-centred working style and the GPs’ questions about the patients’ own thoughts could be regarded as unskilled doctoring. Meeting a male patient from a traditional, hierarchic society who did not want to shake hands with a female doctor could challenge the status power of the female doctor and could lead to irritation and a change in his/her style of working.

The diagnostic process of depression was difficult and the screening instruments were not regarded as suitable. The GPs based the management of potential depressive states on their clinical experience, a sense of intuition. The disease entity of depression was questioned and GPs discussed the risks of medicalization of human stress. Political actions and support groups in areas with many immigrants were many times seen to be more effective in relieving human problems.
Discussion

This thesis includes studies concerning the contextual concept of depression. I started with an interview study among Finnish speaking Romany women who attended the Health Centre for reasons different from the majority of patients. It was obvious that the health problems of the women were closely related to gender, age and the collective culture.

Later, I took part in a research project about depression. A study on exploration and analysis of personal stories of depression in Swedish newspapers focusing on gender shed light on gendered patterns of individuals’ depressed symptoms and explanations in a Swedish context.

The analysis of expressions and explanations of depression in medical research publications highlighted how the gendered and cultural context could influence what is seen as a medical disorder, help-seeking for, and the diagnosis of depression, as well as medical knowledge about depression.

Further, focus-group and individual interviews among GPs showed that the gendered socio-cultural context influenced the doctor–patient encounter and the GPs’ recognition of depression as well as decisions about patient care.

A number of contextual factors forming the concept of depression were brought forward. Many of the contextual factors are already known but I want to develop a more holistic, intersecting, gendered and cultural analysis, which is especially important in Primary Care.

Taken together, the studies brought to light that the concept of depression was always context-bound.

The intersections of culture and gender shaped how symptoms of a depressive mood and their causes were expressed and experienced. They formed the standards for classifying normality and abnormality, how and when persons sought help. On the other hand, the GPs’ recognition and managing of depressed symptoms when meeting and treating immigrants were formed by the GPs’ own contextual views but the universal, scientific diagnostic tools and guidelines were confusing.

An intersectional perspective on the concept of depression can serve as a basis for increasing awareness of possible gendered and cultural stereotypes and for decreasing misdiagnosis and treatment of depression as well as being a basis for further research.

On methods

Study I

The selection of participants and analysis of the paper was inspired by Grounded Theory, at the time of the study a method used and discussed among collaborators. By using the term “inspired by” I refer to the fact that a strict and original use of the method was not applied. Thus, according to the original methodolo-
DISCUSSION

gical rule each interview should be individually analysed immediately after the discussion and every new interview would be inspired by the preceding one. And finally saturation is reached. We made the analysis of the interviews when all the interviews were carried through and after a few interviews we reached a “pragmatic saturation” (Hamberg 1998).

The analysis is based on just a few interviews but the women represented four different core families and the patterns of their life were reflected in the women’s narratives. The Romany women lived with a collective pattern of life in a collective group, which means that the concept of a family of the women included even a wide range of relatives. Discussions with relatives and friends who almost always accompanied the women offered even more information, which I wrote down as memos (Wuest et al 2002).

A severe and tragic event among the group of the Romany made it impossible for me to continue with the interviews. However, discussions with colleagues in seminaries and actual literature about the lives of the Romany have confirmed many of the interview observations (García-Campayo & Alda 2007).

I am a female doctor myself, and from another ethnic group and the Romany women were my own patients. This fact could have had impact on the analysis (Kokanovic et al 2009); the role as a researcher and as a doctor could be mixed up. However, I was quite aware of this fusion and tried to separate my roles. The process was also dependent on trustfulness and mutual understanding of the Finnish language, and it would have been difficult for other interviewers to carry through.

The process of making appointments for the interviews lasted for many months. I perceived that as a sign that the women did not want to participate but at the same time, they did not want to say no to their own doctor. Consequently I stopped planning for new appointments. However, the women themselves afterwards asked for participation in an interview.

The national ethical regulation at that time did not constrain the researcher to have informed consent in interview studies. However the study was performed according to general ethical procedures such as voluntarism, and the possibility to discontinue the participation at any time.

Study II

The analysis of this study, using qualitative content analysis, is based on articles about depressive illness retrieved from three major Swedish newspapers. The focus of the analysis is on the gendered representations of Swedish lay-persons’ experiences of depression.

