Caring for Difference

A Study on Refugee Targeted Health Care

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Abstract

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With health care for refugees as the overall theme, this thesis draws its theoretical reference points from several sources. Firstly, health strategies that target 'refugees' in order to adjust to the new multicultural Sweden, will be discussed in relation to aspects of welfare. Secondly, I will focus on 'cultural understanding' within health care personnel in relation to appeals on difference and diversity. Questions such as different needs and diverse experiences in the search for good health, are being raised and discussed with regards to postmodern themes and guidelines. I will conclude that health strategies that target difference (culture, ethnicity or refugee identity), are although important for the right of good health and good health treatments, a matter for critical reflection – as long as cultural categories in defining the need and experiences of refugees is given in connection to an idea of essentiality or fixed identities.

Keywords: health care, welfare, targeted politics, difference, postmodernism.

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List of Abbreviations

APA	American Psychiatric Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Diseases
NGO	Non-Governmental Organization
PTSD	Post-Traumatic Stress Disorder
SOS	Socialstyrelsen, Swedish National Board of Health and Welfare
SOU	Statens Offentliga Utredningar
SRCRC	Swedish Red Cross Rehabilitation Centre
WHO	World Health Organization
HSL	Hälso- och sjukvårdslagen, Swedish Health and Medical Service Act

1. Introduction

We live in an era where de-collectivization of welfare has become increasingly evident in a number of political contexts throughout Western societies. We also live in a area where global migration has changed the societal landscape of many Western societies. Institutionalized health care is one area in which adjustments to these changes reveal themselves. According to the Swedish Health and Medical Service Act (Hälso- och sjukvårdslagen: HSL.) health care should be provided on the basis of 'care on equal terms. Care shall be provided with respect for the equal dignity of all human beings and for the dignity of the individual.' (1982:2§). In accordance with this, patients are supposed to be treated primarily as patients, that is independently of ethnicity, nationality, income and gender (Fioretes 2002). Yet recently Swedish health policy is paying a great amount of attention to culture and ethnicity, as adjustments to the new multicultural Sweden. Health providers are counseled to reach 'cultural understanding' (SOU 2000:3; Hendersen & Petersen 2002:126) and 'immigrant and refugee health' is regarded as a problematic to which health care should make resolving and constructive contributions. The overall purpose of these health strategies seems to be to construct new forms of health care that are adjusted to ethnical and cultural plurality within the Swedish society.

At a first glance, sociological research on health, does not appear to be occupied with analyzing the importance of health strategies that are moving from sameness to difference and diversity. In this thesis I will demonstrate the potential of some theoretical themes and guidelines in the understanding of the management of health with regards to immigrants and refugees. Health care strategies are bound to be linked to political agendas - a topic which much research has focused on, specially with regards to changes in the welfare state in terms of general versus targeted politics. Health care policy and practice are evidently affected by discourses on welfare, and thus one begins to wonder whether health strategies for immigrants and refugees have anything to do with welfare changes.

In order to understand health care strategies that target difference, I will use health treatments and rehabilitation of (traumatized) refugees, and 'cultural competence' within health care personnel as empirical examples. Although treatments of trauma have been present longer that de-collectivization changes, I will focus on the similarities, since it is rather the pattern of

appeals on difference and diversity within health care, that I am interested in. How can we interpret that patients are 'patients with refugee background' and 'immigrant patients'?

1.1 Statement of Purpose

The purpose of this thesis is to use a constructive theoretical framework in order to discuss what health strategies are being used when health care is adjusting to ethnical and cultural difference - and why. My intention is, in order words, to utilize theoretical themes and guidelines in order to provide an understanding of health care for refugee patients as targeted health care politics. I will focus on targeted health care as a process inevitably linked to political agendas, and hence I will place health care in this context.

1.2 Method and Material[1]

When it comes to a topic such as 'health treatments for refugees' it could be argued that, there is little work published that deals with this theme the way that I intended to do. The base of my material was therefore rather narrow, even though health is clearly a matter for sociological inquiry, considering its place in the sub-discipline within sociology often referred to as medical sociology (Svensson 1993:9-12). Considering my interest and the choice of topic, it seemed suitable to conduct interviews. The empirical journey started off by an unstructured interview with a refugee who had gone through treatment for trauma at a rehabilitation center. Being more interested in medical and psychological knowledge and the practices themselves, I later on contacted Red Cross Rehabilitation Center in Malmö in order to find suitable practitioners working with health treatments for refugees. The interviews that followed were both conducted with psychologists recommended by the interviewee at the Red Cross, and a psychiatrist I found

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[1] This chapter should be seen as a *presentation* of my method and material. In chapter two I take a more problematizing stance in relation to method and material.

by my own persistent efforts[2]. What these interviewees have in common is that they are local actors with a *special competence* in refugee health and illness. Besides local actors with specialized knowledge, I was also interested in general 'culture competence' among health care practitioners, that is the attention paid to 'immigrant and refugee health' within the realm of health. Hence I decide to consult available secondary sources such as textbooks for health care personnel and health reports on the topic. The reports, documents and textbooks were chosen with regards to their relevance for the thesis.[3]. Since both interviews and official documents together with textbooks, are included in my empirical material, it can be argued that this combination provided a sort of dynamic within the material. Considering my interests in elements of 'cultural competence' and strategies, interviews were a suitable complement to written and official documents, since interviews facilitate a deeper understanding (Lundquist 1993:103-104).

Being interested in the role of health treatments for 'refugee patients' I had, from an empirical point of view, the intention of penetrating some discourses that are appealed upon in the context of 'medical treatments of traumatized refugees'. The method tools applied in this paper, are focused on the interpretative elements of interviews and also committed to an interests in discourses. As a concept discourse is usable when theorists analyze for example social effects of language, power relations, contextual and symbolic meanings, and identity constructions (Howarth 1996:116-123). Generally in qualitative methods, the interpretive, subjective and relational role of (the) research(er) is an important characteristic, since this is valued as a fruitful factor in grasping meanings (Devine 1996:138). The method perspective applied in this thesis takes this even further by confirming the assumption that the role of the researcher is not to find an appropriate method to get close to Truths. Instead, one focus on how language - discourses, texts, narratives, stories about reality - is indeed constructing reality (Alatuusari 1990:63). Interviews then, cannot be the basis of facts or universal information about what you are studying (Silverman 1993:106-108). David Silverman addresses this distinction of what research is aiming to capture, in terms of 'externalist' or 'internalist' positions. In the first one, interviews are telling truths or reports about reality as opposed to the 'internalist' view where the interpretive role of

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[2] All interviews were recorded on tape, and the recordings were later transcribed into readable form. Difficulties with tape recorded interviews were present, but I still chose this method since the alternative (to make notes) did not seem suitable. The interviews were conducted in Swedish. Being aware of the problems translation may cause, and wanting to offer a fair version of the words and sentences that are interpreted, I decided to leave them non-translated in the text and offer my own translation as a note each time these are referred to.

[3] Quotations from books and reports are either in their original translation in English, or translated by me. When nothing is mentioned the reader should know that it is the official English translation.

the researcher and the *interaction* between the interviewer and the interviewee is valuable (1993:106). With the importance of interaction in mind, the first interview (with the refugee) was unstructured, while the interviews with the psychologists and psychiatrists were conducted in a standardized interview situation. Knut Halvorsen asserts that unstructured interviews are suitable when the researcher is unsure of what question to pose, for example in the beginning of the research process (1989:85). This was certainly the case in my first interview. The rest of the interviews were standardized in the sense that I had prepared themes and questions in advance (See Appendix). All of the themes were addressed in each of these semi-structured interviews, even though the order of the questions changed depending on the actual conversation and the interviewees' line of reasoning. The result of this was that the interviewees paid different amount of attention to the themes.

Obviously, my theoretical interest within postmodern theory on health, plays an important role for my method as well as for how the material was analyzed. Inspired by Nicholas J. Fox interpretation of the postmodern concept 'intertextuality' as '[…] a reflexiveness over the production of my own text.' (1993:19), I will discuss my method and material further, in a chapter called 'Matters of Methodology'. Here I will make the reasoning process as explicit as possible, in order to open for a critical evaluation of my methodology.

1.3 Theoretical Concepts

Within the sociology of health, there are distinctions made between sickness, disease and illness. While discourses on disease are concerned with physiology (objective biomedical view), others are more interested in illness with references to subjective experiences. Sickness is finally referred to when societal and cultural responses to disease and illness are valuable (Hjern & Angel 2004:106; Fox 1993:4). A crucial point of reference for this thesis is an assumption within sociological medicine, that opposes the separation of medical knowledge from social contexts. Within this line of inquiry discourses on normality and deviance are instead highlighted and representations of the 'healthy' and 'ill' are important. Hence, our focus on health will not presume a binary relation to disease or deviancy (Pierret 1993:9: Lupton 1994:30).

The concept of discourse is used in the thesis accordingly to Pertti Alasuutari's understanding that discourses are: 'keen to stress that linguistic interaction consists not only in the exchange of information but also in the production of different affairs, positions and identities.' (1990:114-115). Apart from this understanding it is also assumed in the analysis that: 'An interest in discourse is interesting in its own right, rather that what lies behind it or what people really think.' (Trinder 2000:53). When discourse is seen as formative for identities, it is then also often a premise in postmodern perspectives that an identity ought to be studied as flexible, fragmented and contextual (Fawcett & Featherstone 2000:13-17).

Difference and diversity are concepts that are commonly discussed in postmodernist theories (especially in postmodern feminism and post-colonialism). What is often emphasized here is that difference is socially constructed, which means then that categories in the social world are not fixed, but products of political, cultural and social relations (Fawsett & Featherstone 2000:15-16). Conceptualizations on difference and diversity are important for the line of reasoning in the thesis, since they also are relevant for my interest in 'refugees' in particular and 'immigrants' in general. Refugees are according to the Swedish Alien Act, persons 'in need of protection' (Stoltz 2000:102; Hjern & Angel 2004:16).

What orientation does the concept of power give to the analysis? Considering my own background as a refugee, I acknowledged the risk of overestimating the possible socio-political meanings of medical and health treatment of 'refugee patients'. Nevertheless, power is a discursive clue in this thesis, confirming the assumption that health practices have structural meanings (Nettleton & Gustavsson 2002:3). In Pettri Alasuutari's view a discursive approach can go beyond speeches and also focus on that some discourses are institutionalized. In this lies the assumption that discourses have limiting and conditioning effects, and that they may as well be challenged in speeches (1990:115).

