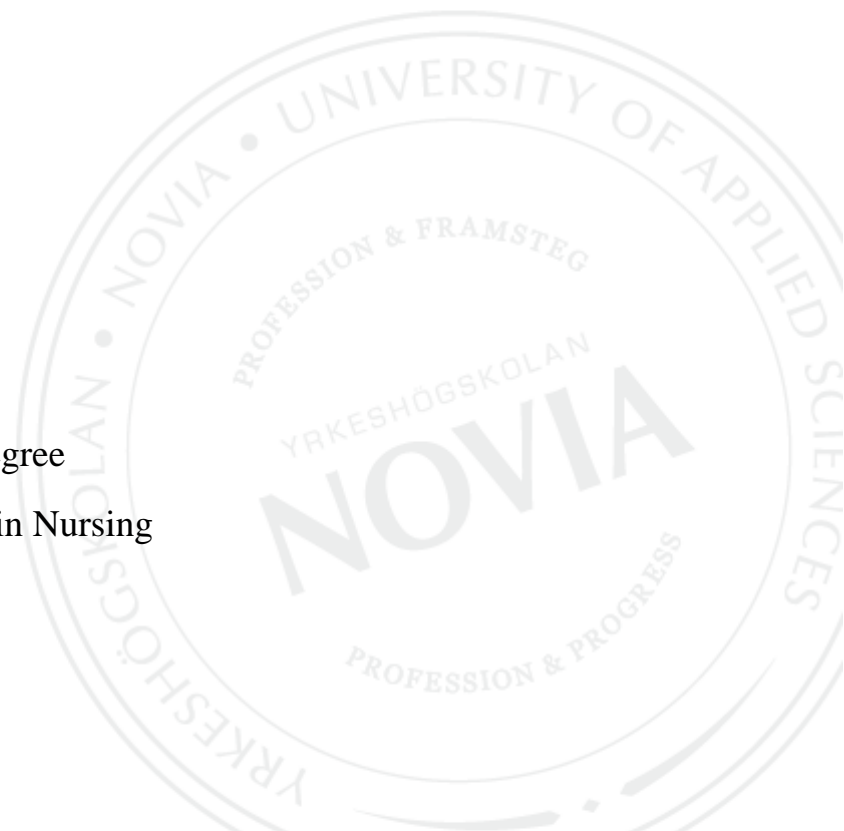


**“Experiences of Adult Immigrants with Posttraumatic  
Stress Disorder – Challenges for Nurses when providing  
Evidence-based Nursing Care”**

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## Abstract

Post Traumatic Stress Disorder remains a chronic psychiatric disorder affecting significant number of people exposed to traumatic events. This has created a significant morbidity among sufferers and shows a substantial impact on health systems, society and the person's daily living activities. The aim of this study is to describe how immigrant patients with PTSD experience nursing care.

Collection of data were accessed through Nelli portal database and qualitative content analysis was used to abstract findings and the findings were grouped according to similar themes. Three main themes emerged from this data analysis ranging from communication need, somatization and need for psychological support and cultural influences affecting diagnosis. With high percentage of displaced people currently increasing around the world due to push factors of migration, there exist a high challenge in the field of mental health. Nurses remain the primary healthcare professionals to bear the most burden, so there is need for culturally congruent care to achieve good quality of care based on evidence-based practice. The results highlighted different interpretation of experiences by immigrant patients and this suggest that there is need for nursing be culturally competent during nursing care delivery.

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Language: English    Keywords: Post-traumatic stress disorder, Culturally congruent care, nurse-patient relationship, Qualitative content analysis, Immigrants.

## Table of contents

1	Introduction .....	1
2	Aim and Research Questions.....	2
3	Theoretical background and previous studies .....	2
3.1	Post Traumatic Stress Disorder.....	3
3.2	Clinical features of PTSD .....	3
3.3	Symptoms of PTSD .....	4
3.4	Social Determinants .....	4
3.5	Assessment of PTSD .....	7
3.6	PTSD and family dynamics .....	7
3.7	Social support .....	8
3.8	Family and coping mechanism .....	8
3.9	Therapeutic Interventions in PTSD .....	9
4	Theoretical Framework.....	10
4.1	Hildegard Peplau's nurse-patient relationship theory.....	10
4.2	Madeleine Leininger's theory of culture care diversity and universality .....	11
	The Sunrise enabler: A conceptual guide to knowledge discovery.....	12
5	Research methodology .....	14
5.1	Systematic Review.....	14
5.2	Data collection .....	15
5.3	Qualitative Content Analysis .....	18
5.4	Ethical considerations .....	20
6	Interpretation of results.....	20
6.1	Communication need .....	21
6.1.1	Language barriers .....	22
6.1.2	Difficulty in developing trust .....	22
6.1.3	Fear of disclosure .....	23
6.1.4	Lack of trust in healthcare .....	23
6.2	Cultural influences affecting diagnosis.....	23
6.2.1	Cultural shaping of symptoms.....	24
6.2.2	Cultural expectations .....	24
6.2.3	Belief systems.....	25
6.3	Somatization and need for psychological support .....	25
6.3.1	Emotional stress.....	25
6.3.2	Sudden upsetting memories.....	26
6.3.3	Comorbidity of developmental and behavioral problems .....	26
7	Critical review .....	27
8	Discussion.....	28

WORKS CITED .....	30
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## **APPENDIX**

Figure 1: Contributing factors affecting onset of a mental health problem (adapted from the commission and social determinants of health. WHO, 2008). .....	6
Figure 2: Leininger's sunrise enabler to discover culture care. (M, Leininger 2004, page 325.).....	13
Figure 3: Findings for keywords searching .....	16
Figure 4: Flow chart representing Inclusion / Exclusion.....	17
Figure 5: Content Analysis using inductive approach.....	19
Figure 7: Abstraction process of various themes relationship.....	21

# 1 Introduction

In the last few years' war, famine and political struggle has increased migrations globally. The war in Syria added more displaced number of people to the ever growing figure and this has increased to 59.5 million displaced people at the end of 2014. Millions of people worldwide have been displaced from their homeland due to the recent increase from internal and external stressors ranging from conflict, persecution, human rights abuse and generalized violence (UNHCR, 2014).

The sudden rise of Post Traumatic Stress Disorder (PTSD) a psychiatric disorder associated with exposure to traumatic events among these growing populations of immigrants remain noticeable within our society. Different stressors associated with pre-migration and post-immigration traumatic experiences give rise to PTSD among immigrants. Traumatic exposure cannot be predicted or controlled and remains a perilous condition with the resultant outcome shown as PTSD (Carr, 2004).

Based upon statistical data, exposure to a traumatic event is somewhat a common experience among displaced people. Traumatic exposure often creates a comorbidity for other negative effects either direct or indirect responses including impact on level of functioning, law-breaking, substance abuse and thus leading to other traumatic exposures (Finkelhor, Ormrod & Turner, 2009; Ford, Elhai, Connor & Frueh; 2010). My major interest in conducting this study on PTSD started when I noticed significant rise in the number of immigrants coming from war zones and recent domestic violence among immigrant families in Finland. My interest grew stronger to conduct this study from a nursing point of view after much deep thoughts. Demographic statistics of people with different background is around 219,675 people living in Finland as of March 2014. This represent about 5.9% change in Finnish population of 5,480,840 (Statistics Finland 2014).

The need to understand and gain knowledgeable competence about this silent-killer disorder starts from me being an immigrant and prior knowledge about different associated symptoms and an appraisal of Finnish society from an immigrant point of view. Furthermore, some policy changes on immigration also put most immigrants at a high risk of developing PTSD. PTSD can exist also in healthy immigrant groups such students, work permit professionals or those married to host country nationals, after encountering mediating problems such as unemployment after graduation, stressful situation and discrimination at work places.

## 2 Aim and Research Questions

The study aim is to describe how immigrant patients with PTSD experience nursing care. This study intends to shed more insights about what kind of trauma people with PTSD pass through and competent ways to address the problem. Immigrants from different cultural background requires congruent culturally care when delivery nursing care. The research questions are:

- Which factors influence patient's experience towards nursing care?
- How can a nurse provide competent care to immigrant patients with PTSD without facing difficult challenges in care delivery?

