

Cultural adaption of mental health services to the Sami

A qualitative study on the incorporation of Sami language and culture
into mental health services

Inger Dagsvold

Department of Health and Care Sciences

Faculty of Health Sciences

UiT The Arctic University of Norway

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*Samene er forbausende lik andre folk, nemlig forskjellig.
The Sami are astonishingly similar to other people, namely different.*

Ole Mathis Hætta

*Eadnái
To my mother*

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Abstract

Research has indicated that the indigenous Sami population experiences more communication problems and is less satisfied with mental health services than the Norwegian majority population. The Sami people in Norway have a statutory right to receive equitable health services, adapted in accordance with Sami language and culture. However, there is limited research on the impact of culture and how to provide culturally and linguistically adapted mental health services to Sami patients. Hence, this thesis aimed to explore the significance of culture and language in mental health care as experienced by clinicians and Sami patients. The study is based on thematic analyses of individual interviews with clinicians and Sami patients in mental health clinics in northern Norway.

The study demonstrated that bilingual Sami patients' language choice in different communication situations is influenced by a complexity of social and cultural factors. The participants reported extensive use of language switch both in everyday life and in therapy, indicating that a person's status as a Sami speaker is not always a question of either-or. Sami patients may have different preferences for what they can talk about, in which language, in what way, and with whom. However, the results must not be confused with the idea that Sami-speaking patients do not need Sami-language therapy. Bilingualism, constant language awareness, exploration of language switch, and knowledge about Sami culture and history may enhance the understanding of Sami patients' needs and preferences when in mental health therapy.

The interviews with the clinicians demonstrated that identification of Sami patients' language needs and preferences as well as offers of language-appropriate services are random. Also, the clinicians referred to Sami culture predominantly in terms of essentialized cultural traits, defining the Sami as "different". The clinicians had several essentialist assumptions about Sami culture but provided limited descriptions of ways to incorporate cultural and linguistic aspects into clinical encounters with Sami patients. The incorporation of culture and language in therapy was, for the most part, a "private matter"; in team discussions at the clinicians' workplaces, Sami cultural issues were seldom included.

The study indicates that the incorporation of language and culture into mental health care is a complex process involving strategies at three levels; institutional systems and structures, health professionals' cultural assumptions and analytical competence, and cultural assessment of interventions in mental health treatment.

Approaches to culturally adapt health services depend on the underpinning notions of culture. In this study, essentialist, stereotypical descriptions of Sami culture dominated. However, stereotypical portrayals of Sami culture narrow the understanding of Sami identity, delimit the identification of Sami speakers and simplify possible impacts of culture within health care. A more dynamic understanding of culture as a continuum between common cultural traits and individual experiences and preferences can increase the understanding of the individual patient's situation. Therefore, the question is not what culture "is", but how culture unfolds in human encounters.

Knowledge of the particular elucidates the general; the study of the possible impact of Sami culture and language in therapy might thus provide general insight into being a patient in need of health care. Also, focusing on Sami language and culture sheds light on the culture and structures inherent in the health care system.

Sami abstract. Čoahkkáigeassu

Dutkamat leat čájehan ahte sámi álbmot vásiha gulahallanválttisvuodaid ja lea unnit duhtavaš psyhkalaš dearvvašvuodasuodjalusain go Norgga álbmot. Sámi álbmogis Norggas lea lágas nannejuvvon riekti oažžut seammaárvosaš dearvvašvuodabálvalusaid mat leat heivehuvvon sámegillii ja sámi kultuvrii. Almmatge leat unnán dutkamat kultuvrra mearkkašumis ja mo galgá addit kultuvrralaččat ja gielalaččat heivehuvvon psyhkalaš dearvvašvuodabálvalusaid sámi pasieanttaide. Dán ph.d.-prošeavtta bajitdási ulbmil lei iskat, identifiseret ja čilget kultuvrra ja giela mearkkašumi psyhkalaš dearvvašvuodasuddjemis, nu movt klinihkkárat ja sámi pasieanttat leat vásihan, lokten dihte ipmárdusa kultuvrralaš ja gielalaš heivehemiin psykiátralaš bálvalusain sámiide. Dát kvalitatiiiva iskkadeapmi lea vuodđuduvvon temáhtalaš analysaide oktagaslaš jearahallamiin klinihkkáriiguin ja sámi pasieanttaiguin psykiátralaš klinihkain Davvi-Norggas.