Considering the concepts of health policy and health care, it can be stated that while most health policy theories focus on the reactive notion of the relation between health and policy, this thesis is concerned with the notion of policy as constructive rather than reactive (Osborne 1997:174).

1.4 Outline of the Study

Following this first introductory chapter, I will present methodological reflection in chapter two. This means that reflections during the process of writing this thesis, will be explicit in the text, together with a discussion on topic suitability and material limitations. Next chapter includes the theoretical framework of the thesis, in which I will discuss both the theoretical field that I am interested in, and more precisely which analytic tools that are guiding the thesis. Chapter four and five constitute a deepening of the analyzing section, where clues that have been gathered along the way are discussed further.[4] In the final chapter my discussion is summarized and in relation to this I propose topics for further research.

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[4] The whole process of writing this thesis is reflected in the outline of this study. And since this process started with methodological worries, these thoughts are also presented in a separate chapter in the beginning. The reflections are not only making the reasoning process explicit, they are also demonstrating an analysis process in which the problem and purpose is dependant of the methodological reflections (Lundquist 1993:118).

2. Matters of Methodology

'Where there was identity may there be difference, where there was truth may we celebrate ambiguity, where there was control may we be generous, where there was repetition may there be multiplicity, where there was inscription may there be desire.' ('A Postmodern Prayer' by Nicholas J. Fox 1993:160)

This section is an attempt to discuss the relations between my method and the theoretical perspectives. With the relations between medical treatments and refugees as the overall theme, this process started off with the intention of conducting interviews with professionals working with traumatized refugees and a refugee with experiences of trauma treatments. As student of sociology I found myself somewhere in the 'post-landscape'[5], interested in discussion about power/knowledge, questions of diversity and the epistemological levels these issues are discussed upon. Here I encountered my first difficulty; the lack of practical knowledge about how I could link the *theoretical* interest within the post critique, to the actual process of conducting interviews, analyzing and writing the thesis. Without any concrete answers to what it means *practically* to study from a postmodern perspective, I even sometimes questioned the relevance of interviews. Given the condition that my interest has become established during these years at the university, it is now obvious for me that if there is any systematic feature in the writing process, it is in the selection of literature. Since there is a great tendency to select literature with postmodern/poststructural/postcolonial themes and theories, it is likely that I end up with a need for questioning the ways social science is produced and constructed. Thus, asking questions with epistemological and ontological character, has repeatedly taken time and energy from the possibilities of actually posing a question about social phenomena and then with a chosen method try to answer this question. Within the postmodern field where knowledge is viewed as *constructions* rather than *reflections* of reality, I therefore as many times before, found myself paralyzed when it got to the point of doing something practical as conducting interviews. Since questions concerning the link between knowledge, language and reality are such an important feature in the post critique literature; I usually get trapped in this web without any practical tools of linking the ideas to empirical findings. Before I have interpreted this difficulty mostly in a

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[5] For the purposes of this section the terms 'post landscape', 'post critique' or 'post theories' are used to refer to poststructural, postcolonial and postmodern perspectives. I do however acknowledge that there are great varieties and ongoing debates on the differences and similarities between these perspectives.

positive way. I have said to myself: 'Well, reflexivity is a good thing. I'm comfortable with the standpoint where the purposes and effects of knowledge are in question. Should it not suffice to discuss that reality is complex and affected buy what we think we know about it?'

But obviously this has not been sufficient for me. During these years as a student, it has come to my knowledge that the preoccupation with critical point of views, can make me questioning so much that I leave the reader (and myself) lonely. The reflexivity is then (mis)understood as, to put it in David Silverman's words, having 'a little to say about a lot', when your aim on the contrary is to say 'a lot about a little' (1993:3).

Fortunately for me, there are indications of a paralyzing feature in methodology debates within the post critique spectrum (see Thinder 2000:54; Featherstone 2000:133; Rossiter 2000:24-30: Turner 1997: Eckermann 1997:164). This notion can also be used as a pure critique of postmodernist theories as apolitical from for example Marxist theories (see Bradley 1996:43-44).

My aim is however not to fall into any critique, because the point of these reflections is not to claim that post theories *per se* necessarily complicates or obstructs the research process. Apparently, there are uncountable examples of theorists who are engaged with 'deconstruction', 'discourses' and 'narratives' as means to understand reality which are compatible with a critical view on knowledge. Equally important to remember is that there is an uncountable amount of theories that already have been exploring what postmodernism 'is' in social science. As stated before, I do not wish to pay attention to the debates about the scientific legitimacy of postmodernism. Instead these reflections should be viewed as comments on the tensions between *a critical view on what knowledge is* on one hand, and the desire *to understand and interpret reality in 'an appropriate way'* on the other. And more importantly, the goal is to emphasize that these tensions have played a crucial role in the process of making this thesis. My way of dealing with the difficulty outlined above has been to write about it let the reader know that this *is* an important part of the thesis. That what I have discussed is not only a background, but parts of the substance, since these reflections have been present at *all stages* of the process.

The framework that guides this thesis incorporates assumptions made by social constructivists when approaching health and illness. Consequently, the postmodern rejection of 'essence of humans' and instead a theoretical search for a subjectivity that is produced by knowledge, expertise and power (Fox 1993:v), is deciding how health is addresses in this thesis.

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Regarding the implications of the postmodern position for social research, MacNay makes following remarks: 'Firstly, where does the post-structuralist deconstruction of unified subjectivity into fragmented subject positions lead in terms of an understanding of individuals as active agents capable of intervening in and transforming their social environment? Secondly, what are the implications of the postmodern suspension of all forms of value judgement, of concepts such as truth, freedom and rationality, for emancipatory political projects?' (1992:1 in Eckerman 1997:152). In line with these questions I have had the following in mind when approaching health care for traumatized refugees:

1. How can I put health care in question without ignoring subjective experiences of trauma, torture and war?
2. How can I explain the use of languages and at the same time stay devoted to the framework of language as constitutive for knowledge?

Questions that are concerned with the practicality of the theoretical 'post landscape' are complex and have generated many debates. It should be clear that although I am interested in these questions, they are *themes* and not the aim of the study. As aims they are too complex and big. Even though I do not intend to answer them, I am posing them to provide hints and clues that are of importance for the thesis.

2.1 Topic Suitability[6]

Concerning my choice of topic R M Lee's definition of sensitive research is one thing I have, in retrospect, paid attention to. In Brid Featherstone's article about research into mother's violence, Lee's definition of sensitive research is quoted: 'research that potentially poses a substantial threat to those who are or have been involved in it.' (2000:126). By threats Lee is referring to research into areas that are (emotionally) stressful, communities that are stigmatized or deviant, or areas that could harm the interest of powerful people or institutions. In my view, dealing with a

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[6] 'Topic suitability' as a methodological reflection is inspired by Brid Featherstone (2000).

topic that interfere both with refugees and medical expertise, can certainly be viewed as 'threatening'. Regarding my own role, *the sensitivity of the topic* made me acknowledge several things: one is the emotional aspects of this topic with regards to my own refugee background. During a pre-study for this thesis I interviewed a person how came to Sweden as a refugee and had gone thorough treatment (for trauma) at the Red Cross Rehabilitation Center. In order to discuss possible outcomes of this interview and how it affected the choices that followed, I will now emphasize the importance of sensitivity. During my first interview, her stories and experiences awakened my own memories and images of my past. Sometimes this was a relief, other times I was feeling anxious about what was about to be disclosed. So how did the notion of sensitivity direct and determine the thesis? Thinking about my influence in relation to the first interview, I made the choice of trying to reduce the risks of taking the matter for granted. I could not blindly assume that her 'refugee identity' was of importance for her stories and the way she talked about doctors and treatments in the health area. Regardless of these efforts, it is clear that this first interview and the stories the interviewee shared with me, was of great importance for the orientation and selection of the thesis. My motivation to put health treatment for traumatized refugees in question and the fact that I was willing to adopt a *critical* stance is undoubtedly connected to the particular stories highlighted by my first interview. And it may be true that other experiences from medical treatment for refugees from another refugee, could possibly have directed the thesis in different direction. Obviously, a critical evaluation of the material from my part, has to take this into consideration.

2.2 How is the Material Used in the Analysis?

Being skeptical of any statements of 'Truth', the notion of interaction in situated interview situations, was above all interesting in relation to 'what was not said' during the interviews. Without the idea of 'empathy' and 'trust' as tools of getting closer to the truth (Alasuutari 1990:89), it can be stated that my influence on the interview situations, as an immigrant background did not necessarily determine a sense of 'empathy' or 'mutual understanding' that got us *closer* to the Truth. Instead, it created a *truth of it's own*. Let me make this more clear: in

the course of the interview with the refugee there were an absence of details and, as I interpret it, an evasive way of talking about the subject. What I mean by evasive is the avoidance of a language that needs to explain or emphasize why her identity as a refugee could have been of any importance for the way she was treated. I was asking myself: Maybe the interviewee's stories took this particular form because there was a sense of 'sameness' and no need to prove anything? Once again, I did not believe that a sense of 'sameness' created a more truthful picture of her experiences as a 'refugee patient' in Sweden. Instead, I concluded that a silent agreement on a 'we' was a factor, which affected the language of the interview and all the more the *use of discourses*. Hence, the interviewee's answers was not necessarily a direct measure of 'an essence' of how refugees are treated by medical personnel, but instead indications of discourses that are applied upon when talking about these practices. This way of analyzing the importance of interview contexts echoes Silverman's criticism of 'authentic experiences'. David Silverman is critical of the efforts to achieve authenticity in the material by for example creating an open interview or letting the interviewer take a passive role. He believes that these efforts are naïve because they fail to view the interview as 'textual' and 'situated' (1993:95-96;199).

Regarding the other interviews, the notion of interaction is equally important. By viewing the local actors as defenders of truths around health and illness (Eckerman 1994:162), I decided that the words the interviewees used as ways of positioning themselves were of importance.