The media portraits of illness may display the dominating beliefs of illness e.g. common knowledge among people (Gattuso et al 2005). The media has also an important influence on gendered, health-rated beliefs and behaviours and contributes to construction of norms of masculinities and femininities (Courtenay 2000) as well as to more holistic understandings of illness (Seale 2003).
DISCUSSION

In contrast to media articles, traditional interviews of individuals may have given a broader view about a person’s beliefs about depression. However, we used media portraits in order to display common gendered beliefs of depression among people in Sweden. Many of the patterns identified in the analysis correspond as well with the findings in other studies based on traditional interviews (Danielsson et al 2009; Emslie et al 2006).

The personal stories were mediated through a journalist but the voices of the individuals could be heard through quotations or their own writings and were rich and colourful. However, the journalists own views and understandings may have shaped the portraits (Warr 2005).

The analysis gave primarily voice to experiences of white, middle-class, successful persons and celebrities and may be class-biased. At the same time, celebrities and middle-class individuals may often have a great influence on common beliefs and behaviours.

The analysis is carried through on the material from the year 2002 and may have lost in actuality but the results of later studies in Sweden with focus on gender have similar findings (Danielsson & Johansson 2005; Danielsson et al 2009).

Study III + IV

The purpose of these studies was to analyse how authors of medical studies wrote about expressions and explanations of depression with focus on gender and ethnicity and started by examining all PubMed publications to be found during the time period 1994-2004. The search was based on the search words “depression”, “gender” and “ethnicity”.

The results might have been different if other databases had been used but the focus of this study was the area of Medicine. The results of medical scientific studies have a great impact, for example, on the guidelines for medical care as well as on how professionals manage and should manage the process of care (Malterud 2006).

The results might also have been different with other search terms, for example with using “culture” in stead of “ethnicity”. However, when I started the term “ethnicity” was chosen with the belief that the meaning of ethnicity (persons, for example sharing the same origin and language) was easier to study and analyse. However, the term ethnicity and culture are complex and have been used inconsequentially in medical studies as well as in this thesis.

In order to obtain knowledge about a more global context we decided to include all published articles rather than using inclusion criteria related to research criteria of high income countries. Selection of only “high-quality” publications could exclude small-scale studies and local knowledge in low-income countries (Kirmayer 2006).

The selection of articles was based on analysis of abstracts. It is possible that selection based on analysis of complete articles would have resulted in more
articles being included. However, the key findings of an article should be presented in the abstracts and we have no reason to believe that the selection for this study is not representative for the purpose of this thesis. The main focus when analysing the articles was on results and discussion in order to grasp the original view of the authors.

The most remarkable discovery for me after the analysis was the relatively meagre results of the analysis despite rich material. I had started my studies with the truth that by studying scientific studies about depression in PubMed it was possible to learn a lot of different expressions of depression, which I knew existed. However, first afterwards I understood that most studies were based on western standardized instruments and did not include contextual concepts or deeper reflections on them.

Study V
An interview in focus groups is seen as a suitable way to receive information from many informants about a specific topic. It also offers an opportunity to raise perspectives in interaction with the participants that would not naturally occur (Warr 2005).

Data generated from the two focus groups of this study are also a mixture of personal and collective narratives that are formed by local norms and beliefs in the participants’ lives (Warr 2005) and are intended to be relevant in particular to the context under study and for the research question of this study (Haraway 1991).

The data of this study were mainly collected by two focus-group interviews among participants who were working in areas with many immigrants and represented a broad variation in gender and age. However, there were also some GPs who had newly begun to work in these areas, adding new and “modern” perspectives. In this way the material could be improved. The fact that four GPs (two in group one and two in group two) were born and brought up outside Sweden could make the information even richer. At the same time, their presence might influence the viewpoints of other GPs and make them more “politically” correct.

The fact that the interviews were carried out by colleagues to the informants made it more likely to increase their willingness to communicate and may have had impact on the richness of the material (Chew-Graham et al 2002). But the interviewer’s and the observer’s experience of primary care may have created a shared blindness and influenced the dialogue, interpretations and the results. The informants may also experience the interview as a test of their clinical experience, especially in a group interview, which could be a weakness of the study. The openness of the discussions and the voluntariness to participate can, however, guarantee sufficient credibility. The results were also discussed with some of the participating GPs at the end of the coding procedure. The individual interviews generated not totally new data but a reinforcement of
the data obtained.