Iskkadeapmi čájehii ahte guovttegielat sámi pasieanttaid giellaválljemii iešguđetlágan gulahallandilálašvuodain váikkuhit kompleksa sosiála ja kultuvrralaš fáktorat. Oasseváldit diedihedje ahte sii viidát molsot gielaide gaskka sihke árgabeaivvis ja divššus. Sámi pasieanttain sáhttet leat iešguđetlágan preferánssat das man birra sáhttet hupmat, guđe gillii, mo ja geainna. Bohtosiid ii ábut almmatge dulkot nu ahte sámegielat pasieanttat eai dárbbáš sámegielat divššu. Guovttegielalašvuolta, čađat áigge fuomášupmi gillii ja gielladárbbuide, giellamolsuma iskkadeapmi ja diehtu sámi kultuvrra ja giela birra sáhttet lohtet ipmárdusa sámi pasieanttaid dárbbuin ja preferánssain mat gusket psyhkalaš dearvvašvuodasuddjema dikšui. Jearahallamat mat leat dahkkon klinihkkáriiguin čájehedje ahte sámi pasieanttaid gielladárbbuid ja preferánssaid identifiseremat dáhpáhuvet soaittáhagas, ja maiddá giellabálvalusaid fáldagat leat soaittáhagas. Klinihkkárat refererejedje dábálaččat sámi kultuvrii välljejuvvon essensiála kulturdovdomearkkaiguin, ja meroštalle sápmelaččaid «earáláganin». Klinihkkáriin ledje ollu oainnut das mii sámi kultuvra lea, muhto sis ledje unnán vásáhusat ja válddahallamat das mo fátmastit kultuvrralaš ja gielalaš beliid sámi pasieanttaid dikšui. Kultuvrra ja giela klinihkalaš mearkkašupmi ja inkorporeren váldojuvvui unnán mielde klinihkalaš čoahkkimiidda ja lei hárve fáddán fágalaš digaštallamiin, ja nu šattai «kultuvrralaš heiveheapmi» priváhta doaibman maid ovttaskas terapevta fertii čoavdit iehčanassii. Dán iskkadeami bohtosat indikerejit ahte giela ja kultuvrra fátmasteapmi mentála dearvvašvuhtii lea kompleksa proseassa mas leat strategiiat golmma dásis;

ásahuslaš vuogádagat ja struktuvrrat, dearvvašvuodabargiid kultuvrralaš ja analyhtalaš gelbbolašvuohta ja divššu intervenšuvnnaid kultuvrralaš árvvoštallan.

Lahkoneamit kultuvrralaččat heivehuvvon dearvvašvuodabálvalusaide leat sorjavaččat vuodđoipmárdusas das mii lea kultuvra. Dán iskkadeamis čilgejuvvui kultuvra dábálaččat stereotyhpá kulturdovdomearkan. Stereotyhpálaš ipmárdusat gáržžidit almmatge ipmárdusa sámi identitehtas, identifiseremis gii lea sámegiela ja badjelgehččet guovttegielatvuođa ja álkidahttet kultuvrra vejolaš mearkkašumiid dearvvašvuodakonteavsttas. Eanet dynámalaš ipmárdus kultuvrras jotkkolašvuohtan (*kontinuum*) mas nuppe dáfus leat oktasaš («stereotyhpálaš») kulturdovdomearkkat ja nuppe dáfus fas individuála vásáhusat ja preferánsat sáhtta nannet ipmárdusa ovttaskas pasieantta dilis. Jearaldat ii leat dan dihte mii kultuvra «lea», muhto mo kultuvra bohtá oidnosii klinihkalaš deaivvademiin gaskal pasieanttaid ja terapevttaid.

Diehtu dan birra mii lea erenoamáš čuvgeha maiddáid dan mii lea oppalaš; sámi kultuvrra ja giela mearkkašumi iskkadeapmi sáhtta maiddáid addit midjiide oppalaš dieđu das mo ipmárdus pasieanttaid ektui sáhtta čuožžilit ja ovdánit iskkadettiin duogáža, konteavstta ja maid dearvvašvuodahástalus mearkkaša guhtiige. Go guovdilastá sámegiela ja kultuvrra, de čuvgeha maiddáid terapevttá ja dearvvašvuodabálvalusa kultuvrraid.