2.2:1 Delimitation

Evidently there are several limitations and selections that play a crucial role for the content of this thesis. Since I am aware of the importance of heterogeneity in both refugees as a group and medical treatments, the following remarks are worth making: When referring to the encounter between health care and refugees, it is important to bear in mind that these encounters have different meanings depending on what the purpose of the medical care is. There is a broad spectrum in the health area and the content differ depending on who the doctors examine or treat and why (see Hjern *et al* 1995). According to the Swedish National Board of Health and Welfare

(Socialstyrelsen), health examinations of immigrant and refugees have two different purposes, where one is directed towards *societal need of security* (from diseases) and the other one, *individual need of care* (SOS 1995:17). Hence, at a common level, there are health examinations for all immigrants and this is emphasized from a perspective where 'the right to get your health checked' is in focus (Hjern & Angel 2004:21). Other times, there are more evident grounds for problematizing this phenomenon, since health or illness is of importance for the asylum process, or for an adjustment to the new society if there are health *treatments* in process. In this thesis, these latter aspects of health care services have oriented and limited the discussion. The treatments that the thesis takes a closer look upon are: medical treatments for traumatized refugees. These aspects of health care depart from a standpoint where the appeals on a refugee's health conditions are interesting in relation to power aspects of this particular phenomenon. The reader might ask: How come power? As mentioned before, medical conclusions that are drawn upon a refugee's health condition can play a crucial role for either the asylum process or for the social identity of individuals. In medical treatments, individuals are counseled to come to terms with their position, and in a sense adjust to 'normality'. At the same time, it is possible that appealing to 'abnormality' (trauma, damages of torture or exile and so on) turns out to be decisive for a refugee's right to residence permit. Two things can therefore be stated: Firstly that *discourses on normality, in this particular context, changes and varies*. And secondly, that the encounter between doctors, psychologist and refugees implies the *exercise of power*.

But what kind of treatments are exactly in focus in this thesis? As stated before, we will address medical treatments of refugees in Sweden. Firstly, this implies an interest in the 'refugees patient', secondly in 'cultural competent' health care in a Swedish context and thirdly a final brief focus on trauma. Considering the thesis' time and space limitations, the 'medical treatments' that will be discussed are limited to 'refugee patients' who already have been granted citizenship. Without abandoning power aspects of health treatments for this particular group, we will not pay attention to the importance of health and care for asylum seekers. In order to address medical treatments of refugees we will broaden the discussion by also focusing on 'health care for immigrants'. In those cases where 'immigrants and health' is exposed it is with the intention of approaching health care strategies in a wider context. That is, strategies that target social and cultural determinants in providing good health.

The role of the concept of trauma should also be discussed. The reason that 'trauma' is underlined in relation to the concept of *Post-Traumatic Stress Disorders* ('refugees with PTSD'), is that 'trauma' is for the purposes of this thesis a better connection to health/illness discussions than PTSD, since it allows that the question of normality still remains open. PTSD, on the other hand, unveils more directly that there is a disorder involved. Wanting to avoid that, I still chose empirical examples of 'refugees with trauma' because an one-sided focus on 'treatment of refugees' would indicate that *all* refugees are potentially ill or a target for medical treatment, which I believe I could not assume.

There are other central assumptions incorporated in the thesis and one has to do with how I approach medical treatments and care of traumatized refugees as targeted health care. Why targeted health care and in what sense? In the following section this question will be addressed.

2.3 The Analysis at Hand: What Indicates that Health Care Focus on Refugees is Targeted Health Care?

Nikolas Rose conceptualizes targeted politics as: 'Strategies that seek to target 'high risk' or 'high need' persons which are thought to require particular attention.' (2001:2). It is generally acknowledged that refugees and immigrants living in Western welfare states, demand particular attention in the health area (SOU 1997:82; Folkhälsointitutet 1998:40; Nationella Folkhälsokommitten Underlagsrapport 13,1999; Törnell 2003:256; Statens Folkhälsoinstitut 2003:16) A common approach among practitioners of Swedish health care, is to pay attention to this particular group both through health policy and strategies that seek adjustments to the 'needs' or 'risks' of refugees - to put it in Rose's words. Even thought there is no tradition of particular responsibility for refugees in the Swedish Social Service Act, refugees are increasingly a target for particular attention by means ranging from medical institutions to NGO:s such as the Swedish Red Cross. The factors that are referred to as 'targets' in this thesis are culture, ethnicity or refugee identity.

3. Theoretical Framework

Up to this point I have only commented that an interest in post theories have had practical consequences for the thesis without emphasizing where this interest comes from. In order to outline the theoretical frame of this paper, it is suitable to discuss the theories more in detail. Firstly, I will answer why this particular focus has been chosen, and secondly the theoretical themes will be developed.

3.1 Why an Interest in the 'Post landscape'?

The interesting element in postmodern theories is the suspicion towards 'grand theories', essentialism, objective truths and modernist conceptions of language as a transparent medium which gives people access to reality (Howarth 1996:117-118; Rossiter 2000:24; Fox 1997:31). In a similar spirit, postmodern social theory of health derives from 'the conclusion that there is nothing knowable outside language and that health and illness need to be 'explained', enter into language and are constituted in language, regardless of whether of not they have some independent reality in nature.' (Fox 1993:6). From a methodological point of view this implies a suspicion towards scientific methods that aim to 'reflect reality', because without acknowledging the constructive and producing effects of knowledge, postmodern perspectives state, there is a risk of only upholding and legitimizing hegemonic orders (Howarth 1995:124). With an insistence that reality is an effect of language it is stated that conceptions about reality are 'representations' that are either heard or not heard - dominant or marginalized. (1994:30-33). It is this acknowledgment of the relation between power and knowledge that interests me. To question objective and neutral knowledge is interesting because it allows to problematize the *effects* of knowledge on reality, and opens up questions about 'the knower'. Regarding this topic Nicholas J. Fox suggests the following questions as a point of departure when addressing health: 'How do discourses on health and illness, be it medical, lay or from other groupings, claim *authenticity*, how do they claim *authority,* and how is it that we are willing *to accept their knowledge of the character of health and illness*?' [my italicization] (1993:9).

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Whether there are statements about the limitations of modernism (Humanism, Enlightenment), oppositions of Westernized knowledge (in postcolonial terms: Western as in products of colonialism) or 'grand narratives', the attractive feature is the condition of responsibility that these perspectives may contribute to (Stoltz 2000:28; Eriksson *et al* 1999:5-9). For example when Edward Said famously proclaimed that Western modern identity has been defined by it's colonialized Other, he talked in terms of an 'intellectual responsibility' which is aware of political and cultural power relations in describing and reproducing 'the Other' (1993:445-446). Echoing an awareness of responsibility, Nicholas J. Fox writes: 'In human sciences, theorizing can have a more direct impact on peoples lives. The subjects of the 'human sciences', unlike atoms, can read the texts which claim to explain the structures by which our lives are organized. […] Working-class mothers learn that they smoke cigarettes not as a consequence of socialization, or self-destructiveness (two prior 'explanations'), but because it provides the only part of their lives over which they have control.' (1993:2).

Now it is time to steer out attention to the ways researchers have addressed matters of health from a postmodern point of view.

3.2 Health and Postmodern Theory

3.2:1 The Medical Complex

'*…[medicine] has come to link the ethical question of how we should behave to the scientific question of who we truly are and what our nature is as human beings, as life forms in a living system, as simultaneously unique individuals and constituents of a population*.' (Nikolas Rose in Lupton 1997:101).

Broadly speaking, the contribution of debates within postmodernism about the question of health and illness, can be discussed in terms of their commitment to social constructivism and their dismissal of the biomedical school, that is the notion of medical knowledge as politically neutral or objective (Lupton 1997:6;31). In most postmodern theories on health and illness, the importance of language is apparent in explaining how power is exercised (Eckerman 1994:155),

suggesting that medical ideas and practices are discussed from point of view where 'essences' are being challenged. Nevertheless, it is important to bear in mind, as Deborah Lupton points out, that the idea of 'good health' as a *universal social good* or *individual right*, is rarely challenged within the postmodern spectrum (1998:1).

When approaching the medical complex, Nikolas Rose suggests five areas of interest or lines of inquiry along which an analysis could be developed. Firstly, he proposes an understanding of the *dividing practices*, as an area of theoretical investigation. That is, practices that distinguish health from sickness, beauty from ugliness, madness from sanity and so on. This line of inquiry is recognized within postmodernism in terms of how medical discourse serve to differentiate people and social groups (Lupton 1994:110). Secondly, medical knowledge can be approaches as a *matter of assemblage*, that is spaces outside the obvious ones (as hospitals) within which medicine has been gained authority. Thirdly, Rose suggests *expertise* as an important feature to take into account when discussing forms of legitimacy. Fourthly, he mentions *technologies of health* as a line of inquiry, since these practices together with the fifth area of interest, *strategies,* enables an analysis to focus on medical knowledge in terms of how normalization is realized (1994:50-52).

3.3 Knowledge, Language and Health

The theory that guides my analysis is sprung out *guidelines* and *themes* offered by theorist within the field of postmodern approach on health and illness. Instead of being applied in order to *answer* questions, they are rather helping me in *posing* questions, and as the word 'guideline' suggests, guiding the analysis by the selections they offer. One major guideline is concerned with language and knowledge. The theoretical concepts of language and knowledge are within postmodernism, according to Nikolas Rose, often credited with both 'system of thought and 'system of action' to the study of social reality (1991:6). Therefore, they can be perceived as a conceptual bridge linking ideas and practices for a discursive understanding of social phenomena. With regards to medical knowledge this means that the point of reference of my analysis will be that: knowledge 'is an effect of power and constituted in language 'rather than something that has 'authority grounded in access to knowledge of reality' (Fox 1993:11). In this light the analysis

also departs from the assumption that medical and psychiatric discourse are defenders of *truths* around health and illness (Eckerman 1994:162). Deborah Tyler is echoing a postmodern commitment to knowledge and language as analytical point of reference, with her theory of 'bounded fields' as targets of power, and further on how these fields, as objects of political thought and intervention, require knowledge (1997:78). This directs us to another guideline which is narrowed down to two concepts: political rationalities and technologies of government. With a Foucaultdian interest for the constitution of subjects by the 'psy-professions', Nikolas Rose uses these concepts when applying Michel Foucault's theory of governmentality (Jones & Porter 1994:11). The concept of 'political rationalities' is linked with a discursive approach within which the importance of language is evident, whereas 'technologies of government' is concerned with implementation and modes of deployment of rationalites. As a conceptual tool, political rationalites is an important theme for the thesis. According to Rose, they have:

(i) *moral forms*: ideas and principals to which power is directed (such as equality, freedom, efficiency and so on)

(ii) *epistemological character*: power is exercised in articulation of an essence or 'nature' of objects.