## 3 Theoretical background and previous studies

The purpose of this chapter is to provide broad evidence and brief understanding about PTSD. Previous studies retrospectively examined PTSD in military personnel returning from conflicts zones and people with traumatic experiences. Previous studies on PTSD has been focused mainly on the behavioral and cognitive theories. Such theories as Horowitz (1976,1986) Stress response theory involves psychodynamic of informed observation during normal/abnormal thoughts processing, Jones and Barlow (1990) in Anxious apprehension model stipulates existence of similarities between panic attacks and traumatic flashbacks; Janoff-bulman (1992) social cognitive model suggests that trauma changes a person's understanding/knowledge from positive to negative outcomes while Pitman, Shalev and Orr (2000) conditional theory focuses conditionability differences as a reflection of genetic or acquired pre-trauma. Ollenick, King and Muris (2002) during the cause of their work came out with information processing theory which was focused on traumatic event rather than analyzing its social and personal context. Despite the landmark initiated by these theorists, mechanism for increased responsibility to trauma were not addressed and successful recovery or differentiation between flashbacks and ordinary memories were not classified

In Finland PTSD is classified as a psychiatric disorder. Treatment is usually offered in specialized hospital and by trained mental health professionals such as psychiatric nurses

and psychologists. Reimbursement of rehabilitative psychotherapy treatments are paid back by the Finnish national health insurance both for citizens and immigrants who are entitled to national health insurance. (KELA, 2012).

### **3.1 Post Traumatic Stress Disorder**

The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA) defined PTSD in 2013 in the DSM-V as a psychiatric disorder resulting from exposure to experienced or witnessed traumatic event such as experience of a traumatic stressor (exposure or actual witnessed or threatened death, injury or sexual violation) reacted to with intense fear and other heterogeneous reactions resulting from traumatic exposures (APA, 2013).

The definition was revised in the 2013 (DSM V) states that an individual must meet the requirements under the four major clusters: intrusion, negative mood, dissociation, alterations in arousal and reactivity, and avoidance. Furthermore, the individual behavioral pattern must have clinically impaired daily living activities regardless of the causative stressor experienced or exposed. (APA, 2013).

A recent classification of PTSD (including acute stress disorder) in the DSM V was moved from its classification of anxiety disorder to a new classification of "trauma and stressor-related disorder".

### **3.2 Clinical features of PTSD**

PTSD is operationalized from the DSM-IV-TR to DSM-V as an anxiety disorder to its current classification in the DSM- V as trauma – and stress – or related disorder. It also moved from three symptom areas, including re-experiencing, avoidance or emotional numbness, and hyper arousal to four main symptom areas: re-experiencing, avoidance, negative cognition or mood and arousal (APA 2013).

Diagnosis of PTSD requires a specific number of symptoms from each of the four major areas. These traumatic exposures regardless of traumatic event associated with it leads to a clinically significant impairment in the individual adaptive and cognitive functioning capacity and pathophysiologic changes.

In the DSM-V (2013) of the Diagnostic and Statistical Manual of Mental Disorders, diagnostic criteria were modified to include exposure to actual or threatened death i.e. directly experiencing the traumatic events, presence of intrusion symptoms associated with traumatic events – recurrent or dissociative reactions (flashbacks), Persistent avoidance of traumatic events associated stimuli such as disturbing conversations, negative alterations in cognitions and mood such as inability to exhibit positive feelings and marked negative feelings and traumatic experiences leading to arousal and reactivity. Infact, the number of presenting symptoms may vary and include those associated with depression and psychosis (APA, 2013).

### 3.3 Symptoms of PTSD

The number of presenting symptoms varies according to severity of the disorder and it falls into four main areas –

- Intrusive thoughts – recurrent memories, flashbacks or longtime psychological distress.
- Avoiding reminders – Memories, feelings and thoughts which are distressing.
- Negative thoughts and feelings – Diminished interest and loss of interest such establishing or maintaining social relationships.
- Arousal and reactive symptoms and often includes the fight and flight reactions (APA, 2013).

According to the American Psychiatric Association (APA, 2013), onset of symptoms called "delayed expression" may typically expressed among individuals but the delay in meeting full criteria. Furthermore, duration of symptoms varies over time and most times symptomatic among individuals. Re-exposure to traumatic events may lead to original trauma experienced and thereby subjecting the individual to diminished cognitive functional capacity, health related issues, social withdrawal and isolation. The may experiences suicidal ideation, negative primary care utilization and health perceptions, sleep problems, avoidance and hyperarousal (APA, 2013).

### 3.4 Social Determinants

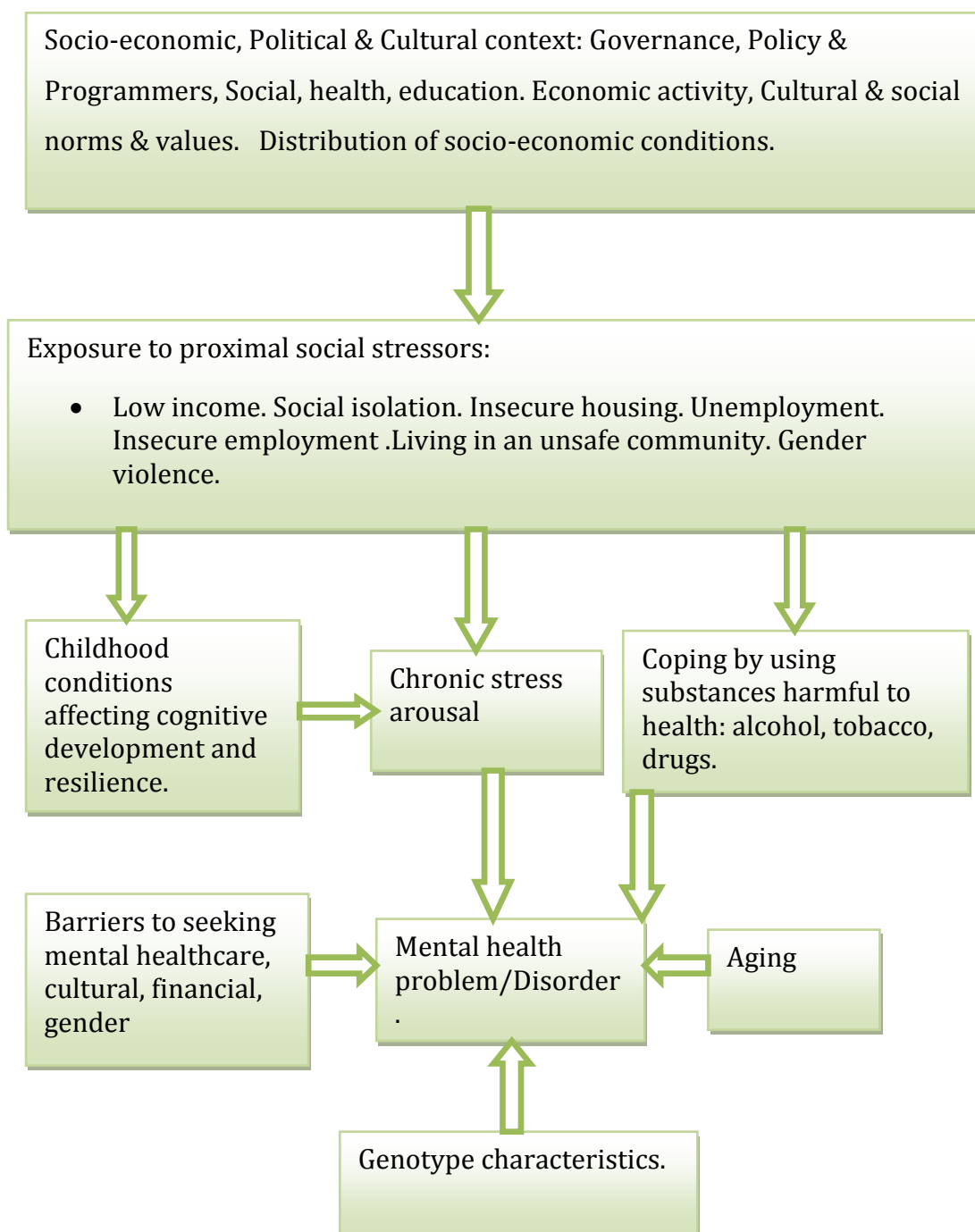
Studies has been ssuggested that exposure to various forms of traumatic stressors gave rise to social disadvantages towards patients. Further observations on the patient health status



regarding their level of education, living conditions, ethnical background prior to migration reveals strong dominance of traumatic effects.