Norwegian abstract. Sammendrag

Forskning har vist at den samiske befolkningen opplever kommunikasjonsproblemer og er mindre fornøyd med tilbudet innen psykiske helsevern enn den norske befolkningen. Det samiske befolkningen i Norge har en lovfestet rett til å motta likeverdige helsetjenester tilpasset samisk språk og kultur. Det er imidlertid begrenset forskning om betydningen av kultur og hvordan man skal gå frem for å gi kulturelt og språklig tilpassede psykisk helsetjenester til samiske pasienter. Det overordnede målet med dette PhD-prosjektet var å undersøke, identifisere og beskrive betydningen av kultur og språk i psykisk helsevern, som opplevd av klinikere og samiske pasienter for å øke forståelsen av kulturell og språklig tilpasning av psykiatriske tjenester til samene. Denne kvalitative studien er basert på tematiske analyser av individuelle intervjuer med klinikere og samiske pasienter i psykiatriske klinikker i Nord-Norge.

Studien viste at tospråklige samiske pasienters språkvalg i ulike kommunikasjonssituasjoner påvirkes av en kompleksitet av sosiale og kulturelle faktorer. Deltakerne rapporterte omfattende bruk av språkveksling både i hverdagen og i terapi. Samiske pasienter kan ha forskjellige preferanser for hva de kan snakke om, på hvilket språk, på hvilken måte og med hvem. Resultatene må imidlertid ikke forveksles med at samisktalende pasienter ikke trenger samiskspråklig terapi. Tospråklighet, kontinuerlig oppmerksomhet rettet mot språk og språkbehov, utforskning av språkveksling og kunnskap om samisk kultur og historie kan øke forståelsen av samiske pasients behov og preferanser når det gjelder terapi innen psykisk helsevern. Intervjuene med klinikerne viste at identifisering av samiske pasients språkbehov og preferanser, samt tilbud om språklige tjenester er tilfeldige. Klinikerne refererte hovedsakelig til samisk kultur i form av utvalgte essensielle kulturtrekk, og definerte samene som «forskjellige». Klinikerne hadde mange oppfatninger av hva som er samisk kultur, men hadde få erfaringer med og beskrivelser av måter å integrere kulturelle og språklige aspekter i terapier med samiske pasienter. Klinisk betydning og inkorporering av kultur og språk ble i liten grad inkludert i kliniske møter og var sjelden et tema for faglige diskusjoner, derfor ble «kulturell tilrettelegging» nærmest et privat anliggende som den enkelte terapeut måtte løse på egen hånd. Resultatene i denne studien indikerer at innlemmelsen av språk og kultur i mental helse er en kompleks prosess som involverer strategier på tre nivåer; institusjonelle systemer og strukturer, helsepersonells kulturelle og analytisk kompetanse og kulturell vurdering av intervensjoner i terapi.

Tilnærminger til kulturelt tilpassede helsetjenester er avhengige av den grunnleggende oppfatningen man har av kultur. I denne studien ble kultur hovedsakelig beskrevet som stereotype kulturtrekk. Stereotypiske oppfatninger begrenser imidlertid forståelsen av samisk identitet, identifisering av hvem som er samiskspråklig, og overser tospråklighet og forenkler mulige betydninger av kultur i en helsekontekst. En mer dynamisk forståelse av kultur som et kontinuum mellom felles («stereotype») kulturtrekk på den ene siden og individuelle erfaringer og preferanser på den andre siden kan øke forståelsen av den enkelte pasients situasjon. Spørsmålet er derfor ikke hva kultur «er», men hvordan kultur utfolder seg i kliniske møter mellom pasienter og terapeuter.

Kunnskap om det spesielle belyser også det generelle; studien av betydningen av samisk kultur og språk i terapi kan også gi oss en generell innsikt i hvordan forståelsen av pasienter kan vokse frem og utvides ved å utforske bakgrunn, kontekst og hva helseproblemet betyr for den enkelte. Ved å fokusere på samisk språk og kultur belyses også terapeutens og helsevesenets kulturer.

List of articles

Article 1

Dagsvold, I., Møllersen, S., & Stordahl, V. (2015).

What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment.

International Journal of Circumpolar Health, 74:1.

DOI: [10.3402/ijch.v74.26952](https://doi.org/10.3402/ijch.v74.26952)

Article 2

Dagsvold, I., Møllersen, S., & Stordahl, V. (2016).

“You never know who are Sami or speak Sami.” Clinicians' experiences with language-appropriate care to Sami-speaking patients in outpatient mental health clinics in Northern Norway.

International Journal of Circumpolar Health, 75(1), 32588.

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Article 3

Dagsvold, I., Møllersen, S., Blix, B.H.

Clinicians' assumptions about Sami culture and their experiences with providing mental health services to indigenous Sami patients in Norway.