(iii) and are articulated in an *idiom*: that is thinkable thorough language (1991:3-7).

These concepts are guiding in the sense that issues such as health care and treatments of traumatized refugee patients, are approached with a sensibility for the common notion within postmodern studies that medical knowledge not only reflects the social and cultural, but also is closely linked with the *formation* of social and cultural relations (Lupton 1997: Hansson & Svensson 1994:116-121)   Nikolas Rose is one theorist who claims that social norms of individuals and populations always have been closely linked to the development of medical knowledge. For example regarding ideas of 'the normal child', he points out that: 'in the universal and compulsory practices of schooling, the idea of 'normal development' in the child was formed, including normal physical development, and all the techniques of weighing, measuring, assessing were invented. They solidified the idea that there were biological norms of height, weight and development and that deviations were biomedical abnormalities - slow development, obesity and so forth'. (2001:20).

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Within the academic field of sociological medicine, the theoretical interest for the societal role of medicine, is sometimes discussed with reference to 'medicalization' or 'medicalization critique'. By medicalization scholars are referring to the influence that medical knowledge exerts on societal norms (Hansson & Svensson 1994:115: Lupton 1994:8; 1997:95). The word 'critique' has however different meanings depending on whether the medical authority is analyzed in political economical terms or from a social constructive perspective. Since the latter is valuable for our discussion, it can be stated that the critique does not apply to 'right' or 'wrong' medical knowledge - in contrast to Marxist medicalization critique of medicine as instrument of oppression (Lupton 1994:9).[7] Despite an agreement on medicalization, among postmodern approaches on health and illness, as the hegemonic authority of the medical (Turner 1997:14), it is also acknowledged that health of the population are concerns for different interests, and not just a function of a dominant ideology (Nettleton 1997:219). In the analysis there will therefore not be conclusion drawn upon health care and treatments merely as a reflection of social reality, be it political economical or in terms of State-centered analysis of regulations and control of health and illness. Consequently, when trying to grasp the context of health treatment for traumatized refugees, I am not interested in the debates *per se*, that is which representation of health management that is more true than the other. This does however not mean that the management of health is not taken into account in the thesis. Contrarily, questions on societal responses to health do have an important feature in the analysis. Within social medical and sociological theory health is commonly approached from an interest in experiences of health and disease or how society is organizing or responding to health and illness (Nettleton & Gustavsson 2002:1-8). Then, obvious questions when discussing health care in a Swedish context, have to be those posed in relation to welfare (and the welfare state), at least as long as health is addressed from an interest in institutionalized and organized health care. In the wake of changes in societal management of health, such as welfare reforms and de-collectivization of welfare, many accounts of explanation have focused on health in respect to societal ideals and individual rights (such as democracy, equality, freedom). Equally contested is the importance of general versus targeted welfare (SOU 2003; Rothstein & Blomqvist 2000; Diderichsen 1995:141-153). For the purposes of this study, the first elusive question will be in what ways health treatment of refugees can be regarded as *targeted health care* when health is analyzed with references to welfare. Differently

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[7] For a clarification between Marxist and social constructivist medicalization critique, see (Lupton 1997).

put, by considering health treatment for refugees as a form of targeted politics, I will argue that these can be analyzed in relation to recent patterns in the management of health. In order to grasp health care that target difference, a central dimension in the understanding will thus lie in discussions on welfare. From this angle, possible political agendas that refugee targeted health care rely on, are finally briefly considered. 'Welfare' and the 'welfare state' are, in other words, conceptual tools in the analysis, helping me to limit the theoretical interest area.

3.4 'Welfarism'

A study of welfare from a postmodern point of view, is bound to occupy the ontological area of power (Lupton 1994:32). Generally, postmodern theories on health and illness are linked with an alternative analysis of political power, in the sense that they suggest that power is to be viewed as non-coercive and in relational terms (Lemke 2000:4; Lupton 1994:99-100). There are other postmodern health theorists, such as David Armstrong, whose view on power 'is concerned with not repressing but with creating.'(1994:23). Although I am not interested in disputing neither the presence nor the absence of an encompassing theory aiding explanation of power in postmodern theories on health and illness, this thesis will carefully affirm the general suggestions about non-coercive and relational view on power. In this sense health as a part of welfare, will enhance our understanding of which factors that are important for the rationale of health treatments for a particular group.

Within welfare studies there is little academic doubt on the contemporary 'crisis' of welfare. A number of scholars associated with postmodern perspectives have provided accounts on the contemporary developments in the management of health that go beyond a political economical perspective or ideological matters (Bunton 1997; Rose 1991; Nettleton 1997; Petersen 1997). Drawing on Michel Foucault's examination of Western thoughts in relation to health, most of the theories are concerned with welfare in relation to neo-liberalism, (Nettleton 1997:225), that is changes in the society that are reactivating liberal principles (Petersen 1997:193).

By the concept 'welfarism', Nikolas Rose is referring to the development of social and health care services in Western societies. One important feature in welfarism is according to Rose, the determination of the relations between the state, public powers, expertise and the citizen - all together managing and being responsible for good health. The rationality of welfarism is elaborated in relation to problematizations (such as 'integration of citizen into the community', 'the problem family'), which are connected to an assembly of alliances, devices, politico-ethical aspirations, methods within which power is exercised. Hereby Rose is dismissing a common conception about welfare as incorporated only in the state apparatus or state power (1991:22-29). This dismissal is best understood with regards to Rose's alternative conceptualization of 'the State': 'Rather, the state can be seen as a specific way in which the problem of government is discursively codified, a way of dividing a 'political sphere', with its particular characteristics of rule, from other 'non-political spheres' to which it must be related, and a way in which certain technologies of government are given a temporary institutional durability and brought into particular kinds of relations with one another.' (1991:6). In Rose's conceptualizations, the welfarist rationality is further on embedded in aspirations to *know* in order to govern health, since 'governing a sphere requires that it can be represented, depicted in a way which both grasps its truths and re-presents it in a form in which it can enter the sphere of conscious political calculation.' (1991:11).

4. Welfare for All? – The Responsibility of Good Health

'Our contemporary social order is built on the ability of self-determination, by giving citizens a collective right to self-government. And this not only in political terms: every person in our modern society stands alone more than ever. She has no longer an intimate, solidary narrow circle to rely on, like the family, the village or the church.' (Alva Myrdal & Gunnar Myrdal 1935:309 in Sulkunen 2002:74)

The quotation above illustrates Nikolas Rose's account of welfare in terms of 'mutuality of social risk and responsibility' (1991:24). That is, a contract of responsibility on the part of the government as 'a way of providing freedom from pre-modern social bonds.'(Sulkunen 2002:73). Many accounts of the welfare state focus on welfare, as a state-centered commitment to efficiently and indifferently, offer social, economical security and equal opportunities to the population (Oakley 1994:6-9). Our focus will be on the assumption that the ideas and principals incorporated in welfare are connected to a mode of government which wants to create a 'political reality it already suggests exists.' (Lemke 2000:13). Nevertheless, our discussion starts by approaching health from a point of view where health of the population is concerns for the government (Osborne 1997:182). This is an important clue for the analysis since it highlights a central feature in welfare, which is the question of universalism. In a recent political rhetorical perspective, Western welfare states are committed to 'welfare for all', that is an universalistic agenda where services such as universal school system, a public health and social service system, is provided for all with the help of extended state politics. The rhetoric of welfare as a matter of political indifference on the part of society, is particularly evident in the originating debating on welfare in Sweden (Blomqvist & Rothstein 2000:35). The Swedish welfare system is, as a post-war product - constructed around some sort of agreement on generalized and tax-based politics as means of providing 'equal opportunities' for individuals. Discourses on welfare represented welfare as a 'fairly explicit commitment to the broad goals of economic development, full employment, equality of opportunity…social security, and protected minimum standards as regards not only income but nutrition, housing, health, and education *for people of all regions and social groups*.' (Gunnar Myrdal 1958:45 in Oakly 1994:4 [my italicization]).

But the idea of welfare as an universalistic affair has been contested and challenged, and more importantly these challenges has lately been accompanied by welfare reforms (Blomqvist & Rothstein 2000:36-44; Bergmark 2000:395-411). As post-war 'welfare-states' in the West has come under challenge, these challenges mediate ideas of an intervening State on one hand, and a free non-intervened individual on the other (Rose 1991:1). Some of these challenges deal with unjust or inefficient aspects of extended state politics, and instead critics stress the need for welfare reformations from two (different) perspectives (Oakley 1994:6-16). One is concerned with the need for 'free markets' since constraints on the 'liberty of the individual' or 'freedom of choices' are indicating that state regulated services have contra-productive effects in which the individual is the losing party (Petersen 1997:193). The other perspective pays attention to 'diversity' and 'diverse experiences' of individuals or groups as indicators of the limitations of an universalistic welfare agenda (Oakley 1994:9.15).

Summarizing, moral forms of welfare (political rationalites) consider ideas and principals such as 'equity' 'freedom', 'diversity' or 'choice' to which the management of health should be directed. In spite of a public and academic tendency to give credit to oppositions such as freedom versus authority, autonomy versus sovereignty (Rose 1991), there are however scholars who attempt to over-bridge dualism in the debate. Pekka Sulkunen, for example, assert that 'the moral foundation of the Nordic welfare state rests on similar conceptions of the self-controlling individual. In neo-liberal discourse the welfare state is often represented as a collectivism that undermines individual responsibility and sense of justice, achievement and merit. In reality, however the credo of the Nordic welfare states […] was very individualistic.' (2002:73). Other take issue with the search for essential functionality of the Western welfare state, by emphasizing that *responsibility* also is ascribed to the individual. Sarah Nettleton writes in a similar vein that norms of 'healthy behavior' are not only promoted on a collective level, but they also intervene with individual choice and lie within the control of individuals - within neo-liberal political agenda (1997:208).