Marmot and Wilkinson (2006) suggests that social disadvantage establishes etiology of mental health problems among these immigrants population because intense exposures which they found themselves triggers stress arousal which acts as a precursor to mental health. Thus lack of systematic response towards marginal status leads to traumatic experiences thereby increasing higher risk of PTSD.

The world health organization (WHO) during the Geneva Convention in 2008 illustrated the outcome of social determinants of health among individuals exposed to proximal social stressors. The figure 1 below illustrates the contributing factors towards mental health disorder.



**Figure 1: Contributing factors affecting onset of a mental health problem (adapted from the commission and social determinants of health. WHO, 2008).**

### 3.5 Assessment of PTSD

Assessment of patients exposed to traumatic events should be followed up with a rational and integrated treatment approach. The first phase of action is to determine if the patient has been exposed to traumatic event and observe the main stressor that triggers re-experiencing and traumatic arousal. Assessment of PTSD includes collecting of pre-morbid data of the patient, family history by objective or subjective method. This framework falls into stages ranging from screening (self-report checklist), presumptive diagnosis (semi-structured interviews) and treatment progress -objective or projective. (Shives, 1998, p68-69)

Weathers, Ruscio and Keane (1999) recommended assessment tools which include DSM-V clinician administered PTSD scale (CAPS) which remains a standard scale in recent use, Beck anxiety scale – primary care, Life event check (LEC) which can be used in line with CAPS to facilitate exposure to traumatic events and brief trauma questionnaire.

### 3.6 PTSD and family dynamics

Johnson states that,

*“From the cradle to the grave, humans desire a certain someone who will look out for them, notice and value them, soothe their wounds, reassure them in life’s difficult places, and hold them in the dark”* (2004, p. 34).

Family dynamics among individuals exposed to traumatic events or exhibiting symptoms of PTSD varies according to various perspectives. A good prior knowledge of interpersonal of PTSD attributes will help family members of traumatized individuals to respond and accommodate the individual negative impact as a result of trauma stress.

Calhoun, Beckman and Bosworth (2002) demonstrated that family members caring for traumatized individuals experience very strong level of burden and low level of psychological adjustment. This often leads to dysfunctional family conditions such as high conflict level and low cohesion among family members.

In certain families, societal value system plays an important role in caring for these traumatized individuals where their family members are obliged to show emotional support, protection and long time care while some certain families allows the individual to seek care in the hands of professional caregivers and restricted to homes meant for such

individuals. Family dynamics either creates a positive or negative impact on the individual and family members. The traumatized individual tends to get reassurance and emotional support from the family members, as a result of lack of this; avoidance, withdrawal and negative behavioral pattern may result and the individual tend to be harmful to themselves and other family members. Negative impact on the family members of PTSD individuals includes verbal and physical abuse, lifestyle changes and physical violence.

### **3.7 Social support**

Social support systems involves family members, local support groups, friends and religious groups which provide social interactions and visitations to help traumatized individuals back into normalized living conditions and establishing social relationship.

Cohen, Underwood and Gottlieb (2000) in their study stipulated two theoretical framework for social support system which include the stress buffer and main effect framework. These support systems helps the traumatized individual to regain ego and psycho-social well being.

Eriksson, Vandekemp, Gorsuch, Hoke, Foy, (2001) in their study on humanitarian aid workers exposed to traumatic events and traumatized individuals found out that social interaction among traumatized individuals with high level of social support system and aid workers with low level social support systems were higher in terms of showing symptoms of PTSD in aid workers than in traumatized individuals. The aid workers showed more symptoms of PTSD than individuals exposed to traumatic events.

### **3.8 Family and coping mechanism**

Individuals exposed to traumatic stressor experience symptoms of PTSD and duration of overcoming it may last few months or a lifetime process (APA, 2013). Traumatized individual usually experience a period of worsening symptoms or half-life period of improvement. Recovery process takes a gradual process and coping with PTSD is usually a challenging one both for the individual and family members.

Coping mechanism involves recognizing and accepting traumatic experience impact and adhering to a postive actions and attitude to overcome the disorder. This is a collective approach which involves various support groups but the individual's family remains at the

front line because they have a very important role in assertive approach so that the expectations of the traumatized individual are not truncated. The collective approach in coping mechanism for the individual involves high prioritized communication with family members, friends and other support groups so that social isolation, avoidance which are recurring symptoms of PTSD are eliminated (Robert, 2003)

The concept of hardiness (ability to withstand rough situations) as a coping mechanism has been found to help people exposed to trauma. Hardiness has been positively- correlated with emotions and resources required to achieve positive outcomes, mood openness and positive transformational characteristics (Maaddi, 1999a).

### **3.9 Therapeutic Interventions in PTSD**

Developed nations implement models for therapeutic intervention for PTSD in the form of individualized therapy, processing and analyzing reactions and counseling plans (Jones, 2008). An integrated approach to PTSD when dealing with immigrants was recommended by the WHO to include more broad range considerations such as cultural background, coping mechanism and sociocultural values and resources. (WHO, 2012).

The use of non pharmaceutical and pharmaceutical interventions remain well-known treatments in PTSD. This treatment options involves using psychotherapy and pharmacotherapy approaches towards achieving better outcomes. Studies conducted on treatment options for PTSD listed cognitive-behavioral treatment (CBT), cognitive processing therapy including eye movement desensitization and reprocessing (EMDR), centered therapy, support counseling and cognitive restructuring as an evidence based treatment modalities. (Foa, Keane & Friedman, 2000; APA 2004; Chard, 2005; APA 2013).

Psychotherapy involves cognitive behavior therapy and support systems which tend to alleviate traumatized individual's response to trauma while pharmacotherapy tend to treat the symptoms with antidepressants such as selective serotonin reuptake inhibitor (SSRI) medications (APA, 2004).

## 4 Theoretical Framework

Theoretical framework used in this study are Peplau's developmental theory and Madeleine Leininger's Culture Care. The collection of these two theories will be used as a guide through this study to determine what things to look for when analyzing PTSD. This is an exploratory study on immigrants with PTSD and nursing care.

### 4.1 Hildegard Peplau's nurse-patient relationship theory

This theory is applicable to psychiatric settings. Peplau (1952, p.16) defines nursing as "significant therapeutic, interpersonal process". The core aim of this theory is based on the interpersonal process and its' identification of nurse-patient relationship as the center of all nursing care. Clinical and extensive knowledge of psychiatric illnesses and treatments are required by a nurse before entering this professional relationship and also to act in a more professional manner. The nurse acts like a resource person, counselor and teacher during the interaction period with the patient. The nurse selects appropriate nursing intervention through gained clinical knowledge. A well-developed competent skill from interpersonal, social and intellectual is required by the nurse in order to evaluate and interpret possible outcomes during nurse-patient relationship interaction (Peplau, 1987).

#### **The orientation Phase**

This involves a developmental phase where nurse-patient relationship is still understanding each other's expectations and roles. This phase is like a push/pull effects where the patient felt needs require nurse's help thus making the nurse to establish a constructive approach on possible best nursing intervention. In this phase, the nurse implementation of nursing interventions and patient's goal evaluations are established (Peplau, 1992).

#### **Working phase**

This phase comprises of identification and exploitation phases. It has a double approach method which focuses first on the patient (deriving benefits through available resources to improve well-being) and the nurse in another approach as a counselor, resource person and teacher in which the patient actualises his well-being.

### **Exploitation Phase**

The patient takes an active role and this role is geared towards a common goal of regaining well-being and in this phase new challenges are established.

### **The Resolution Phase**

This is the concluding phase where the patient gains freedom and may not need nursing guidance. The patient acts independently and shows strong indication to manage care.

## **4.2 Madeleine Leininger's theory of culture care diversity and universality**

In 1995, Leininger's definition of transcultural nursing states that:

*“a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways.”* (p. 58).