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1 Introduction

1.1 Personal motivation

I have been working as a nurse since 1986, and over the years, the significance of Sami culture in health care encounters has become part of my professional reflections and considerations. Professional reflection about the presence of Sami patients and impact of culture proceeded simultaneously with my acquisition of knowledge about Sami history and the lives of the Sami residing in different parts of Norway. I started to notice my Sami patients (in cancer care), and eventually, I realized that despite my being an experienced nurse, there was something in the interaction and the Norwegian language communication with Sami patients that I could not fully grasp. The professional cancer nursing norms at that time idealized direct statements; we were trained to “call things by their proper name,” to emphasize and ensure that the patient had understood the seriousness of the situation. The professional norm-regulated communication contrasted with some Sami patients’ indirect, evasive ways to communicate. At that time, and I am not proud to say this, I considered the evasive way of communication as denial, delaying the process of moving through the phases (from shock and denial to acceptance) in the model of crisis processing. In my master’s thesis, I explored, among other things, “Sami communication about cancer”. However, I realized that the encounters with the patients were influenced by the professional cultural norms and values inherent in cancer nursing. I realized that the culture of (cancer) nursing had a major influence on how I interacted and communicated with the patients. I cannot recall having reflected on the possible impact of language, except for offering to provide an interpreter. This led me to reflect on the impact of the professional cultural norms guiding the clinical work, and how such norms may result in superficial and erroneous interpretations of patients’ forms of expression and behaviour. Later, in my work as an advisor in physical and mental health facilities, and as a lecturer in health programmes, I have attempted to integrate Sami cultural perspectives into health care in practice. I have questioned how health professionals relate to their duty to “culturally adapt” care and treatment to “Sami patients’ culture” and how they transform or operationalize culture theory in (mental) health care. This has been easier said than done. Thus, in my PhD, I wanted to explore the impact and incorporation of Sami culture in health services for the Sami. In sum, my personal and clinical background, knowledge and perceived knowledge gap, narrow preconceptions, curiosity and interest in improving health care for Sami patients have inspired and guided my research.

1.2 A moment of surprise

Initially, in the present study, I did not intend to investigate the impact of language since I do not speak Sami sufficiently well to conduct interviews in Sami and therefore could not explore the use of the Sami language in the therapy sessions. However, already during the first interviews, it became obvious to me that my preconceptions had narrowed my understanding of language and that my interview guide excluded a topic that appeared to be far more complex and important than I had foreseen, namely bilingualism (described in the first article). In one particular interview with a Sami patient, the participant discovered, to his surprise, and shock, that despite speaking Sami as his mother tongue, he was not familiar with words in Sami to express his feelings. He was not used to talking about such matters in Sami, claiming that it was easier to talk about feelings in Norwegian. This interview, upon which I will dwell further in the discussion section, was of major significance for my understanding and the direction of this thesis. What has surprised and taught me the most in this work was to be confronted with my narrowing preconceptions of the meaning of language. The interview with this participant made me reflect on how narrow assumptions about language and culture might influence both the identification and understanding of Sami patients.

1.3 Delimitation of the focus of the study

In this thesis, I focus on the cultural and linguistic aspects in clinical encounters between Sami patients and clinicians. The study was conducted in mental health services; however, mental health assessments, diagnostics and treatment regimens are not studied here. For the study aims, see Chapter 4.

1.4 Outline of the thesis

The thesis consists of eight chapters. The present introductory chapter includes personal motivation and an outline of the thesis. In Chapter 2 (Background), I describe the Sami population in Norway and their right to receive equitable health services adapted to their language and culture. Chapter 3 presents previous research, while the aims of the study are presented in Chapter 4. In Chapter 5, I present theoretical perspectives. Chapter 6 contains the methodological framework, methods and ethical considerations. The results are presented in Chapter 7, followed by a discussion of the methods and the results in Chapter 8. Finally, in Chapter 9, I provide the concluding remarks and suggest some implications for further research and clinical work.

2 Background

The Sami are an indigenous people residing in Norway, Sweden, Finland and the Kola Peninsula in Russia. This study concerns health services to the Sami in Norway. First, a historical account for the assimilation process towards the Sami, before describing Sami societies today.