Returning to Nicholas Rose's account on welfarism as a way of 'growing on a national and economical level through social responsibility', an analysis of health as a part of welfare requires acknowledgement of forms of power (1991:23-24). But does this mean that health care necessary involves state power or state responsibility? The answer is no. Let us briefly consider social fields that are involved with the question of health and illness. We have

insurance companies, doctors and researchers, commercial companies - all with their ideas of good health. There are medical institutions with concerns for what and who to treat. There are NGOs and lobbyists who demand the rights to health and equal treatment. And, of course, the patients themselves who shape our ideas as to what is 'suitable for treatment'. (Rose 1991). That the rationale for good health consists of different forces is an image that one the interviewees is keen to share:

'Men den diagnosen [Post-Traumatic Stress Disorder, *my remark*] har kommit till 1980 i USA, just på grund av de där administrativa... Just som förhållandet i Sverige där PTSD har blivit en stor diagnos överallt sedan sex år tillbaka, på grund av allt samhället kräver en diagnos, så har diagnosen skapats inom American Psychiatric Association 1980 i DSM 3, för första gången, på grund av man skulle kunna administrativt ge någon form av ersättning till Vietnamveteranerna'.[8] (Interview 2004-11-22)

With the exercise of power in mind, it is apparent that there are structural dimensions to individual cases of the 'healthy' or the 'ill'. As has been pointed out, the upshot of remarks on the limitation of the welfare state, have had political implications. What I have tried to do so far in this chapter, is to review health as a part of welfare. While conclusion has been drawn upon public and academic focus on health care in terms of 'equity', 'individual freedom' or 'diversity', the question of health care for traumatized refugees as targeted health care, still remains unsolved. In the following chapter I will briefly consider this question.

4.1 Targeted Health Care and the Rhetoric of Need

In the setting of Swedish welfare system, Karin Blomqvist and Bo Rothstein outline five principals that are important for the development of social services:

(i) *equal access* (ii) *equal treatment* (iii) *equal and high quality* (political evaluation of process and result) (iv) *strategic maintenance of solidarity* (fulfillment of the need of those groups that

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[8] 'But this diagnose [Post-Traumatic Stress Disorder, *my remark*] came about 1980 in the USA, just because of these administrative... just like the case in Sweden where PTSD has become a major diagnoses everywhere for the past six years, because society demands a diagnose, the diagnose has been developed within American American Psychiatric Association 1980 in DSM 3, for the first time, so that one could give some sort of administrative compensation to the Vietnam Veterans.' (Interview 2004-11-22)

could afford to turn against state regulated services) and finally (v) *social integration* (equal treatment and access as way of reaching understanding for other groups) (2000:64-66).

As we saw in connection with the theme of moral forms, ideas and principals such as these can be represented as ethical or political aspirations sprung out of collective responsibility. With this in mind, the rationale for targeted health care, can lie in claims that question the *potentials* of equality in services that supposedly are 'maladjusted' to the needs or demands of a particular group. Thus, questions are raised upon the realization of principals of equality and whether welfare really is for all. Before we continue this line of reasoning, let us consider good health a little further.

In the Swedish Health and Medical Service Act, it is stated that: 'Priority for health and medical care shall be given to the person whose need of care is greatest.' (1997:142). As a part of welfare, health is then interesting in its adjustment to different needs. This means that, public health care is oriented, besides preventive health and promotion, towards who needs it the most (Blomqvist & Rothstien 2000:110;156). The question of need, is a task for the medical institution as well as, as argued before, other forces dealing with health issues. It is therefore also a widespread and complex question when general versus targeted welfare politics is argued. John Hutton and Lars Engqvist write: 'In Sweden, the responsibility for financing and planning health services has traditionally been devolved to county councils. Provision of services has also been through publicly owned and managed hospitals and health centers with a small number of private organizations offering services under contracts with county councils.' (2003:14). With this in regard: What does is then mean that the welfare state or extended state politics are being challenged? These challenges underlie the idea of 'new times' (Whitty et al 1994:190) requiring what Rose terms 'new modes of government' '(Rose 1991:18-20). As one of my interviewees puts it:

'[…] vi har tidigare undvikit att sätta diagnos på tillståndet på flyktingar, utan vi har kunnat genom någon form av ömsesidig dialog, förklara för varje individ hur livet och deras tillstånd påverkar dem […]. Tyvärr har, som jag upplever tillsammans med andra kollegor, samhället blivit hårdare och hårdare, vad gäller att se behoven hos flyktingar. Vad det gäller att med begränsad tid, utrymme och med mer begränsad budget, schablonmässigt och kategoriskt hantera allt detta som ett problem, då har många blivit ifrågasatta för deras tillstånd. Samhället behöver beskrivningar, de behöver veta att de lider av… *vad?*. De behöver en diagnos.'(Interview 2004-11-22).[9]

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[9] '[…] we have earlier avoided to diagnose the condition of refugees, instead we have thorough some sort of mutual dialogue, explained for each individual how life and their condition is affecting them […] Unfortunately, as I experience together with other colleagues, society has become tougher and tougher when it comes to seeing the needs of refugees. When it comes to, with limited time, space and with a more limited budget, stereotyped and categorical handle all this as a problem, then many have been questioned for their condition. Society needs descriptions (Interview 2004-11-22).

An image of need asserts itself in the material. One pattern of consistency in the interviewees' self-understanding lies in viewing trauma as an indicator for particular attention. Thus, even though the Swedish Health and Medical Service Act, encourage health care independent of 'culture' and 'ethnicity, equally there seems to be an agreement on the epistemological character of refugees, by recognition of their *need* of particular attention. The agreement is supported by the importance given to social determinants, in affecting mental illnesses of refugees, as traumatic experiences together with migration related factors explain why refugees mental states are object for extended attention. One interviewee state:

'[…] primära orsaken till deras ohälsa är ju de här traumatiserade upplevelserna. Sen finns det ju sekundära som handlar om migrationsrelaterad stress, utanförskap, segregation, ekonomiska svårigheter.' (Interview 2005-02-03). [10]

According to the interviewees treatments based on a 'refugee identity' then exist because society or individuals need it. In a report written by the Swedish Public Health Committee (Nationella Folkhälsokommitteen) in 1999, health strategies that recognize socio-political and cultural conditions surrounding immigrants (and refugees) are part of a national public health agenda, in which integration of citizens into society is inevitably linked to health issues (Underlagsrapport 13, 1999:35-37). It is stated the well-being of immigrants and refugees in terms of 'good health' and 'integration to the Swedish society', require health policy adjustments. In a sense, it is therefore the social determinants surrounding refugees, that constitute a legitimate ground for strategies that recognize differentiated needs - if welfare is supposed to be for all. Whether this recognition is a sign of targeted health politics, is not yet evident in our discussion. Earlier, we discussed targeted welfare strategies in terms of moralities that consider 'diversity' or 'freedom of choice' as principals to which strategies should be directed. And as challenges to universalistic welfare we also briefly mentioned that these appeal to 'new times'. With reference to Blomqvist and Rothstein's account on *equal access* and *equal treatment* as core principals of Swedish welfare, questions sprung of acknowledgement of diversity, are challenging universalistic health care in which the Western welfare state is ignoring the 'new multicultural West' (Henderson & Petersen 2002:126).

In this 'new times', one is asking whether refugees have *equal access* to health care, in spite of example language barriers? And with regards to ethnicity as a factor upon which

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[10] […] the primary reason for their bad health is these traumatic experiences. Then there are secondary ones, that are about migration related stress, exclusion, segregation, economic difficulties.' (Interview 2005-02-03)

one is valued, refugees are thought to have difficulties to be *treated equally* in the medical sphere. Other times acknowledgement of diversity in lies in claiming that, in order to realize 'welfare for all', special attention should be given to diverse experiences of refugees, such as 'ethnicity', 'cultural values' and 'trauma', in the new multicultural Sweden (Törnell 2003:258-261). The notion of 'diversity' is important for our discussion for two reasons. Firstly, claims about welfare as gender or ethnicity blind, raise interesting questions about the integrating welfarist rationality. Voices with a political agenda are, as mentioned before, question whether the presumed *integrating* function of mutual health institution always is preferable for everyone. And instead they assert that there are circumstances in which *heterogeneity* and awareness of *difference* is of greater importance. Regarding this topic, Blomqvist and Rothsteins account of *strategic maintenance of solidarity* and *social integration* can give rise to a more problematizing approach on the particular attention that is given to 'the refugee patient' in health policy. How are other groups (and their will to pay taxes for the maintenance of welfare) affected by welfare politics targeted to this particular group, that is services that do not include them? And how is solidarity and understanding maintained if people do not 'meet' in mutual and equal health settings? Secondly, diversity as a challenge for generalized welfare politics, is interesting when targeted politics are offered as solutions for the negligence of gender, ethnicity, religion or family values, that is factors that are thought to influence whether welfare services are accessible for everyone or not (Vogel *et al* 2002, Arbetslivsinstitutet Report 96).

In order to make the link between targeted health care and extended attention more clear, it is necessary to discuss practices and strategies that demonstrate targeted health care as solution or adjustments. As concluded before, appeals on how *social conditions affect health conditions* legitimatize that immigrants and in particular those with refugee background, should be subjected to extended attention in Swedish health care policy (SOU 2000:3). Social determinants can be those specific to the origin countries of the refugees (war, poverty, torture etc), but also societal conditions such as discrimination, racism or exclusion in the 'new' country where they have been granted citizenship, are concerns for health policy (Törnell 2006:268). Many times this acknowledgement of social and cultural factors as determinants for health condition, is transformed into specific strategies that health care workers act upon, for example the awakening of 'cultural understanding' as a way of health care services more responsive to the need of all societal groups (Henderson & Petersen 2002:126). Besides strategies that: '[…]

suggests that municipal authorities with public health responsibility and health related issues, should regularly report on the living conditions and health of different ethnical groups in comparison to the general population.', national health and welfare agencies repeatedly underline that it is necessary to 'reinforce cultural and linguistic competence of personnel within health care […]' (Nationella Folkhälsokommittén Underlagsrapport 13, 1999:40)[11]

Clearly, the conditions which are thought to accompany ethnicity or 'refugee identity', make up the 'high risk' or 'high need' of this group, which not only decides the rationale to *know*, but also directs targeted regulation toward 'the most problematic' - to put it in Marina Valverdes words (in Rose 2001:2). For example, in a report from 2000, where the responsibility of authorities for the maintenance of public health is discussed, 'Immigrant' is one category among others such as 'Tobacco', 'Allergies', 'Sexuality Transmitted Disease', that is seen as problematic and require targeted care when it comes to health of the population. (Nationella Folkhälsokommittén Underlagsrapport 19, 2000:6-10).