**On findings**

In daily practice the gendered socio-cultural context was highly present when GPs met and treated men and women from different cultures with symptoms which could indicate depression (paper V). The GPs were struggling for clarity because of difficulties in “realizing the background”, in the patient-doctor encounter and in ”optimizing management”. The medical model for the diagnosis and treatment of depression did not tally with the everyday experience of the GPs.

The results of the study among GPs above have been collected and discussed with other studies in the thesis, in order to highlight, how gendered and cultural context and their intersections construct and/or influence the process as to how a depressive mood becomes a disease of depression in Primary Care.

The topics of decision process which are focused on in this thesis (beliefs and behaviours, previous history, expressions, communication and GPs’ decisions) are based on different themes in paper V.

The topics of decision process are viewed from patients’ (Romany women and media portrayals), medical experts’ as well as doctors’ perspectives, as shown in table 1.

Each topic begins with a compressed summary of results from different papers in this thesis.

**Beliefs and behaviours**

- help-seeking and the medical construct of depression

A depressed mood could among several cultural groups be seen as “a normal state” (papers III, V) or according to religious traditions, such as those of Hinduism as a “desirable, normal quality of life” and not an illness to seek help for (paper III).

A depressed mood could be “written off as madness” or “collective loss of face for the family and family shame”, which could lead to social isolation or sanctions (papers III, V).

The collective control of the family or society decided if and when an individual sought help or not and is the pattern of help-seeking (papers I, III).

In the Swedish and western context depressed men were seen to be more reluctant to seek help than women (papers II, III, V) but used more alcohol (papers III, V). Male Orthodox Jews in the US and the UK had less positive attitudes to alcohol and used less alcohol than Protestants and had equal rates of depression between men and women (paper IV).

“The Swedes accept the concept of depression much more today and you do not talk about pulling your socks up” (paper V).

Rapid political changes and westernization of psychiatric beliefs and practices, such as in Latvia after the collapse of communism, transformed the concept of neurasthenia from a general feature of human experience and social problems to a new individual, diagnostic category of depression. This was followed by educational campaigns by pharmaceutical companies (paper IV).
Table 1. Different topics of decision process viewed from patients´, medical experts´ and doctors´ perspectives.

<table>
<thead>
<tr>
<th>Topics of decisions process</th>
<th>Paper I Roma women</th>
<th>II Media portrayals</th>
<th>III Experts´ views (expressions)</th>
<th>IV Experts´ views (explanations)</th>
<th>V GPs´ views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs and behaviours</td>
<td>Collective help-seeking behaviour and attitudes to health.</td>
<td>Men more reluctant to seek help than women.</td>
<td>Depression seen as a normal state, madness or collective family shame. Men reluctant to seek help and used more alcohol.</td>
<td>Male Orthodox Jews had less positive attitudes towards alcohol than Protestants. Western psychiatric beliefs transformed neurasthenia into depression.</td>
<td>Men reluctant to seek help, positive attitudes to alcohol. Depression more accepted in Sweden today.</td>
</tr>
<tr>
<td>- help-seeking</td>
<td>Hierarchical gender order, traditional rules, collective punishment, life events.</td>
<td>Depression among men explained by overwork and stress. Depression among women explained by a variety of reasons (e.g. workload and brooding personality).</td>
<td>Non-western depression explained by economic hardship, changing conditions, culture conflicts, violence, chronic illness, body dissatisfaction, cultural concepts.</td>
<td>Non-western depression explained by trauma, severe life events, violence, changing gendered socio-cultural context.</td>
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<tr>
<td>- medical construct of depression</td>
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<tr>
<td>Previous history-</td>
<td>Hierarchical gender order, traditional rules, collective punishment, life events.</td>
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<tr>
<td>- an explanation of depression</td>
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<tr>
<td>Expressions of depression</td>
<td>Pain, depressed mood, collective similar symptoms.</td>
<td>Men had mostly physical symptoms, women expressed more emotions.</td>
<td>Bodily expression, culturally different areas, cultural concepts. Not to show emotions desirable behaviour in Japan. Depression as term non-existing in some cultural groups.</td>
<td>Often bodily expressions, culturally different. Diffuse symptoms among low educated. Depression as term non-existing in some cultural groups.</td>
<td></td>
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<tr>
<td>Communication</td>
<td>Collective patterns.</td>
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<td>GPs´ decisions</td>
<td>GPs own attitudes could lead to biased diagnosing.</td>
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<tr>
<td></td>
<td>Diagnostic criteria unsuitable, diagnosis with a sense of intuition. Risks for stereotypical. Diagnosing, depression a normal reaction to severe life circumstances.</td>
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</table>
The studies in this thesis show that beliefs about depressive symptoms as a medical problem or not, as well as help-seeking behaviour, vary with gendered socio-cultural context and from one time to another. The domination of western psychiatric beliefs has also importance for rates of depression in different contexts.