2.1 Historical account: The Sami and the assimilation policy

From about 1850 until around 1960, the official Norwegian policy towards the Sami was one of assimilation. According to Minde (2005), the assimilation policy in Norway was not unique. Minority groups and indigenous peoples worldwide have been subject to assimilation policies, referred to as “Russification”, “Americanization” (Minde 2005, p. 8), or, as in Norway, “Norwegianization”. The assimilation policy was strongly linked to the emergence of powerful nation-states, where the aim was to strengthen the state by the appearance of ‘one nation, one language’. Minde (2005) stated that the assimilation policy was based on two conditions: nation and security building strategies, and social Darwinist ideas about race. The Sami “appeared as a distinct people who lived in certain places in such concentrated communities that their existence was considered a problem, which called for a special national policy”, i.e. the policy of assimilation (Minde, 2005, p. 7). However, according to Eriksen and Niemi (1981), the Sami were to be assimilated predominantly for civilization purposes (Eriksen & Niemi, 1981, p. 56). The purpose of civilization was based on social Darwinist racial ideas, classifying groups of people as either primitive or civilized. The Sami were classified as “primitive” compared to the Norwegians, and were described as dirty and slovenly, “degenerated and heading towards extinction” (Eriksen & Niemi, 1981; NOU 2001:34). Social Darwinist ideas provided the assimilation policy with ideological legitimacy. The policy aimed to elevate the Sami to a higher level of civilization by bringing about a change from Sami to Norwegian language, culture, and identity (Eriksen & Niemi, 1981; Minde, 2005). The school and the church were considered effective arenas to effectuate the policy. Among the policy tools were boarding schools, assessed as the most effective setting for assimilation and health and social care of Sami children. The national tuberculosis prevention strategies assessed health and social care of the Sami as vital to stopping the spread of tuberculosis (Ryymin, 2008, 2011). Another assimilation tool was the establishment of “*Finnefondet*” [the Lapp fund] in 1851, which funded the boarding schools and rewarded teachers’ efforts to linguistically assimilate Sami schoolchildren (Minde, 2005). The

Education Act of 1880 prohibited the use of the Sami language in schools, both in class and during breaks (Eriksen & Niemi, 1981; Koskinen, 1995; Minde, 2005).

The assimilation policy also interfered with access to land, housing choices and financial matters. For example, the Land Act of 1902 required that citizens had Norwegian names, spoke Norwegian as their everyday language, and were capable of reading and writing Norwegian in order to purchase state land in Finnmark County (NOU 2001:34). Access to bank loans became crucial when those who lived on what was defined as state land were forced to buy the land they had used for generations. To obtain bank loans, the Sami had to have Norwegian family names and move away from traditional Sami areas to Norwegian settlements (Bjørklund, 1994; Olsen & Eide, 1999). In several areas of society, it was difficult, if not impossible, to “be a Sami”. The assimilation policy had a profound impact on whether Sami individuals considered themselves as Sami or not. For example, in Kvænangen municipality in Troms County, the proportion of Sami was reduced from 44% to nil in the period 1930-1950, while the proportion of Norwegians increased from 40% to 100% (Bjørklund, 1985). According to Minde, “[t]he consequences of the Norwegianization process were individualized and [Sami ethnic identity and speaking the Sami language] were in part associated with shame. Being taken for a Sami in public was a personal defeat” (Minde, 2005, p. 142). The assimilation process resulted in a language shift or reduced Sami language fluency among many Sami, while many also concealed their Sami identity.

2.2 The revitalization process and contemporary Sami societies

In the decades following World War II, in order to counteract the assimilation policy, the Sami initiated a process of ethnic incorporation, i.e. they used their ethnic membership for the “mobilization of group spirit and joint political action vis-à-vis the majority population” (Eidheim 1971, p. 68). Sami political rights were gradually established. In 1956, the Sami Committee, appointed by the Ministry of Church and Educational Affairs, declared that the state should strengthen and develop Sami culture, rather than continuing the policy of assimilation (Ryymin & Andresen, 2009). The Alta case (1979-82), concerning the building of a dam in the Sami inland, intensified Sami resistance against the Norwegian political system and was crucial in the revitalization process (Minde, 2005). The Sami Rights Commission was established in 1980. The work of the Commission resulted in the Sami Act of 1987, ensuring legal rights to safeguard and develop their language, culture, and way of life

(The Sami Act, 1987). Moreover, the Sami Parliament was established in 1989. In 1990, Norway ratified the ILO Convention 169 on Indigenous and Tribal Peoples in the Independent States of 1989. In Norway, the convention applies to the Sami people, who, since 1990 have been recognised as an indigenous people. The incorporation process gradually resulted in more positive descriptions of the Sami people, which, together with acknowledgement as a people, have been important for the pride and collective sense of identity of the Sami (Minde 2003). In 2018, the Norwegian authorities decided to scrutinize the previous assimilation policy, and established the Truth and Reconciliation Commission. The purpose of the Commission's work is to lay a foundation for the recognition of the experiences of Sami, Kven and Norwegian Finns in relation to Norwegian government policy, examine the consequences of the policy, and propose reconciliation measures (Stortinget [The Norwegian Parliament], 2018).