Let us bear in mind that market regulations also take part of the idea of 'new times'. In moral form considerations of 'freedom of choice' and 'individuality', marketization of welfare is also regarded as a solution to failures on the part of welfare politics. (Oakley 1994:8) Welfare reforms by means of privatization and entrepreneurs, are viewing 'free markets' or 'diverse markets' as responsive to people's *different needs*. As it is stated the '[…] Swedish government […] is now supporting the development of a diversity of management forms. It intends to enable a diversity of private, cooperative and non-profit entrepreneurs to be involved in the delivery of primary care. Delegating responsibility to local managers of facilities will enable greater innovation and adapting to local needs and circumstances.' (Hutton & Engqvist 2003:14). This means the rhetoric of differentiation and need can be traced in de-collectivization of welfare, since targeted strategies by private providers are regarded as *responsive to the need*. This responsiveness is equally valid for immigrants and refugees (Blomqvist & Rothstein 2000:36;47;125-12). It is however important to underline a distinction between market regulations on the health area and targeted health care. Evidently, targeted health care does not necessarily imply that private health providers are welcomed. Although it should be clear by now, I will stress that private regimes are not the only strategic field within which health treatment for a particular group is provided. Contrarily, targeted health treatments for refugees

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[11] My translation.

are constituted by cooperative strategies ranging from state (in the Swedish context: county councils) regulated health care centers for refugees, lobbyists to NGO:s dealing with mental health care for refugees . What these strategies have in common is, as argued before, that they appeal to what Tomas Lemke calls 'a reality they suggest already exists.' (2000:13). Even though most of the debate on welfare circles around targeted politics in term of a retreat of government or an non-intervened state, our line of reasoning will therefore not take conflicts between *possibilities for responsive or attentive care* and *an intervening state*, as given and unproblematic. Meaning that, targeted health care is, although challenging universalism, not a matter of strategies beyond the idea of welfare state, but incorporated in the very idea of a government that requires *knowledge* of the fields acted upon (Tyler 1997:78-79) . From this perspective, health care for 'refugee patients' clearly is a political issue since health and illness (normal and deviant, death and birth) are political and economic issues related to societal factors; for example what Denise Gastaldo mentions as labor force, economic growth and distribution of wealth (1997:113-115).

4.2 National Health and Global Health

Up to this point, we have addressed welfare both as a conceptual tool, and also as something more than an abstraction. Briefly it has been mentioned that it can, in a Swedish context, be understood to consist of the following core services: education, social security, personal social services and the National Board of Health and Welfare (Bergmark 2000:395-411). Besides being a matter of welfare, health care is also a question of political discourse on an international level. Echoing the critique of the biomedical framework of health during the 70's, issues such as poverty, migration, racism are currently prescribed as having fundamental connections to health - a view than is not only promoted by the WHO, but also acknowledged through national policy (WHO 1997:21;1998). As a form of critique of health in terms of quantifiable variables, social and cultural determinants of good health are the center of attention in health policy and the practical realm of health care (Webb and Wright 2000:88). Thus, references to 'collective cultural

patterns and behaviour' in the health care, can be understood in the light of the importance that is given to factors such as income, social class or status and gender - in relation to good health. Then 'social and cultural determinants' are evidently being considered in relation to other groups than just refugees. And patients are no where only patients: we are 'women patients', 'poor patients', 'middle-class patients' and so on. The reader might ask here: Why is then the strategies that target 'refugees' an interesting case? In defence of the questioning stance that is taken in this thesis, a central line of reasoning is that 'cultural awareness' and acknowledgement of 'The refugee identity' run the risk of confirming stereotypes about 'the Other'[12], that is fixing categorisations or essentializing differences.(Fioretos 2002:148,154; Eriksson *et al* 1995) The question is then not whether or not difference is valuable in relation to good health, but rather how institutionalized practices can be regarded as having power implications. In the light of our discussion about 'cultural understanding' in the health area, we will therefore turn to questions concerning 'the refugee patient' as someone 'different'. As argued before, the rationale for 'cultural understanding' in health care is frequently discussed in terms of strategies to visualize that which is decisive for the well-being of people whose experiences differ: '[…] For the Swedish [health care] personnel working with people with a different cultural background, it [cultural understanding, *my remarks*] implies getting to know their customs and traditions, their way of thinking and if possible their languages.' (Ekblad *et al* 1996:4 in Fioretos 2002:152) Hence, emphasis is put on either 'difference', 'culture', 'ethnicity', or 'refugee' as categories to which consideration should be taken when health care is provided - in order to maintain good health. For the purposes of this study, a look upon *presumptions* about concepts such as 'culture', 'refugee' and 'ethnicity' are of importance. Who is 'the refugee patient'? In order to discuss how concepts such as these compose the targets in targeted health care, we will turn to the interview with the 'refugee patient'. When is she emphasizing the importance of being different and when is she stressing the opposite? When is difference positive and when is it negative?

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[12] Within social theory, the notion of 'the Other' is discussed in terms of binary constructions between 'us' and 'them'. Difference and 'the Other' as analytical categories, are thus referring to identity *construction* of 'us' in opposite relation to a 'we', with the assumption that there is no essentiality in neither (See Fioretos 2002)

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4.3'The Refugee Patient'

4.3:1 Different Yet Not Strange

Initially in the interview, an emphasis on racism is put when explaining experiences of health treatments. The interviewee talks about 'rasistiska läkare som inte ville ta på min kropp'[13] (Interview 2004-10-17), and also recalls a scenario where a group of people (including a doctor among them) at a camp was disbelieved when asking for help for her sick child. Besides referring to this incident as a negative one, the interviewee connects this sense of maltreatment to the deviancy of the group:

'Sköterskan sa: "På måndag kommer läkaren.. ni får vänta. Du må vara läkare i ditt land, här är du *ingenting…*"[14] (Interview 2004-10-17)

Differently put, there is in her story a sense of powerlessness connected to the being 'different'. Within health care, experiences such as this make up evident reasons for why 'cultural awareness' or acknowledgement of difference is important in grasping what is a suitable case for treatment. That recognition of difference sometimes is valuable in the health area, is something the interviewee confirms.

'Jag säger inte att flyktingar är bättre individer…men man har inte samma upplevelser.. Viljan att komma är inte samma. Vissa har varit tvungna….olika skäl. På den tiden fanns inte läkare som kunde det här med flyktingar… Men det finns ju nu…'[15] (Interview 2004-10-17)

At the same time, in the episodes of maltreatment, the interviewee states:

'Det handlar inte om yrke…utan hur man är som människa. En bra läkare som är utbildad för att hjälpa människor, bryr sig inte om varifrån man kommer.'[16] (Interview 2004-10-17)

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[13] 'racist doctors who didn't want to touch my body' (Interview 2004-10-17)

[14] 'The nurse said: There will be a doctor here on Monday…you will have to wait. You may be doctor in your own country…here you are *nothing…*' (Interview 2004-10-17).

[15] 'I am not saying that refugees are better individuals, but you don't have the same experiences. The desire to come is not the same. Some have been forced…different reasons.. Back then there were no doctors who knew about this with refugees….but there are now.' (Interview 2004-10-17).

[16] 'It's not about professions, but how you are as a person. A good doctor who is educated to help people doesn't care where you come from.' (Interview 2004-10-17).

Does this mean that the interviewee is referring to 'difference' as something one should not care about? Well, both yes and no. In the course of the interview it is apparent that being viewed as 'different' is paradoxical, complex and contextual. On one hand, the interviewee talks about her difference as a sort of obstacle that stands in the way for being treated independently of where you come from. And on the other hand, she talks about recognition of her background and history as something that is included in a positive experience of medical care. When being acknowledged by health care personnel and asked to share her obvious difficult experiences, the interviewee recalls this as a positive moment.

4.3:2 A Victim of…What?

'Victimization' is frequent theme in the field of socio-medical work with refugees (Hjern *et al* 1996: Angel & Hjern 1992). There is a sort of an agreement on the need of refugees to be taken well care of, because they are *victims* of some kind. When refugees are thought to be either traumatized, in grief, in psychological conflicts, or rootless because of being different or in exile, these differences make up suitable categories for treatment. In my material there are however indications of challenges of discourses on victimization. In the interviewee's explanations of both maltreatment and being taken good care of, she expressed an unwillingness to be pitied:

'när du kommer till ett främmande land…är du ingen 'stackars dig'.. inte en konstig person…[…] du mår inte bra mentalt, så… personen som ska ta hand om dig ska se… att du vill bli bättre. Jag kände att jag behövde hjälp.. inte någon som ställer frågor hela tiden… Man vill att någon frågar:' *Vill* du…berätta? Vill du det?´ Det är lättare att göra bedömningar så.. inte någon polis som frågar. (Interview 2004-10-17).[17]

In retrospect, I speculated upon the interview's dislike of being pitied, as a way of distancing herself from discourses on victimization. With this in mind I also speculated on how I reacted on

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[17] 'when you come to an unfamiliar country…you are not a 'poor you'…not a strange person…[…] you are not feeling well mentally, so…the person who is going to take care of you is supposed to see…that you want to get better. I felt that I wanted help…not anyone asking questions all the time… You want that someone asks: "*Do you want….to tell? Do you want that?*" It is easier to make judgements that way….not a police asking questions..' (Interview 2004-10-17).

her discomfort of being pitied. While the interviewee herself initially associates good medical care to 'contact thorough the human' (Interview 2004-10-17), there is a sociological question mark to a statement of something being 'human'. From a constructive perspective it would be reducing simply to show that the interviewee is confirming the powerlessness of refugees when stressing the need for cure or treatment. There are as well indications of the contrary; that presumption about refugees as victims is not something the interviewee necessarily wants to relate to. Being viewed simply as 'human' is in the interviewee's point of view, preferable compared to being pitied - that is seen as a victim. Within sociological theory, there are constructivistic approaches that problematize different notions and images of victims by stating that there is no essence to being a victim. Instead, notions of what and who is a victim, are regarded as social and political products. (Åkerström 2001:278).