In the course of caring for people with diverse cultural background from the nurse, it is important that nurses or professionals need to have knowledge of transcultural nursing. This will be used to discourse the issue of cultural dynamics which is a very detriment nurses face during initiation of nurse-client relationship. The fundamental purpose of transcultural nursing is using evidence-based knowledge so that nurses learn care values and practices and then use this knowledge safely and responsibly when caring from people with different cultural background. (Parker & Smith, 2010). With the introduction of culturally congruent care which is the primary goal of transcultural nursing to provide culture specific and congruent care to people from diverse cultures (Leininger, 1999). Culturally congruent care is only conceivable when ensuring those predictive tenets occurs within nurse-client relationship. (Leininger, 1981): whereby the nurse and the client create a new or different care plan for client wellbeing. Here professional knowledge and generic care are required so that diverse ideas are put into nursing care actions and goals. (Leininger, 1991a). Marked differences between generic and professional care ideas and actions could lead to serious client-nurse conflicts and other complications. (Leininger, 1978, 1995). Accomplishing a better result, care and knowledge skills are prerequisite for

the client wellbeing and this requires mutual collaboration of nurse and client working together to identify, plan, implement and evaluate each caring modality. Results from such actions stimulate nurses to create a nursing plan using new acquired knowledge together with evidence based knowledge in providing satisfying holistic care to clients (Leininger, 1991).

### **The Sunrise enabler: A conceptual guide to knowledge discovery.**

The Sunrise enabler developed by Leininger in the quest for evidence-based culture care established a holistic and general conceptual view of major constraints that affects culture care diversity and universality.

The Sunrise enabler model focuses on human care, socioculture influences and the effects of a society's culture and value system relating to values, behavioral patterns and practices. The Sunrise enabler model serves as a paradigm for cognitive guidance to aid nurses when establishing different influences on culture-based care and health care assessment of patients. (Leininger 1995,1997b; Leininger & McFarland, 2002).

The nurse follows up any discovery at any point in the enabler during the patient's ideas and experiences about care meeting. Reflections should be made on every aspect of the enabler model to obtain a holistic data, this will enable the nurse to establish a well-structured decisions, actions and care plan for the patient thereby holding back his or her own etic biases in abeyance in order to achieve a specified care plan. Specific domain of inquiries are initiated by the nurse during the study such as domain of inquiry (DOI) focusing on specific contexts for example "culture care of a specific context" to obtain a conceptual picture on specific data while using the enabler and tenets of the theory to achieve a positive and holistic care meanings, values, practices and beliefs for the patient (Leininger 1985,1991a, 1995,1997b; Leininger & McFarland 2002).



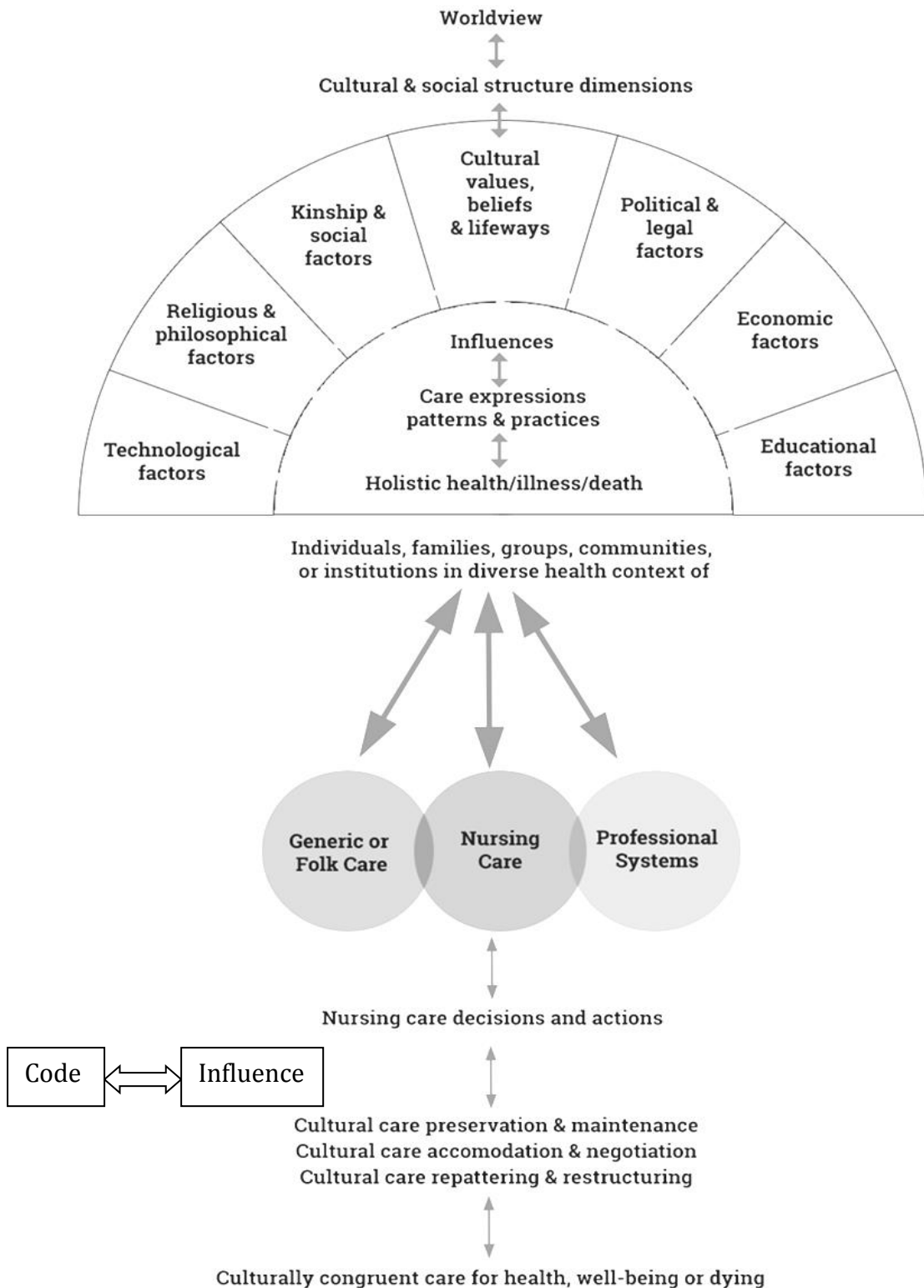


Figure 2: Leininger's sunrise enabler to discover culture care. (M, Leininger 2004, page 325.)

## 5 Research methodology

Qualitative research approach consisting of description of the systematic review and content analysis methods of research will be applied in this study. Qualitative method applied in this study tends to develop methods for addressing questions of a particular interest and involving clustering various data collection strategies (i.e. triangulation). Methods used consist of the systematic review and content analysis process of research approach. Inductive content analysis approach was used for this study.

### 5.1 Systematic Review

A systematic review is a structured review that methodically integrates research evidence based on a specific research questions which tries to identify, select and synthesize all prioritize research questions that are relevant to the theme been studied.

Systematic research is carried out using sampling and data collection procedures which are carefully developed and pointed out in a determined protocol. This protocol requires discipline and transparency so that the reader finds it easier in assessing conclusions of the entire process. A good systematic research tries to avoid inappropriate conclusions rising from biased review process or selected themes included in the review such that relevant studies are been selected based on inclusion criteria (Polit & Beck. 2012, 653).

Integration of research evidence is essential and should be supportive of evidence-based practice and abide by the same systematic inquiries with the original research investigations and simply not a literature review which involves interpretation of a particular topic (Polit & Beck. 2012, 653).

In more recent studies, systematic studies review is used to refer to the term of systematic review which follows a disciplinary and audible process to integrate findings from both quantitative and qualitative studies and other mixed methods studies. Though mixed methods studies reviews been introduced for systematic research but they tend to answer multiple questions when clustered together. This tends to compare differences and similarities when reviewers cluster their themes to further develop strategies for doing well reviewed studies (Polit & Beck, 2012, 654,672-673).

## 5.2 Data collection

Data collection seems intense and exhausting experience because the study focused on stressful life events which require gathering high level of concentration and deep thoughts using inclusion and exclusion criteria in selection of quality articles (Polit & Beck, 2012, 534).

In the event of searching for data for this study, I searched for articles related to my study theme through the Novia university of applied sciences Nelli-portal database where I accessed it through the meta-search engine. I also accessed the academic search elite Database (EBSCO) and CINAHL with full text option which gave 9 articles from qualitative study approach. The articles emerged from journals ranging from nervous and mental health, Immigrant and minority health, psychiatric mental health nursing, nursing research and cultural diversity through EBSCO. I narrowed my search within the timeframe 2000 to 2015 so that I can get the latest research information dealing with PTSD.