Historically, the Sami lived in rural areas in the Northern, Lule and Southern Sami regions. Sami culture and way of life are often described as reindeer husbandry and small scale fisheries in rural areas, and living in an extended family system. According to H. Gaski (1997), the Sami language has “no traditional concept that covers the whole spectrum of meanings of activities which comprise the components of “culture”. The closest one can come is *Sámi vuohki* which is best translated “Sami ways”, that is, way of being, way of living, mentality and values” (H. Gaski, 1997, p. 10, author's italics). Moreover, Sami culture refers to Sami naming traditions, the *gákti* (the Sami traditional clothing), the Sami *dáidda* (art), *duodji* (handicraft, both artistic and practical objects for everyday use), and the *yoik* (the Sami traditional form of music) (H. Gaski, 1997). In addition, descriptions of Sami culture include references to the Sami religion (pre-Christian shamanism, and later, Laestadianism) and a Sami world view, Sami perceptions of illness (illness can be caused by other people or forces outside the body), folk medicine, the use of a *guvllár* (traditional healer), a Sami way of communicating (indirect, using metaphors, non-verbal language), and Sami norms such as *ieš birget/iešbirgejupmi* (to manage on your own, do not show weakness and do not ask for help) (NOU 1995:6, 1995). The norm of *ieš birget* is referred to as a central part of Sami child rearing, which, along with *narrideapmi* (teasing), is aimed at “hardening” Sami children and preparing them to cope with challenges in life (Balto, 1997).

Contemporary Sami societies are as complex and diverse as other societies, and the Sami population and their needs and preferences are heterogeneous. Today, many Sami have

moved from rural villages to towns and cities (Sørli & Broderstad, 2011). The Sami are the majority population in two municipalities in the interior of Finnmark County (Kárásjohka/Karasjok and Guovdageaidnu/Kautokeino) and also inhabit several other municipalities and cities across the country. The Sami have adapted to other ways of life than the pastoral economies of reindeer herding and fishing, and they are now engaged in many professions and occupations (Hassler, Kvernmo, & Kozlov, 2008; Solbakk, 2004). However, reindeer herding is still considered the most typical Sami livelihood, although less than 10% of the Sami population is occupied in reindeer herding. Employment in primary industries has been reduced (Sámi allaskuvla [Sami University of Applied Sciences], 2009). The statistics on employment in the STN¹ areas indicate that the majority of the population (both Sami and non-Sami) are employed in public administration such as health and social services, education and commerce (Statistics Norway, 2018). Previous gap in socio-economic conditions and living conditions among the Sami and the Norwegian majority population has narrowed considerably (Hassler et al., 2008; Silviken & Kvernmo, 2008). There are Sami kindergartens and school classes in many places, but no official statistics exist on the educational level of the Sami. In the STN areas, the level of education is lower than in other areas in the region and the rest of the country. However, there are significant local differences in the level of education within the STN area. For example, the level of higher education among women in the most typical Sami municipalities, Karasjok and Kautokeino, well known as reindeer herding area, are among the highest in Norway (Statistics Norway, 2019). Students with documented Sami language competence can apply for admission on the Sami quota to higher health professional programmes such as psychology, nursing, physiotherapy and medicine (Samordna opptak [The Norwegian Universities and Colleges Admission Service]). Public services to the Sami are a part of the Norwegian welfare state. In addition, some Sami institutions have been established, such as the Sami Parliament, the Sami University of Applied Sciences, the Centre for Sami Health Research at UiT The Arctic University of Norway, a Sami department in the Norwegian Broadcasting Corporation (NRK Sápmi), *Sámi sierrabibliotehka*/the Sami Special Library and two Sami theatres (Sámi allaskuvla [Sami University of Applied Sciences], 2017; Solbakk, 2004). Moreover, Sami centres and Sami language centres owned by private organizations and/or municipalities have been established in several places in the Sami regions.

¹ The STN areas are certain areas with a relatively large Sami population covered by the Sami Parliament's grant scheme for business development.