The common western individualised illness beliefs and behaviours differ from a more non-individualised, collective control of illness, such as described in studies I and III and can lead to other forms of stigma related to family shame and social isolation, which interferes with help-seeking.

In the western context according to traditional stereotypes of western hegemonic masculinity men are strong and there is a threshold for men for expressing emotions, and needing help is not a masculine trait (Connell 1995). To use alcohol may serve as a way for men to practice hegemonic masculinities and for self-care of a hidden depression instead of seeking professional help (Brownhill et al 2005; Connell 1995).

Equal rates of depression among Orthodox Jews who had more restrictive attitudes to alcohol consumption confirm the relationship between depression in men, the use of alcohol and rates of depression, as is shown even in studies among the group of Old Amish where alcohol was prohibited (Egeland & Hostetter 1983). It shows at the same time that there are alternative masculinities in relation to hegemonic masculinities formed, for example after ethnicity or religious norms, which influence men’s health behaviour (Courtenay 2000).

In practice when meeting and treating men from different cultures it is important to evaluate not only what men feel but also what they do. At the same time it is important to understand that the structural, gendered socio-cultural norms can differ and change among individuals and to avoid stereotypical pictures of masculinity and men’s health behaviour in order not to under or misdiagnose men.

Further, when planning strategies for prevention or management of men’s and women’s depression in different cultures it is necessary to reflect also on the meaning of a gendered socio-cultural context, which is a powerful determinant of help-seeking behaviour and of gender differences of depression (Mahalik et al 2007).

Changes in attitudes and acceptance of depression as a disease in Swedish society, verified by GPs and spread by media, have surely an impact on why help-seeking for depression has rapidly increased in recent years.

Attitudes about normality and illness have varied not only in a gendered socio-cultural context of individuals but even western psychiatric norms have changed. In the West the gender of melancholy has originally been seen as masculine, bordering on normality and illness, with a high status among men from higher social classes. After the turn of the century 2000 melancholy has successively, in co-operation with the dominating social practices, become a low-status, feminine disorder of depression (Johannisson 2009, Hirshbein 2006).
This may have contributed to the manifestation of stereotyped expectations of a feminine-gendered pattern of depression (Kilmartin 2005).

However, according to western psychiatric knowledge today, normality and disease are often seen in a pan-human sense, as universal and transcultural (Kirmayer 2006). The domination of western psychiatric knowledge, in turn, has been interpreted as a sign of modernization in economically developed countries (Finkler 2004). The rapid change of medical beliefs, such as diagnosing neurasthenia as depression in Latvia, can be seen as an example of how depression has been individualized and medicalized into a western modern disease of depression.

**Previous history – an explanation**

The hierarchical, unchallenged gender order, a traditional system of rules and collective punishment caused depressed symptoms and pain among young Romany women (paper I). In a Swedish media context, men’s depression was explained by overwork and stress, whereas women’s explanations included combinations of social, psychological and biological explanations (paper II).

Both in studies by experts and among GPs economic hardships, changing conditions, culture conflicts and severe life events, especially men’s violence against women in “other cultures”, arranged marriages, pressure upon the women to bear sons, were seen to cause a depressed mood among, poor immigrant women especially (papers IV, V). Changing gendered socio-cultural context (paper V), other chronic illnesses and body dissatisfaction (paper IV) were also seen to cause depressive symptoms.

The explanations for depression in all studies had a strong emphasis on socio-cultural causes and studies by experts and GPs with a main focus on poor women from other cultures.