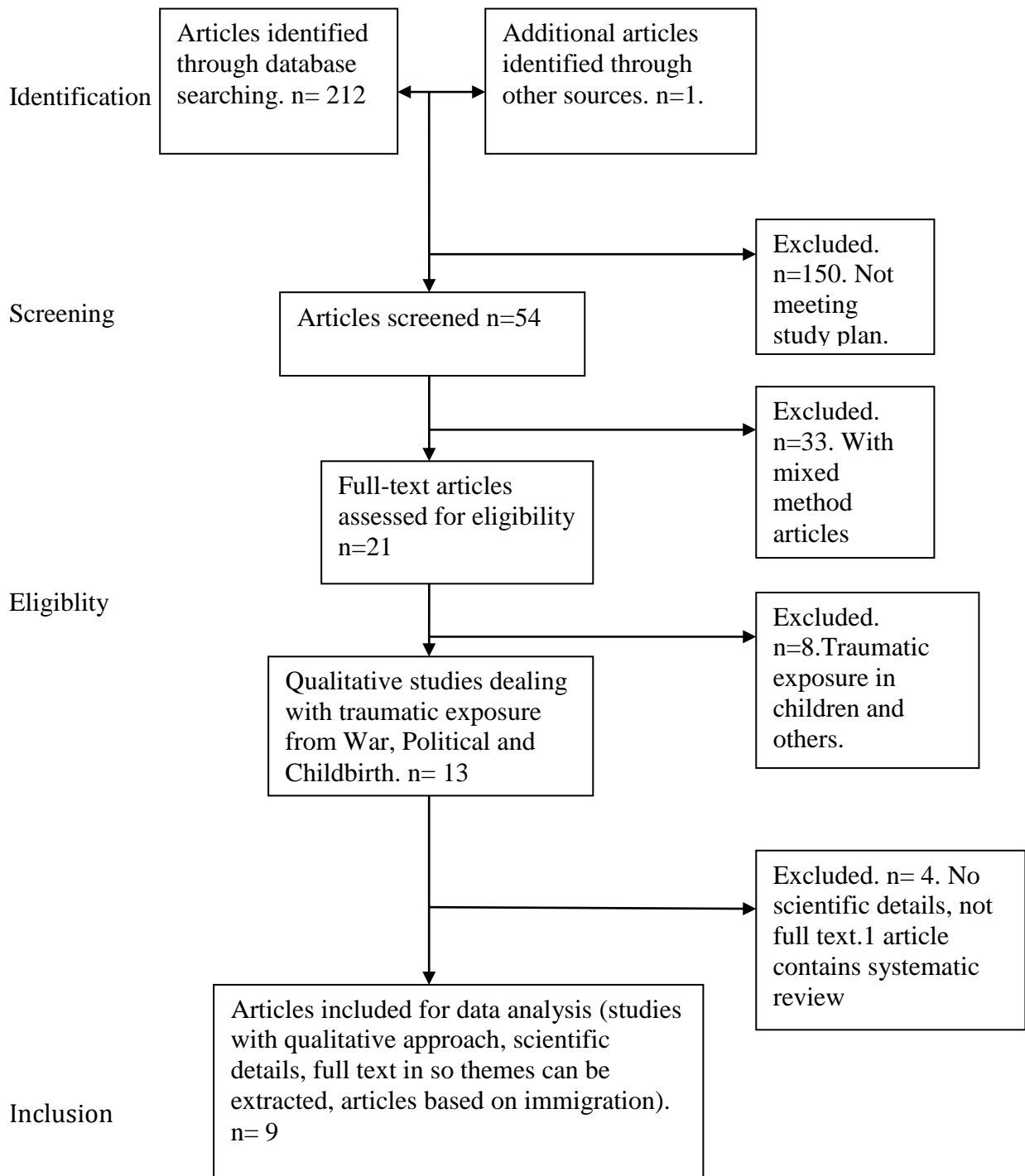
Accessing through Sage online database by keying PTSD and immigration from the year 2000 – 2015 gave about 9 articles. Articles were collected from different journals in psychiatric mental health nursing, Journals of cultural diversity, Journals of immigrant and minority health, Journals of traumatic stress, Journals of community psychology and European child and adolescent psychiatry.

After going through these articles from different sources, I used the inclusion and exclusion criteria to eliminate articles. Inclusion articles includes those studies that are relevant to my topic, scientific articles with structured abstracts and do not require log-in requirement, Full text format with evidence based theories, were included while excluded articles are those which are irrelevant to my study, out dated articles, articles without scientific evidence based facts.

**Figure 3: Findings for keywords searching**

Database	Boolean/Phrase used for search	Hits	Chosen
EBSCOhost	<i>Ptsd/immigrant/qualitative</i>	8	1
Julkari	<i>Mental health/immigrants</i>	186	1
Internal journal for equity in health	Re-direction from Pubmed.	1	1
Pubmed	<i>Ptsd/asylum/qualitative</i>	7	1
Ebsco	<i>Ptsd/refugees/qualitative</i>	9	4
Evidence-based nursing journal	<i>Ptsd during childbirth</i>	2	1

**Figure 4: Flow chart representing Inclusion / Exclusion**



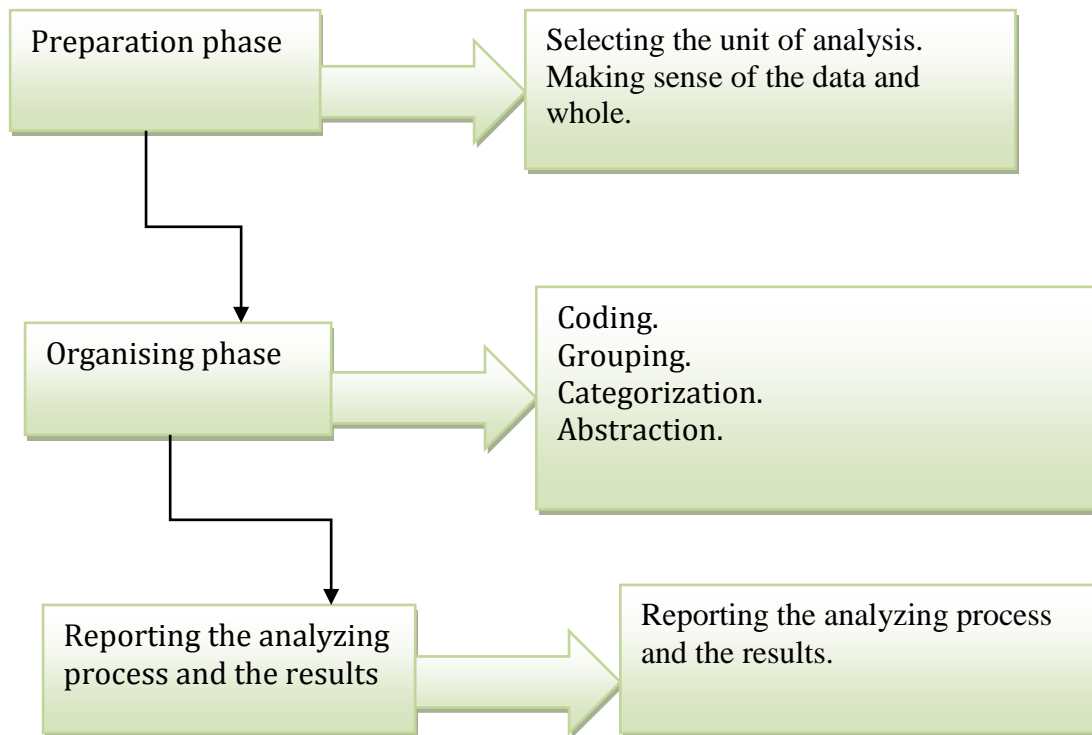
### 5.3 Qualitative Content Analysis

Polit and Beck defined content analysis as “the process of organizing and integrating material from documents, often narrative information from a qualitative study, according to key concepts and themes”. (2012, p.723). Nursing studies use content analysis as a major analyzing data choice in qualitative studies but only little has been discussed about it in most research books (Elo, & Kyngäs, 2007, 107).

Content analysis is a method of analyzing written, visual and verbal communication messages (Cole 1988). This is a process whereby the narrative qualitative information are clustered and categorized into themes and concepts. Furthermore, data are categorized into smaller groups and names, then coded into type of order in which they belong.