2.3 Sami languages

The Sami languages belong to the Finno-Ugric language group, and they differ in the various regions. Sami is an official language in Norway. Hence it follows that Sami and Norwegian are languages of equal worth and status. There are three main Sami languages and regions: Northern Sami (with the greatest number of Sami speakers), Lule Sami and Southern Sami. Within the main languages, there are several dialects and minor languages such as Pite Sami and Skolt Sami. The precise number of Sami speakers in Norway today is not known. Estimates vary between 23,000 (Ministry of Local Government and Modernisation, 2014) and 35,000, depending on how one defines Sami-speaking (Magga, 2002; NOU 2014: 8, 2014). Sami language competence varies between generations, family members and geographical areas, since the intensity of assimilation varied in periods and between Sami areas. Today, most Sami speakers are bilingual, speaking the national language as well as one of the Sami languages (Helander, 2002; Outakoski, 2015; Ravna, 2000; Todal, 2013). The number of monolingual Sami speakers is assumed to be small, predominantly pre-school children, persons with intellectual or cognitive disabilities and older citizens (Ministry of Health and Care Services, 2009). The possibility to use the Sami language in schools gradually improved. The Education Act of 1959 permitted the use of Sami as language of instruction, but only after applying for permission from the Ministry of Education (Koskinen 1995). In 1969, parents were given the right to demand Sami as language of instruction for their children, and since 1990, Sami children have the right to be taught in Sami (Koskinen, 1995). Although the Sami languages are small, endangered languages, new generations of Sami speakers are coming, continuing the need for Sami-speaking health professionals and a language choice in health services to Sami-speaking Sami of all ages.

2.4 Who is Sami?

The Sami population is estimated at about 100,000, of whom roughly 40,000-50,000 live in Norway. However, the estimated number of Sami in Norway is based on historical census data and has remained unchanged since the 1970s (Pettersen & Brustad, 2015). In Norway, it is prohibited to register individual ethnicity data, and there are therefore no census data available on the Sami population and the precise number of Sami in Norway is not known (Pettersen & Brustad, 2015). Moreover, there are no official statistics on mental health, living conditions or health services use for the whole Sami population (Silviken & Kvernmo, 2008; Young, Revich, & Soininen, 2015). Neither health organizations nor health professionals have

information about the ethnic identity of patients. In clinical work, it is forbidden to register ethnicity just for the sake of it; it has to be of clinical relevance, and solely recorded in the individual patient's journal. Many Sami have Norwegian names and do not possess visible cultural markers or knowledge typically associated with Sami culture or traditions (K. Sørli & Broderstad, 2011; T. Sørli, Hansen, & Friborg, 2018). Many Sami express a feeling of grief concerning the loss of their language and traditional knowledge, and many therefore feel excluded from the Sami communities because of the lack of identity markers (Dankertsen, 2014). Consequently, it is not easy to identify a Sami patient by the person's looks, and the sense of Sami self-identification may be ambiguous; people who may "look like" Sami may not self-identify as Sami even if their ancestors were Sami. Nonetheless, health institutions and health professionals in Norway are obliged to provide equitable health services to the Sami, adapted to Sami language and culture. All in all, identifying and drawing conclusions about Sami ethnic identity is not a straightforward task, and must be left to the individual to decide.

2.5 Health services to the Sami in Norway

Included in the establishment of Sami political rights is the right to receive equitable health services. In Norway, the health services are part of the public welfare state system, and health services to the Sami are integrated into this. The welfare state in Norway was established in the 1950s, a time when "*social and cultural equality*" was politically promoted (NOU 2004:13). In the early phase of the rebuilding of the health services after WWII, the population in Norway was considered homogeneous (Ryymin & Andresen, 2009). However, already in the nineteenth century, general practitioners (GPs) working in Finnmark County had reported language barriers with Sami patients in the inland. Also in the 1950s, GPs reported a need for linguistic and cultural adaption of the national anti-tuberculosis strategy. In order to increase participation in the screening programme and thus increase its success, the anti-tuberculosis programme was accommodated to the nomadic reindeer herders' seasonal cycle of migration, and information about tuberculosis was provided in the Sami language to the adult population (Ryymin, 2011, p. 56). However, accommodation of the health care services did not last. Health professionals in Finnmark continued to report language problems and difficulties with scheduling resulting from the seasonal migration pattern of the nomadic reindeer population (Ryymin, 2008; Ryymin & Andresen, 2009; Skodvin, 2012). Eventually, the focus has shifted from 'equal services' to 'equitable

services’; emphasizing the necessity of adjusting the provision of health care to the Sami population. The welfare state principle of equitability means “equal rights and equal access to high-quality, state-funded health services, regardless of among other things, [place of residence], ethnicity, language and culture” (Ryymim & Andresen, 2009, p. 97).