There is considerable evidence in research today, that severe life events and economic hardships are associated with depression and are often more common among women (Patel & Kleinman 2003). However, the relationship between, for example poverty, gender and depression, is multidimensional. Poverty can lead to ill health but ill health can also lead to poverty (Östlin et al 2004). Notwithstanding, poverty is difficult to measure and compare, because it can have different meanings in different contexts (Östlin et al 2004).

For example, a study by Das et al 2007 in five low and middle-income countries from Latin America, Eastern Europe and Asia showed that changes of gendered life circumstances have a greater impact on mental health, not the levels of poverty per se. It may be impossible to isolate “pure” cultural behaviours and norms from social, economic and religious contexts and their different power dimensions which form the individual, and lived experiences (Helman 2007). Therefore it is important both in research and practice to have a contextual, multidimensional approach in order to avoid stereotypes about “other” women suffering from a pathology of their culture (Nazroo 1999).

The Romanies are often labelled as an ethnic group causing many social problems and stereotypical statements about the culture of the Romanies are to
be found. The Romanies are, however, an example of an ethnic group where subordination of women, young women being the most low-ranking, and collective, socio-cultural rules intersected, which could lead to being left outside and cause depressive symptoms and pain. Thus, it is not the culture of the Romany women but subordination of women in a collective culture context which leads to symptoms.

In the western context today the criteria and guidelines of depression are based only on symptoms lasting at least two weeks (DSM-V; ICD-10) and do not include contextual dimensions. To exclude the impact of all gendered socio-cultural explanations for a depressed mood, which are described by patients, experts and GPs in the thesis, as reasons for depression may lead to transforming severe life circumstances of a huge number of individuals into a medical disorder of depression in accordance with Horwitz and Wakefield (2007).

**Expressions**

The studies have described that in several non-European languages there is no term for depression but there are cultural concepts of depression, for example “thinking too much” or “nerves” (papers III, V).

Depressive symptoms were often experienced as bodily symptoms (papers I, III, V) but in culturally different areas of the body (paper III) or with culturally different expressions (papers III, V). Romany women had often “collective”, similar symptoms (papers I, V). Patients with a low level of education displayed often non-distinctive symptoms (paper V).

*The inhibition of positive effects seems to be socially desirable behaviour, for example in Japanese society* (paper III).

In the western context women seemed to express more emotional symptoms of depression and men more physical symptoms (papers II, III). Women in Sweden used metaphors like “feeling cut off”, “inner darkness”. Men expressed more physical symptoms, for example chest pain, but also metaphors like “powerless and bone-tired” (paper II).

In western medicine, feelings of sadness, lack of energy and social withdrawal are commonly labelled as depression through universalising criteria (DSM-IV, ICD-10). Our different studies showed, however, that the clinical presentation of expressions of illness is influenced in all societies by different socio-cultural and/or gendered norms or the level of patients’ education. Bodily expressions of depression, such as pain, are sometimes said to be more common among patients from traditional, non-western countries, for example in Asia because of restrictions in public pain behaviour, e.g. the open expression of emotions is not encouraged in China and Japan for example (Kim Li & Kim 1999).

But our results in accordance with other studies (Helman 2007; Patel 2002; Kirmayer & Young 1998) showed that bodily expressions were common everywhere but the choice of the target organ could differ not only individually but also with culture (socio-culturally embodied pain).

In the Swedish context, the analysis showed that expressions of depression in quite a homogeneous, middle-class group were also formed by norms of femi-
DISCUSSION

ninities and masculinities (Connell 1995). Swedish men expressed a depressed mood mainly with bodily symptoms, such as chest pain whereas women showed more emotions. However, in order to avoid common, stereotypical descriptions of femininities and masculinities it is important to note that even women may have difficulties in expressing emotions as shown by Emslie et al (2007).

In some cultures there are cultural, local concepts of a depressed mood, which may include biological, psychological and social meanings and link an individual illness with the sufferers’ relationship with their community and with the natural environment and are fully understood only in the context in which they appear (Kokanovic et al 2008). But in the Swedish context also there were local metaphors to express a depressed mood, which shows that expressions are context-bound everywhere.

The scientific studies offered few reflections about the different cultural or gendered expressions of depression although the focus was on ethnicity and gender. Studies were mainly carried through with western universal criteria of depression which may in turn influence the diagnosis of depression and the results of the studies.