5. Health Care Service for Refugees

In this section we will take a closer look upon health care service for refugees by addressing the following questions: How are refugees subjected for psychological statements about pathology versus normality? What dominant psychological diagnoses is medical and psychological expertise resting upon when treating refugee related illnesses?

A concept of commonly used when refugee related illnesses are highlighted is: *Post-Traumatic Stress Disorders*, PTSD (Sondergaard 2002; Törnell 2003:263). It is a relatively new diagnostic category, even though pathological reactions to trauma, war and violence have been recognized for a long time (de Silva 1998). First appearing in the third edition of American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM III) in 1980, the diagnostic category is connected to post-Vietnam War USA (Yule 1999: 3-5; de Silva 1999:118). Besides being a product of its time, PTSD can also be related to the development of DSM. DSM III, in which PTSD is recognized as a syndrome, is often seen as a response to the crisis in legitimacy of psychiatry in the 1970s. Nikolas Rose discusses this response in terms of a new way of seeing mental disorders as illnesses that are followed by '*a set of o*bjective criteria' and responsive to a '*specific kind'* of treatment. This explains, according to Rose, why the number of categories of psychiatric illness recognized in DSM has increased so rapidly a long with each edition. The latest DSM IV (1994) defines nearly 350 categories of psychiatric illness (Rose 2001:3). Regarding DSM's influence in terms of power and control, Laing has stated that DSM is 'very useful for controlling the population because you can bring [the criteria, *Eckerman's italicization*] to bear on practically anyone if the occasion seem to demand it… a mandate to strip anyone of their civil liberties.' (Laing 1998:61 in Eckerman 1997:163).

Internationally, PTSD as defined by the APA was sanctioned by the World Health Organization in the tenth edition of *International Classification of Diseases* (ICD) in 1993 (Yule 1999:5). In the wake of this international recognition many accounts of explanation have focused on the causes PTSD and the correct care of it. Nevertheless, PTSD is a socio-political product that is, in scientific debates, discussed in terms of how societal responses to the Vietnam veterans was affecting the medical and clinical search for symptoms of disorders. Further on, there are

scientific acknowledgement of how an insurance-based North American health care system (and not a socialized medical care) where symptoms lead to compensation, could possibly have influenced the outcome of PTSD as a diagnostic categorization (Yule 1999:3; Interview SRCRC 2004-11-22). In one of the interviews this ongoing scientific debate is of evident importance in explaining the relevance of PTSD in their work with refugees. As a way of pointing out the sensibility of PTSD to subjective contra objective judgements, the interviewee gives the following scenario:

'[…] har alla läkare och psykiater som har ställt den här diagnosen verkligen följt noga de kriterier som måste uppfyllas för att man ska kunna ställa en sån här diagnos? Eller har de schablonmässigt; aha, du kommer ifrån det stället, du har upplevt krig…ah, ja, PTSD?! Alltså det problemet finns också, det finns ett stort mörkertal, många människor med PTSD som inte söker hjälp, men det finns också ett stort tal…så att säga, överdiagnostiserade, det finns många människor som har, lider av olika former av förluster, depressioner, sorger och kris som diagnositeras med PTSD, tyvärr på grund av deras härkomst'. (Interview 2004-11-22).[18]

Considering PTSD as a political and social product, the interviewee pays attention to possible outcomes, in terms of a critical view on how overrated connections between 'origin' (that is culture, ethnicity, nationality) and PTSD indeed are present in the medical and psychological sphere.

Since there is an understanding of *trauma* incorporated Post-*Traumatic* Stress Disorder, most of the academic inquiry on PTSD, implicitly or explicitly include references to *experiences* of trauma or *reactions* to trauma (Yule 1999:10-12). Despite an absence of an agreed definition of what exactly causes PTSD and how it should be treated, there is little psychiatric doubt that reactions to trauma are indeed clear cut cases for the psychiatric and psychological sphere. The ambiguity of PTSD means that it all boils down to interpretations. DSM together with ICD have invoked definitions that are indeed, although contested, dominant in the practical realm. Practitioners at Swedish Red Cross Rehabilitation Centre (for traumatized refugees) assert that: 'Merely experiencing a trauma is not an indication for treatment in and of itself. A significant trauma-related symptom, such as the presence of PTSD or depression, justifies treatment'. (Lidforsen *et al* SRCRC 2005:3). Following DSM's definition, trauma can then

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[18]'[…] are the doctors and psychiatrics who have made this diagnoses, really following the criteria that must be fulfilled in order to diagnose. Or have they in a stereotyped manner, oh, you are from that place, you have experienced war, oh yes, PTSD?! Meaning that this problem also exists, there are underreports, many people with PTSD that do not seek help, but there are also a great amount of.. sort of speak.. over-diagnosed, there are many people who have, are suffering from different forms of losses, depressions, grieves and crisis, who have been diagnosed with PTSD, unfortunately because of their origin' (Interview 2004-11-22)

evolve 'normal reactions' to abnormal events (Yule 1999:10-11), which consequently makes PTSD an indicator of abnormality.

Abraham de Swaan's inventory of the scientific debate on war survivors' mental condition (trauma) asserts the fact that these are clearly centered on topics such as causes of diseases, diagnoses and the correct organization of treatment (1990:195). If not making up a clear majority, the applied use of PTSD and trauma (including what my empirical material shows) is similarly seldom involved with critical perspectives on 'mental illness' or 'mental health care' (Petersen *et al* 2002:121). Instead, a great deal of the debate within the practical realm of mental care for refugees with PTSD is, as de Swaan argues, concerned with the illness in itself, leaving out critical and self-reflexive views of the practices and strategies. A self-understanding that is not critical, is consequently also withdrawn from political and moral discussion (Hansson & Svensson 1994:131-133).

What I would like to add to this is that targeted health treatments for refugees are also withdrawn from critical views on what presumptions about 'ethnicity', 'culture' or 'refugee identity' means in a broader perspective. Let us take a closer look upon how categories as 'culture' and 'refugee' can be used. Practitioners at the Swedish Red Cross Center Rehabilitation Center state that cultural values are one central category to which help should be directed when trauma is addressed: 'The experience of trauma has to be understood in the context of the client's life experiences, cultural values, as well as his/her expectations.' (SRCRC 2005:8). Another assumption is one which concerns 'the refugee patient': 'refugees are people uprooted against their will and have left virtually everything behind. This part of the job [trauma rehabilitation, *my remark*] deals with two simultaneous goals, to investigate and to sorrow the lost of social, professional and individual identity'. (*ibid* 2005:9). Again, these references to 'culture' and a 'refugee identity', are understood in the light of adjustments that welfare is making to the expected 'different needs' of people. Differently put, they can also be understood in terms of the presumed importance of social and cultural determinants for health and illness, and strategies that seek to reinforce 'good health for all'. As mentioned before, our analysis will not question why health strategies are taking social and cultural determinants under consideration in order to provide 'good health'. Neither is 'good health' put in question. Evidently, there is something such as 'good health' and evidently subjective experiences of trauma, torture, poverty and discrimination are affecting the well-being of individuals. How are we then putting health

treatments in question? What is argued in the thesis is the importance of critical discussions about what is included in categories such as 'culture', 'refugee', 'ethnicity' when these are directing the targeted care. How are these categorizations made and in relation to whom? Ingrid Fioretos is, in an article about 'cultural understanding' within Swedish medical and health care, critical of the use of 'culture', 'immigrants' or 'refugees' within health care, since they are indicate fixed or essentialized categories. She suggests that they merely are constructing differences between 'us' and 'them'. As an example she mentions that a refugee identity that is presumed to be 'uprooted' also implies indications of roots that are historically and politically established in the 'Swedish earth'. To generalize about refugees in term of homogenous or fixed categories, is therefore in this metaphorical way of reasoning, the same thing as confirming stereotypes about 'the Other' and at the same constituting a 'we'. (2002:165-166). Fioretos rightly conceptualizes an image of roots in terms of adjustments to a new society. Prevalent throughout my interview material is an acknowledgment of medical treatments and rehabilitation for traumatized refugees in terms of its necessity for integration. One interview shares the following metaphor when stressing why targeted health care for refugees is necessary for the integration process:

'En människa som förlorar 80-85% av sin inlärningsförmåga, koncentrationsförmåga, och kommer till ett nytt samhälle där A och O är att ta in så mycket som möjligt utav språket, kultur och navigeringsstrategier för att kunna så fort som möjligt bli självständig och därmed kunna så att behålla så att säga värdighet och självbild, så är det en fullständig nödvändighet att människan måste kunna gå innan man kan kräva att han eller hon ska spela fotboll… i ett lag dessutom vars regler är fullständigt okända jämfört med den bollek man hållit på med hemma. Om man inte kan gå och plötsligt ska spela fotboll, så är det minsta man kan kräva att man ska kunna använda sina fötter. Utan då… ja, det säger sig självt.' (Interview 2004-11-22).[19]

But it this really the case that it, in the interviewee's words, 'goes without saying'? It is really self-evident that integration is facilitated by health practices, when these equally could be considered as *dividing practices*? The image of integration is also evident in the following:

'Det går inte att bara sätta de på skolbänken och sen fixa jobb, allt frid och fröjd och sen ska de integreras. Problemet är att vi inte kan integrera dem, om de inte först får rehabiliteras. Eh, när man drabbas av posttraumatisk stress som så många gör.. jag har precis en studie som jag har på skrivbordet, också från Karolinska, eh, där man påvisar att när man drabbas av posttraumatisk stress så *kan* man inte studera.' […] Lika lite som man skulle kunna kasta in, när

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[19] 'A person who loses 80-85% of his learning ability, ability to concentrate, and comes to a new country where it is crucial to absorb as much as possible the language, culture, and navigation strategies in order to, as soon as possible, become independent and hence be able to keep dignity and self-image, sort of speak, then it is totally necessary that this person will have to be able to walk before one demand that he or she is to play football.. in a team with totally unknown rules, compared to the ball game you have been engaged in back home. If one can not walk and suddenly is supposed to play football, then the least one can ask for is that one is able to use one's feet. Without it, well, it goes without saying. (Interview 2004-11-22).