During preparation for data analysis, the materials were read through several times to get a general sense and meaning of the materials of immense interest. Furthermore, articles selected are grouped according to similarities so that they can make a meaningful categorization into various themes thus making a general theme from the whole materials been analyzed. The table below explains an approach been used for this study.

**Figure 5: Content Analysis using inductive approach**



**Preparation, organizing and resulting phases in the content analysis process using inductive approach.**  
(Elo & Kyngäs, 2007, 110)

## 5.4 Ethical considerations

Polit and Beck described ethics as "A system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants" (Polit & Beck, 2012,727). There is need to engage in proper ethical guidelines because wrong data analyse remains a large ethical issue; the synergy between scientific soundness and validity of the study in relationship with data analyzed which reflects core of a good research are often missed out. Furthermore; scientific conduct during a research study should be adhered to in order to avoid of making up falsified data or readings. Emphasis should be laid so that research aims and questions are not deviated from the primary themes (Polonsky, 1998).

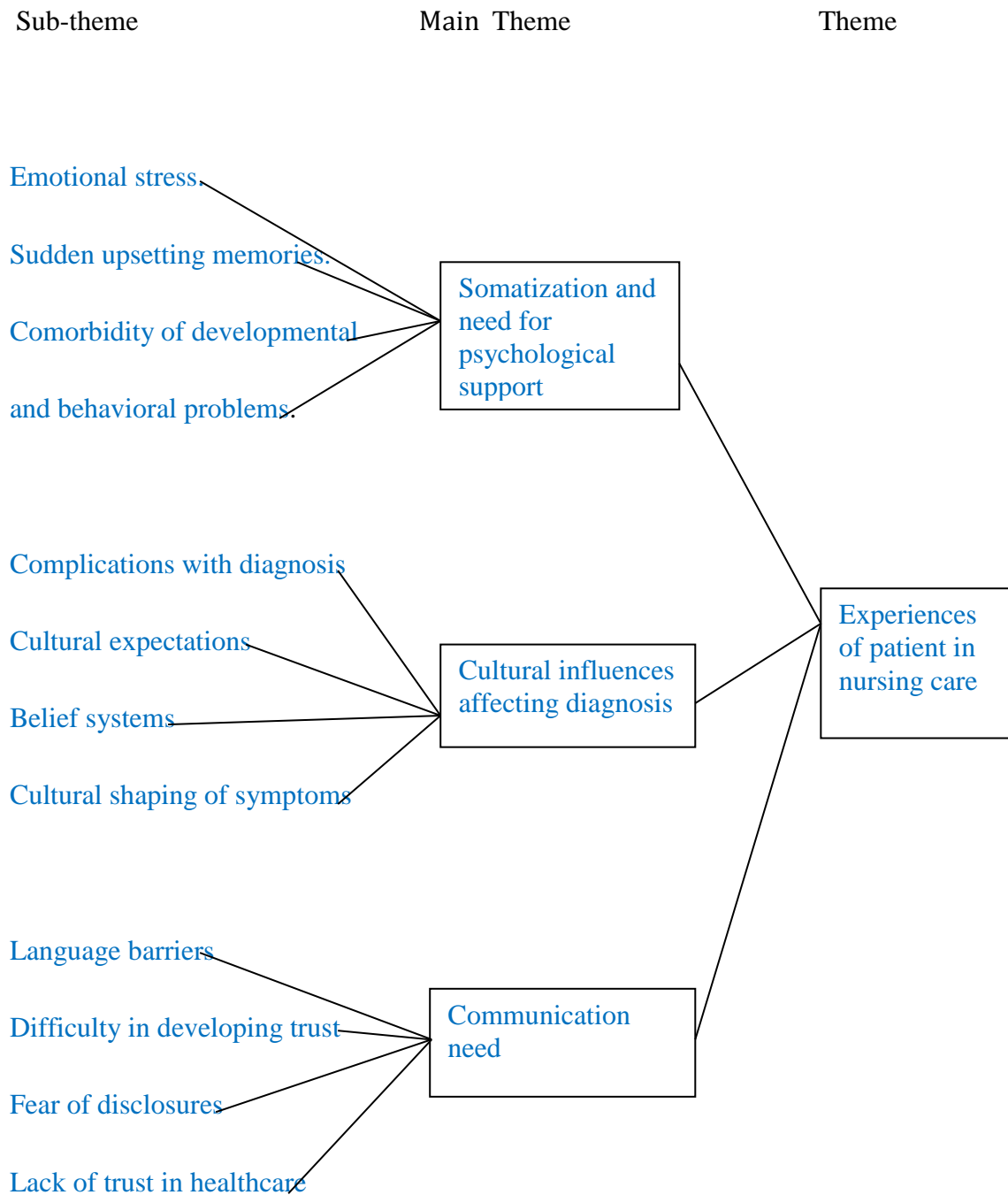
Unethical and dishonest practices that may lead to violations and research misconduct thereby hampering good quality and valid result should be avoided. Research misconduct includes fabrication, falsification, plagiarism and misappropriation. Fabrication involves making an observation which corresponds to an unrealistic result from his/her chosen methodology. Falsification involves publishing a falsified outcome by deliberating missing out important points thereby leading to unreliable results. Plagiarism means directly copying other people's works without giving proper referencing to them while misappropriation is illegal laying claim of another researcher's work as your own .(Finnish Advisory Board on Research Intergrity, 2012, 32-33).

## 6 Interpretation of results

According to the nature of this study about lived experience, data collection was selected and analyzed based on the study theme from the theoretical background. Qualitative content analysis by inductive approach was used in data analysis of this study to identify most important themes required. Data contents were narrated into smaller groups and then were organized and coded into a named unit. The named units range from A1 – A9. Refer to appendix.



**Figure 6: Abstraction process of various themes relationship**



## 6.1 Communication need

Disparities in language differences pose a great risk in effective diagnosis and treatment amongst these immigrants with PTSD in their host countries. Effective communication

between care givers and patients should be seen as the centre-point for effective treatment. In every clinical setting, effective care plan for any patient starts with taking proper medical background. It is impossible to diagnose immigrants admitted to mental health facilities that lack the knowledge of national language, though most times interpreters are used during consultations but indirect communication between the three conversants makes it more difficult to determine the symptom severity and observational methods during consultations (Sima et al, 2012).

### **6.1.1 Language barriers**

This is sub-theme emerged from most articles as the most deliberating factor affecting nursing assessment and proper diagnosis of the illness among immigrants. Language issues has been a huge problem noted because a communication disparity may lead to wrong diagnosis and use of interpreters as noted in most psychiatric settings most times seems ineffective because some felt needs complained by the patient might not be expressed perfectly. According to Gilliver (2014) it was noted that differences in culture and language remains a major obstacle in diagnosis and treatment when the do not share a common language and use of interpreters is not always a good option.

*”For some health care providers like me, Farsi is our second language in the profession not used on a daily basis. Since we got our education in English, we don’t know how to translate some phrases to Farsi. We don’t understand some slang or Farsi idioms related to health. Therefore, it is health care providers who cannot understand or communicate with them. The language barrier is for both sides, both sides could run into problems”* (Dastjerdi, 2012, p.3).

### **6.1.2 Difficulty in developing trust**

This sub-theme emerged because most immigrants felt difficulty in developing trust. Hence the tend to hide most symptomatic signs during assessment or consultations, as a result of this healthcare professionals will not be able to get the right diagnosis. Since it often takes several months for assessment if a patient has PTSD, so this may prolong the diagnosis from months to years.

*“Since our community is not large, and people know each other, they are reluctant to talk about their limitations and personal issues. Despite a language barrier, in order to keep their face and honor they prefer to have non-Iranian health care providers or social workers”* (Dastjerdi, 2012, p.4).

### 6.1.3 Fear of disclosure

Most patients remain isolated because of the factor because the lack the courage to disclose about the illness. Because in most immigrant communities a disclosure of being mentally ill can be viewed negatively thereby resulting in social exclusion of the patient in most communal gathering. Unlike in advanced nations where people are treated fairly, most immigrant cultural systems conformed the person in isolation and this is always told to everyone when one is perceived as showing some psychiatric problems. Also, this might mitigate against getting a decent job that requires good mental health condition thus some immigrants decide not to disclose their problems in fear of not losing their jobs.