Communication

Verbal and non-verbal communication was difficult, nuances could disappear and an eye-contact was difficult to evaluate. Communication was often time-consuming, especially through an interpreter and to mention depression could be shameful (paper V).

The Romanies seldom came alone and it was difficult to separate the problems of an individual (paper I, V).

Patients’ previous history remained mainly unknown and many of the GPs were not acquainted with the patients’ former experiences (paper V).

A patient-centred working style could be regarded as unskilled doctoring by patients from other cultures. “A man who does not want to shake hands with me as a woman gives a signal of a possible troublesome contact” “maybe an immigrant does not trust a female doctor”. “I try to be more resolute with hesitating men and I want to show that I am the doctor” (paper V)

Verbal and non-verbal communication are central elements in the interaction during the patient–doctor encounter and misunderstandings in communication were frequently reported. The use of interpreters, if needed, have been seen to be the largest gain for good communication even if verbal support did not compensate for the linguistic insufficiency (Harmsen et al 2008).

According to western medicine a patient-centred working style and mutual understanding are crucial in a good patient–doctor encounter (Pendleton et al 1984) but there are differences in patients’ willingness to make decisions (Schouten & Meeuwesen 2006). The GPs with a Swedish background especially emphasised the difficulties in asking about the patients’ previous history. This is in accordance with a study by Wachtler et al (2006) about the absence of questions about cultural discords when GPs met an immigrant patient, which can lead to a worsening of mutual communication and patient care.

One of the reasons for poorer mutual communications can be unequal po-
wer in relation to gender in a patient-doctor relationship. Female GPs from a majority group could enter into both a gendered and cultural status conflict when, for example, an immigrant man refuses to shake her hands. Unequal gendered power relations in the consultation could challenge the doctor’s authority. When challenged the GPs attempted to change their working style into a more authoritative one as a way of retrieving control (Johansson 1998). This may lead to poorer contact and risk for misdiagnosis.

GPs’ decisions – Disorder versus normal reaction

GPs stated that symptom manifestations of depression were unclear. Various bodily symptoms or use of alcohol were potential signs. Diagnostic criteria and screening instruments were not suitable (paper V). The use of positive effect questions in western depression-screening instruments could be biased in, for example a Japanese context or among Hindi (paper III).

Clinical experience and a sense of intuition were the main assets in diagnosing but “many patients are suffering and sad, maybe not what we really mean with depression”. (paper V).

GPs of Asian origin are less likely to diagnose depression among depressed Punjabi patients than patients from England because of similar cultural illness beliefs (paper III).

“It is easy to be prejudiced against women from the Middle East…it is depression”. “An unemployed immigrant woman with many children who cannot speak Swedish, living in economic hardship…it is a normal reaction...what can we do?” ”We can’t manage their problems with a lot of pills. A person feeling bad because of her life situation.” “Drugs are the only thing you can give quite promptly”. “Sick-leave certification is a solution for a severe social situation” (V)

GPs’ own beliefs and attitudes can lead to gendered, stereotypical thinking both about men and women (Hamberg et al 2004). In this thesis the GPs seemed to be aware of the risks of gendered stereotypical thinking and therefore misdiagnosing of depression. The GPs described, however, many portraits of “a suffering woman” from the Middle East with another cultural gender order, living here isolated at home and caring for many children. These portraits illustrated a gendered cultural conflict which in turn could lead to stereotypical thinking, even among GPs.

All the GPs, and some experts in my thesis, questioned the relevance of the classification criteria of depression based mainly on emotional symptoms. Diagnostic tools were not possible to use because of difficulties in estimating different expressions and uncertainties in communication among immigrant patients but also because the symptoms were diffuse and the main symptoms of a depressed mood were bodily. These results are in accordance with other research reports about the limitations of existing, universal criteria of depression in primary care (Gask et al 2008; Parker 2007; Andersson et al 2002; Chew-Graham et al 2002).

The GPs diagnosed patients with a sense of intuition. They preferred the older nosology and divided depression into “reactive” and “endogenous” (Pilgrim 2007) and understood patients’ depressed symptoms mainly as normal reactions
to severe life events and changes in gendered socio-cultural power relations. The GPs were ambivalent about giving drugs to patients with possible reactive depressive features and to medicalizing human suffering in accordance with other studies (Kleinman 2007; Dowrick 2004; Horwitz & Wakefield 2007).