Estonia-katastrofen var, alla de överlevande om man föreslog då att någon månad efter att det här hade hänt, att de skulle sätta sig på skolbänken och lära sig arabiska, åtta timmar om dan.' (Interview 2005-02-03)[20]

Apparently, PTSD (or trauma) is figuring in terms of obstacles for membership into society, which means that *normalizing practices* are in the interviewees' stories the same as *integrating practices.*

I have argued in this thesis that the attention paid to the epistemological character of refugees, is thought to target areas which include a better understanding of the needs of refugees in relation to good health and well-being. Further on, question have been raised about whether these targets are resting upon generalizations about 'ethnicity' and 'culture' and a 'refugee identity'. 'Cultural understanding' could then be the same as a search for essentials of 'the Other'. This search can be illustrated by the following sentence in a book written for improving health care personnel's understanding of Muslim women: '[Muslim] women are very embarrassed of their bodies. When a women goes outside the home, she must always be accompanied by a man. If the husband or the father follows her, he is always the one who answers questions that are posed to the wife or the daughter.' (Hansson 1998 in Fioretes 2002:158 *my remark*). When generalizing points such as these are thought to enhance a transcultural understanding within health care personnel in Sweden, one wonders: But what about the medical practitioner's own values and views in the encounter between refugees and medical care? As longs long acknowledgements of essentiality in 'ethnicity' and 'culture' are thought to improve the way health is provided to 'the Others', one also wonders whether 'cultural awareness' or 'cultural understanding' do have integrating effects or if they also can be regarded as differentiating the Other?

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[20] 'It is not possible to put them in class and then fix jobs, everything all good and then they are supposed to be integrated. The problem is that we can not integrate them, if they are not firstly rehabilitated. Eh, when you are stricken with posttraumatic stress as many are.. I have a study on my desk, also from Karolinska, eh, where it is shown that when one is stricken with posttraumatic stress it is not possible to study' […] Just as unlikely that one would put, at the time of the Estonia catastrophe, every survivor, if you would suggest then that a month or so after this had happened, that they would be put in class and learn Arabic, eight hours a day. (Interview 2005-02-03)

6. Summarizing Discussion

Welfare Adjustments to Difference and Diversity?

In the thesis it has been argued that recent patterns of de-collectivization of welfare is an important clue for the understanding of targeted health care. With references to principals and ideas to which welfare strategies are directed, it has been shown that patients are 'patients with different needs' or 'diverse experiences'. Conclusions have been drawn on the importance of appeals on diversity, when universalistic welfare is challenged and targeted health care is regarded as responsive to the *need* of for example refugees. We have concluded that this rhetoric of 'different needs 'is included in the epistemological character of those who differ in terms of health provider's acknowledgements of culture, nationality, ethnicity or refugee identity. In the case of medical and health treatments of traumatized refugees, it has been stated that this group is targeted with references to both 'high need' and 'high risk' - that is, multiple factor affecting the social and psychological well-being of refugees. Acknowledging experiences that differ and also affect the well-being of refugees, we have discussed that strategies to achieve 'good health' for all, are locating the problematic within social, cultural and psychological conditions such as, migrations related conditions, discrimination, racism, exclusion and trauma. However, in this line of reasoning we also acknowledged that the question of *need* is complex, and that appeals of diversity has to be considered in relation to a broad spectrum of forces dealing with 'welfare for all'. Meaning that, appeals on diversity and difference have obvious political implication for refugees in terms of their right to good health or good treatment in the health are.

It is difficult to draw any general conclusion from my study. Although theoretical perspectives on welfare turned out to be relevant in the context of 'medical and health treatment of refugees', it is difficult to know whether these practices are directly dependent on welfare changes. Even though it has not been my intention to argue that targeted health care, as appeals on diversity, would not exist without de-collectivization and welfare reforms, I still think that it is important to make this remark. Thus, regarding the importance of de-collectivization and welfare reforms, I believe that the validity is in need of further investigation. I suggest an idea historical

focus on appeals on diversity in relation to clear time distinctions for example in Swedish health policy.

Adjusting to Diversity or Differentiating 'the Other'?

Having discussed the emphasis that is been put on social and cultural determinants in health care in terms of 'cultural understanding' and 'cultural awareness', we approached targeted efforts that deal with determining how refugees differ and how health care should adjust to these differences or diverse experiences. Health adjustments to the 'different need' or 'diverse experiences' of refugees, were in the thesis addressed with from a critical perspective, not so much with regards to the efforts to maintain good health for refugees, but instead by underlining that there are risks attached to the 'targets' *as long as they are with-drawn from critical discussion*. Differently put, although we asserted that 'difference' in the health area have constructive dimensions, there is no question mark attached to different needs and diverse experiences *per se*. When health care for traumatized refugee was discussed in the thesis, trauma was the obvious determinant we addressed. In this discussion attention was given to trauma diagnoses as social and cultural products. With all of this in mind, what was then discussed as risks, when a group such as refugees, are subjected for targeted health care? Firstly, by drawing attention to a view on 'refugee identity' as a product of expertise, knowledge and power, we acknowledged that this is interesting since it allows that identity is regarded as fragmented and contextual. In accordance with this I secondly argued that, the search for the 'culturally and ethnically different patient' or 'refugee patient', runs the risk of being a search for essentiality and generalizations about a culture or about refugees. In institutionalized health practices that target 'the Other' there is, in other words, the risk of jeopardizing multicultural or diverse needs, by essentializing 'the Other'. In the discussion we questioned for example why 'cultural awareness and understanding', which is resting on assumptions about the Other, does not include medical and health practitioners' own cultural view?

In this light I suggest further research on the relations between identity constructions and the importance of difference - a theme that generates questions that are suitable for an identity perspective or for discussions concerning how appeals on diversity and difference

can *make a difference*, that is providing good health for refugees. Another interesting line of inquiry would be to focus on appeals on diversity with regards to the relations between civil society and institutionalized health care.

Postmodernism - an Apolitical Affair?

Since health care has been addressed with the help of postmodern themes and guidelines in this thesis, a final reflection upon postmodern health theories will also be taken. With initial thoughts and reflections on methodological implications of what was mentioned as the theoretical 'post-landscape', I finally decided that health care was going to be approached from this perspective with some reservations in mind. The reservations was primarily concerning the political dimension attached to an issue such as health and how I could discuss health in a constructivist vein without neglecting that refugees are experiencing torture, war, racism and other circumstances related to migration and exile. My material demonstrated both a refugee's unwillingness to be pitied and seen as a victim on one hand. With the help of a discussion on discourses on victimization, I attempted to argue that the 'deviancy' of refugee identities - be it in the sense of victimization, strangeness (different) or normality - is not an absolute or Natural condition. Rather it is changeable and contradictory. On the other hand, there were evident indications of the assumption that conditions *particular* for refugees, are important for the well-being of refugees and the way they are treated within the health area. Of course, when 'different need and experience' is acknowledged in a refugee context, this can be done with a political agenda which is in defense of refugees *right to good health* and *good treatment* in the practical realm of health care. Considering this, we have concluded in process of analyzing, that postmodern health theory rarely challenges the idea of good health as an universal good. And hence, the attention that is given to strategies that regard health care for refugees in pathological terms or with references to bad health, was not questioned in that matter in the analysis.

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Appendix

List of Interviews

Interview 2004-10-17 with a refugee who has gone through treatment for trauma.
Interview 2004-10-17, psychiatrist working at a Refugee Trauma Center.
Interview 2004-11-22, psychologist at Swedish Red Cross Rehabilitation Center.
Interview 2005-02-05 psychologist at Barn- och ungdomspsykiatrin (with special competence in refugees).

Intervjuguide

Inledande:

- Kort om min uppsats, presentation, motiv.

Möjligheter och begränsningar

- PTSD ett centralt begrepp inom arbetet med traumatiseradeflyktingar. Vilka möjligheter och hinder anser Ni PTSD medför?
- Hur beroende är ert arbete av politiska beslut eller politiskt klimat? Vilka riktlinjer/policyn grundar sig ert arbete på?
- Innebär förekomsten av symptom på psykisk ohälsa nödvändigtvis ett behov av behandling och hjälp?
- Vad särskiljer normala reaktioner från patologiska reaktioner, på extrema händelser?
- Finns det situationer där utlåtanden eller omdömen är svårare att genomföra? Vilka?
- Hur, när eller på vilka grunder utvärderas hjälpbehov och behov av behandling?

Integration och välfärd

- Kan det tänkas finnas övergripande integrationsstrategier i ert arbete? (Skillnad mellan myndighet och organisation?) Del av integration?
- Vilka kopplingar, anser ni, att det finns mellan hälsa och integration?

Flyktingar och hälsa

- Vem den "sjuke flyktingen"? Går det att generalisera eller är det individuellt?
- Vilka huvudsakliga skäl skulle Ni anse till flyktingars och asylsökandes ohälsa?

- Vad är Er uppfattning om asylprocessens påverkan på flyktingarnas mentala hälsa? Livet i exil?

Arbetsmetoder och strategier

- Finns det skillnader i Era arbetsmetoder beroende på om personerna har fått uppehållstillstånd eller inte?
- Vad det gäller arbetet med flyktingar som inte fått uppehållstillstånd: Anser Ni möten med läkare och psykologer (eller vårdpersonal) vara en del av asylprocessen eller är det en separat del?
- Finns det speciella riktlinjer att följa som skiljer sig från andra typer av bedömningar av mental hälsa?
- Hur mycket information och vilken typ av information om flyktingarna får Ni ta del av?
- Skiljer sig arbetet åt beroende på om det är män, kvinnor eller barn det är frågan om? I så fall, hur?

Övrigt

- I svensk asylpraxis är ett asylskäl "humanitära skäl". Vad är humanitära skäl ur er, dvs medicinsk eller psykologisk, synvinkel?
- En mycket öppen fråga: Finns det, enligt Er mening, några likheter mellan läkarbedömningar av flyktingar och de bedömningar som görs på Migrationsverket?