*“They tell me that even if they accept my diagnosis and visit a psychologist, it will create more problems for them. They say, “I have no coverage for that, and I cannot afford it. Moreover, my manager thinks that I have some mental issues, and I might lose my job. It goes on my record, and it will have a negative effect. After that, whatever happens will be judged based on my psychological status”. After listening to them, I believe I would think and feel the same way”* (Dastjerdi, 2012,p.5).

### 6.1.4 Lack of trust in healthcare

Most patients do not trust in migrated country healthcare systems. This remains a mitigating factor against accepting that they are mentally ill or show symptoms of PTSD. This issue is a result of communication barrier or lack of education if there exist high level of illiteracy among them. Most times, a patient feels that he/she was wrongly diagnosed because of his/her ethnic background and often disagrees with nursing assessment and care plan. Hence, they neglect their individualized care plan and often do not take their medications. Also risk of marginalisation contributes to disagree with the healthcare systems of migrated country.

*“Sometimes you feel left out and think being an asylum seeker, you are different”* (O’Donnell et al, 2007, p.7).

## 6.2 Cultural influences affecting diagnosis

Culturally congruent care plays an important role in positively affecting the patient’s individualized care delivery. In most cases, patient’s own belief system and cultural

expectations creates a barrier for efficient diagnosis, treatment options and symptoms interpretation (Sandhu et al, 2012). Cultural congruence is required in delivering quality care whereby patient's own belief system and expectations are fitted into the care plan. Lack of cultural congruence leads to misunderstanding between accepted value system or typical behaviour in patient's own culture and complications in diagnosis.

### 6.2.1 Cultural shaping of symptoms

This attributes how different cultures view symptoms associated with PTSD diagnosis. It can be viewed differently according to their belief systems. For example, a sign of these symptoms can be perceived and attributed to religious or traditional beliefs, pathological or non pathological perceptions. So it entirely depends on the orientation and interpretation on PTSD outcome.

*"There is the risk of interpreting a certain behaviour or attitude or discourse in an individual from a different culture as something mystical, but for them it is part of their culture"* (Sandhu et al, 2012, p.n/a).

*"I was so devastated at people's lack of empathy. I told myself what a bad person I was for needing to talk. I felt like the Ancient Mariner doomed to forever be plucking at peoples' sleeves and trying to tell them my story which they didn't want to hear"* (Tatano, 2004, p.221).

### 6.2.2 Cultural expectations

This sub-theme emerged because their own small community presumes every person remains in good psychological, socioeconomic and physical balance. Any aspect lacking can be seen as a sign of weakness. In assessing of patients, they require healthcare professional to judge them as individual and not to stereotype or assumed that everyone from similar culture are the same because no culture is homogenous. Because they do not understand the healthcare system and ethical issues, these immigrants feel threatened if their mental health status might be shared among their own people.

*"Our community is a small community. People know each other somehow. We meet each other on different occasions. We grew up in a hush-hush country, and we are very cautious about sharing personal issues. They worry that their stories may leak out to the community. They feel threatened"* (Dastjerdi, 2012, p.4).

*“She probably has a hard time putting her experience of physical problems into a context. She may be scared that if she refers to it as something related to her social life instead of physical illness she may feel it is all wrong. That is probably different compared to ethnic Danes”* (Koitzsch, 2013, p.5).

### **6.2.3 Belief systems**

This sub-theme emerged as one of the challenges mitigating against diagnosis and nursing intervention towards actualizing a conceptual care plan for the patient. It is usually a conflicting issue because it is not an easy task to alter someone belief systems such as religious, ideological and philosophical beliefs. This factor affects most other areas such as lack of trust in migrated country healthcare systems, prolong clinical diagnosis and unacceptance of somatic manifestation of symptoms and cultural shaping of symptoms.

*” One must clarify what the individual’s ethnic and cultural background means for the symptoms he/she is presenting. Is he talking about spirits? Given the cultural and ethnic background, how much are you used to considering supernatural and non-physical phenomenon as something you actually relate to”* (Sandhu et al, 2012, p. n/a).

## **6.3 Somatization and need for psychological support**

The sub-themes under this signifies most of the negative impact of PTSD from the patient’s perspectives. An individual care plan is the best treatment option or delivery care in accordance with evidence based nursing practice whereby the aforementioned symptoms are tackled. This can be used to evaluate and specify an effective appropriate goals for the patient’s.

### **6.3.1 Emotional stress**

This sub-theme emphasizes on the experiences of most immigrant. Sometimes, this can result as comorbidity of various symptoms such as increased anger, hyper arousal and flashback memories.

*“I can’t stop my mind from wandering and thinking about the past. I had an accident at work and I cut off two of my fingers”* (Eisenman et al; 2008, p.1389).

*“But now that the war’s over you have the result, little negative thoughts. Usually if you found a soldier who had died you thought, ‘I’ll take off his trousers and put them on myself because I need them.’ We picked everything soldiers had on them, rucksack, weapons, trousers. If he has a good shoe you take it and put it on. Sometimes you slept a little beside a soldier who was dead and now you wonder, you think now, what have I done? You think about it until you get a little nervous” (Wallin & Ahlström, 2005, p.138).*

### **6.3.2 Sudden upsetting memories**

Frequent flashbacks about past exposure prior to migration often resurfaces and this factor limits the proper diagnosis because of differentiation from other psychological problems.

*“Establishing a diagnosis is a problem in treatment. Re-experiences in the framework of post-traumatic stress disorder may be confused with psychotic symptoms or a normal reaction to an abnormal circumstance” (Sima el al, 2012, p.n/a).*

### **6.3.3 Comorbidity of developmental and behavioral problems**

This sub-theme emerged during analysis. This is as a result of developmental problems happening simultaneously with behavioral problems such as hyperarousal with increased anxiety or disruptive behaviours. This remains a major setback during assessment process.

*“Yes, it affects my health a lot. When someone has gone through something as horrible as this it affects both one’s mental and physical health. I can’t sleep. I have nightmares and feel stressed out all the time” (Eisenman et al, 2008,p. 1388).*

## 7 Critical review

Lincoln and Guba's evaluative criteria was used to critically review the quality and trustworthiness study. The framework consists of four major criterias which include credibility, dependability, confirmability and transferability (Polit & Beck, 2010, 492).

Credibility entails that the respondent is confident that the findings should be trustworthy and the investigation is comprehensive. Dependability entails that findings corresponds to supported data in a consistent approach. Confirmability evaluates that the neutrality of the respondent thereby eliminating bias and personal motivation while transferability entails the degree of applicable to other contexts such as settings or people (Polit & Beck, 2010, 492).

The themes that emerged from qualitative content analysis where presented in any a way that it will support the current study thereby abiding that data is well-developed and respondent own interest were justifiable. The respondent trust that the study pointed out most evidences associated with diagnosis of the disorder and different challenges facing proper diagnosis and care delivery to these immigrants from a nurse's point of view.

I would point out by concluding that this study is far from being conclusive in the sense that further studies should be step up from here; thus supporting that transferability criteria is applicable to other contexts.

Limitations of the study were noted in the area of time constraints and formal applications to various healthcare settings to get formal interviews and respondents so that the effects of PTSD incidence across multicultural immigrants living in Vaasa will be addressed. But I was able to assessed full text articles required for my study and my study was written in a way that it will be easy to understand. Despite limitations, articles analysed with qualitative content analysis suggests that PTSD accounts for decreased daily living activities among these immigrants and there is urgent need to address this issue.

## 8 Discussion

This part of the study deals with theories and results from analysed data. The main study aim is to describe the experiences of immigrant patients with PTSD. With the current wave of push factors of migration such political instability, wars, natural disasters, lack of opportunities and traumatic exposures, there is a major tendency that traumatic exposed immigrants will experience huge mental health conditions which are precursors to PTSD. The major influx of these immigrants will create a major challenge towards healthcare utilization and care delivery among healthcare professionals especially nurses. The major experiences immigrant patients with PTSD were noted during data analysis of the articles but two main critical factors that I want to highlight are Belief systems and lack of trust in healthcare.

According to Sandhu et al (2012) the mentioned that belief systems remains a critical and conflicting issues among these immigrant patients because it is not an easy task to change their ideological and philosophical orientations especially in adult immigrants.