The GPs were struggling for clarity between patients´ gendered socio-cultural problems, the norms of Swedish society and the obligation to follow the norms of evidence-based medicine or well-tried experience. However, the medical evidence about the efficacy of the new generation antidepressants, which were recommended according to Swedish guidelines (SBU 2004), had been questioned just before the study started (Kirsch et al 2008). The efficacy of the antidepressants was shown to be below recommended criteria for clinical significance for others but the most severely depressed patients. However, the GPs had few alternatives but medicines to offer. The GPs could see the risks that sick-leave could lead to more isolation and medicalization of normal suffering and were usually restrictive. At the same time a sick-certificate could compensate for the GP´s dilemma (Swartling et al 2007).
Conclusions

This dissertation shows that the concept of depression is always context-bound and situated.

– Beliefs about depressive symptoms as a medical problem or not, as well as help-seeking behaviour, vary with gendered socio-cultural context. Help-seeking behaviour has importance for the rates of depression among men and women.

– The psychiatric beliefs and practices are also context-bound. They are based on a dominating, western, cultural and gendered view of knowledge, which defines diagnosis and classification criteria of a depressed mood and can contribute to individualization and medicalization of local social problems.

– The patients, the medical experts and the GPs described that expressions of a depressed mood could be gendered and often included bodily symptoms with cultural variations. However, the medical tools were universal and based on mainly uncontextualized, emotional symptoms, which made them unsuitable to use in practice. The GPs´ diagnoses were based on intuition and practical knowledge but diagnosing was especially difficult among patients from cultures other than their own.

– The patients, the medical experts and the GPs considered that a depressed mood and suffering was mainly a reaction to severe gendered socio-cultural life circumstances. To follow existing criteria of diagnosis and guidelines of depression without contextual issues could according to the GPs lead to medicalization of gendered socio-cultural life circumstances among immigrants.

– The GPs stated that patients previous history often remained unknown with the risk of stereotypical, generalizations of patients’ culture and gendered socio-cultural norms and could lead to misdiagnosis of a depressed mood.

Implications for practice

This thesis shows the medical encounter is a critical point where stereotypical misdiagnosis and disparities may originate. This is especially critical today when physicians meet patients with many cultural backgrounds which may be unknown or known to the doctors only via media. The GPs asked for more cultural competence. However, individuals’ beliefs and behaviours are not culturally fixed entities. Thus, situational awareness and dialogue about an individual patient´s gendered socio-cultural views (gendered norms, family roles, religious beliefs and physician authority) and previous background are central issues to a successful understanding and diagnosing of depression.

Not only situational awareness but also self-awareness and reflections on the physicians’ own gendered cultural norms, behaviours and potential prejudices about, for example, particular groups, is essential for correct medical decisions, management and equal care.
This thesis shows further, that the use of standardized psychiatric knowledge is limited in general practice. The characteristic of primary care is the emphasis on “medicine of the whole person”. Contextual expressions of depression and social problems are often present in patient narratives of depression but the gendered socio-cultural framework is not present in the diagnostic tools or guidelines. Besides, these guidelines are based on a western view of illness and therefore difficult to use in primary care. Thus, there is a need for new contextualized tools for general practice care and research in different local contexts. There is also a need of physician education with focus on a holistic understanding of depression rather than the quite often limited instrumental focus of today’s education.

At the moment, there is much welcome discussion in media about the meaning of context for health and ill health and about medicalization of ill health for such as depression. The opinions among different individuals, some of them feeling discussion insulting, and among medical professionals, are conflicting. It is to be hoped that this discussions leads to inclusion of context to the concept of depression, which is lacking today.

With contextualized tools for care of depression it is possible to reach better quality of treatment for patients who need medical care. Contextualized knowledge is also crucial in order to avoid patients’ social problems being seen as psychiatric problems, for example suffering based on gendered or cultural inequality, which demand political and economic solutions.
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References


REFERENCES


Malterud K. (1990). *[The general practitioner’s encounter with women patients]*. Oslo: TANO.


REFERENCES


Warr D.J. (2005). “It was fun…but we don`t usually talk about these things”: Analyzing Sociable Interaction in Focus Groups. Qualitative Inquiry, 11(2), 200-225.