Acculturation may have little effects on their orientation but remains unacceptable towards psychiatric problems because in some cultures it might be seen as a sign of bad omen or weakness. And this remains a major challenge towards accepting symptoms of PTSD or need for nursing care, so nurses need congruent culturally care when providing nursing care. In one of my personal experiences during psychiatric placement, I have witnessed where an immigrant argued with nurses that he was wrongly diagnosed but from my observations, he showed symptoms of PTSD where he experiences anxiety and flashbacks on several occasions. Difficulty in developing trust remains a major setback in nursing care for immigrants patients with PTSD. Dastjerdi (2012) in his studies noted that immigrant patients' lack of trust in nursing care often leads to improper diagnosis, follow-up of individualized care plan or need for psychotherapy. Most immigrant patients with PTSD feel uneasy to disclose their previous medical history prior to immigration or current traumatic experiences because of fear that they might end up in psychiatric homes or hospitals, affect their residence applications or securing a good job later in the future. Most likely, lack of trust can be from the part of nurses also in the sense that inadequate nurse-patient relationship or poor nursing approach towards immigrant patients can lead to mistrust. Thus, Peplau's nurse-patient relationship theory can be applicable to establish trust so that an effective therapeutic outcome can be achieved in nursing care and thus eliminate this challenge for nurses.



Madeleine Leininger's theory of culture care diversity and universality postulated that caring for people from diverse cultures or similar cultures, remains an important need in nursing practice. With this core aim, it is highly required that nurses provide culturally congruent and competent care since the world is becoming more multicultural so nurses need to understand these diverse cultures, beliefs, values and ideas when providing nursing care (Leininger 1991b, 1995). The area of culturally congruent care has been a major challenge in nursing practices to provide competent care during nursing actions/decisions for immigrants with PTSD. In the course of this study, the sub-themes that emerged such as language barriers, complications in diagnosis, cultural shaping of symptoms, cultural expectations, belief systems require nurses to be well-developed in knowledge of culturally congruent care to be able to guide their actions and decisions during holistic care of patient well-being and health. Leininger's theory is applicable to this study because it will help nurses to understand culture care diversity during assessment of PTSD immigrants from diversified cultures, so that these immigrants diversified cultures are preserved, accommodated and repatterned. Communication barriers limits remains a major challenge for nurses these days especially if there exists language differences, it will be hard for the nurse to get the proper assessment thus wrong actions/decisions are made. At the moment when there are more internally displaced people, culturally congruent care should be welcomed in nursing care so that these immigrants health and well-being are maintained.

Hildegard Peplaus's nurse-patient relationship theory was used in this study because its main outcome is focused on patient's (immigrant) personal development thus making both nurse and patient appearing as strangers. Peplau's statement that

"anything clients act out with nurses will most probably not be talked about, and that which is not discussed cannot be understood" (Peplau, 1989a, p.197). Communication was viewed as a major factor in facilitating nurse-patient relationship. Peplau's theory is applicable in this study tackle the emerged themes where the patient prior to receiving treatment exhibit fear of disclosure and lack of trust in healthcare delivery and difficulty in developing trust. During the nurse-patient relationship, the patient may express openness or decide not to disclose anything. At this stage, the nurse may be able to recognize, evaluate the patient if he/she opens up or at a later stage when trust has been established. In the course that trust has been established, the nurse-patient work as a team to achieve a common goal for the patient based on assessment and nursing diagnosis. Peplau's nurse-patient relationship theory occurs in four phases so that the patient can attain a successful outcome.

Hopefully, future studies will examine PTSD incidence levels among selective migrant groups and traumatic exposed immigrants.

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## APPENDIX

**Articles used for Data Analysis**

Articles	Author(s)/Year	Aim	Method	Results
<b>Experiences with treating immigrants: A qualitative study in Mental Health services across 16 European countries.</b>	Sima Sandhu, Neele Bjerre, Marie Dauvrin, Sonia Dias, Andrea Gaddini, Tim Greacan, Elizabeth Ioannidis, Ulrike Kluge, K. Jensen, M.Lamkaddem, R. Puigpinos- Riera, Z. Kosa, U.Wihlman, K.Wahlbeck.	Delivering care to immigrants across European countries from the professional experiences. These include first generation immigrants.	Semi-structured (open questions) interviews in 16 European countries. Face to face interviews from 2008-2010. Qualitative study	Highlights specific challenges to treating immigrants, complication with diagnosis difficulties and risk of marginalization.
<b>A1</b>	2012			

<p><b>PTSD in Latino patients: Illness, Beliefs, Treatment preferences and implications for care.</b></p>	<p>David Eisenman, Lisa S. Meredith, Hilary Rhodes, Bonnie L. Green, Stacey Kaltman, Andrea Cassells, Jonathan N. Tobin.</p>	<p>Understanding illness, beliefs and treatment preferences for Latino immigrants with PTSD</p>	<p>Semi structured, Face to face interviews.  Qualitative study</p>	<p>Somatic and medical problems associated with Trauma and its' consequences on their lives.</p>
<p><b>A2</b></p>	<p>2008</p>			
<p><b>Mothers with PTSD after traumatic childbirth struggles to survive and experienced nightmares, flashbacks, anger, depression and isolation</b></p>	<p>Cheryl Tatano Beck  2004</p>	<p>Description of essence of mother's experiences of PTSD after childbirth.</p>	<p>Qualitative study.  Participants were recruited approach from Trauma and Birth stress Trust.</p>	<p>Highlights daily living survival and symptoms of PTSD attributed to mothers after childbirth experiences. Five main themes describing their experiences were noted.</p>
<p><b>A3</b></p>				



<p><b>“They think we’re ok and we know we’re not”. A qualitative study of asylum seekers’ access, knowledge and views to healthcare in the UK.</b></p>	<p>Catherine O’Donnell, Haggins M, Rohan Chauhan &amp; Kenneth Mullen. 2007</p>	<p>The study aimed to understand barriers faced by asylum seekers &amp; ways to help them access healthcare in the UK.</p>	<p>Qualitative study Focus group &amp; Interviews</p>	<p>Different problems experienced by these immigrants were highlighted such as difficulty in healthcare access, wrong beliefs about healthcare systems in the UK.</p>
<p>A4</p>				
<p><b>The case of Iranian Immigrants in the Greater Toronto area: A qualitative study.</b></p>	<p>Mahdieh Dastjedi 2012</p>	<p>Identification of obstacles and issues of Iranian immigrants faced when accessing healthcare.</p>	<p>Qualitative study. Individual interview.</p>	<p>Highlights non-satisfaction among Iranian immigrants due to lack of language barriers and lack of healthcare services knowledge in Canada.</p>
<p>A5</p>				
<p><b>Unaccompanied young adult refugees in Sweden, Experiences of</b></p>	<p>Anne-Marie Wallin &amp; Gerd Ahlström. 2005</p>	<p>To understand the perception of young adult immigrant after years</p>	<p>Qualitative study. Interviews</p>	<p>The researcher pointed out appropriate factors such as level of</p>

<b>their life situations and well-being</b>		settlement in Sweden.		contentedness with their life experiences and factors such as loneliness, despondency, mental health problems faced by immigrants.
<b>A6</b>				
<b>How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark.</b>	Natasja Koitzsch Jensen, Marie Norredam, Stefan Priebe, Allan Krasnik. 2013	The aim is to investigate how general practitioners experiences providing care to refugees with mental health problems.	Qualitative study.  -Semi structured interviews.	The article pointed out different themes associated with referral pathways for refugees and strategies by general practitioners in the healthcare treatment of refugees.
<b>A7</b>				
<b>Recovery from Post-traumatic stress symptoms: A qualitative study of attributions in survivors of war.</b>	Dean Ajdukovic et.al 2013	This study explored factors where people traumatized by war attributes the recovery from PTSS to war experiences.	In depth interviews  Qualitative study	Factors of recovery are largely consistent with the models of mental health protection, that of resilience and psychological interventions were suggested to establish recovery from PTSD.
<b>A8</b>				

<b>Recent research on the Mental Health of immigrants to Sweden: a literature review</b>	Stephen Gilliver, Jan Sundquist, Xinjun Li, Kristina Sundquist. 2014	The study research aim is to summarize and interpret recent research on mental health of immigrants to Sweden	Qualitative study	The study result showed increased risk of common mental disorders in immigrants in Sweden and notable differences immigrant groups and between genders.
<b>A9</b>				