The health services in Norway, including mental health services, are divided into primary health services in the municipalities and specialized health services organized in four regional health authorities. The municipalities are responsible for the treatment of persons with psychological and/or drug related problems. Mental health care for adults consists of decentralized specialist health services at district psychiatric centres (DPC), specialized hospital departments and private practice contract specialists. Both types of institutions offer in-patient, outpatient and ambulatory treatment (Helsedirektoratet [The Norwegian Directorate of Health], 2018a). Clinicians in mental health services are medical doctors, psychologists, nurses, social workers, occupational therapists, and physiotherapists.

2.5.1 Sami patients’ rights to equitable health services

The rights of the Sami people to equitable health services are based on their status as Norwegian citizens and as an indigenous people, articulated in national legislation and international conventions. As Norwegian citizens, the Sami are legally entitled to health services, and as an ethnic minority and indigenous population, they have the right to receive health services in accordance with Sami language and culture. Article 27 of the UN Convention on Civil and Political Rights of 1966 protects minorities from negative discrimination and provides the basis for active support, and forms part of the basis for the inclusion of Section 108 in the Norwegian Constitution in 1998 (Ministry of Health and Care Services, 1998). According to Article 25 in the ILO-convention No.169, indigenous people have the right to enjoy the “highest attainable standard of physical and mental health”, and the right to receive adequate health services. The services should to the largest possible extent be community based, while “maintaining contact with other levels of health care services”. Moreover, the health services should be “planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.” Also, the convention emphasizes the importance of training and employment of local community health workers (ILO No. 169, 1989).

According to the Proposition to the Patient Rights Act, passed in 1998, the design of a service offer and treatment programme must involve the necessary considerations of the Sami patient's cultural and linguistic background. The proposition stated that Sami patients have the right to interact with personnel with the necessary linguistic and cultural competence (Ministry of Health and Care Services, 1998). The Patient Rights Act states: "Information must be adapted to the recipient's individual conditions, such as cultural and linguistic background". The right to receive equitable services is implemented in several laws, such as Helseforetaksloven [Health Authorities and Health Trusts Act] (2001) and Helse- og omsorgstjenesteloven [Health and Care Services Act] (2011). The Health Personnel Act (Helsepersonelloven [Health Personnel Act], 1999) obliges health professionals in Norway to comply with the Patient Rights Act and other legislation ensuring the population's right to receive health services.

In addition to the Patient Rights Act, the Sami Act states that, in the Sami Language Administrative District², the Sami have an extended right to use the Sami language to protect their own interests vis-à-vis local, regional or national public health and social institutions. Moreover, the Sami and the Norwegian languages have equal worth and status (Ministry of Local Government and Modernisation, 2014; The Sámi Act, 1987). However, health institutions are not obliged to employ Sami-speaking personnel; it is considered sufficient to use an interpreter (Ministry of Local Government and Modernisation, 1990; NOU 2016:18, 2016; Skogvang, 2009). Medical records must be written in Norwegian (Forskrift om pasientjournal [Regulations on Patient Records], 2001). Consequently, therapy provided in the Sami language must be documented in the Norwegian language in the patients' medical records. If a patient requires a transcript of her or his medical record, it will be in Norwegian. To meet the needs of Sami-speaking patients, The Sami Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS), has developed a practice where they offer their patients a review of their medical record in Sami with Sami-speaking health professionals (Personal communication with psychiatrist Frøydis Nystad Nilsen, MD, of

² The Sami language administrative district includes: Guovdageaidnu suohkan/Kautokeino municipality, Kárášjoga gielda/Karasjok municipality, Deanu gielda/Tana municipality, Unjárgga gielda/Nesseby municipality and Porsáŋggu gielda/Porsanger municipality in Finnmark County, Gáivuona suohkan/Kåfjord municipality and Loabága suohkan/Lavangen municipality in Troms County, Divtasvuona suohkan/Tysfjord municipality and Aarborte/Hattfjelldal municipality in Nordland County, Snåase tjielte/Snåsa municipality, Raarvihken Tjielte/Røyrvik municipality and Røros municipality in Trøndelag (Ministry of Local Government and Modernisation).

SANKS, Nov 2018). It is not known whether other institutions provide the same service to Sami patients.

2.5.2 Targeted mental health services to the Sami

To improve access to and outcome of health services, in 1983, members of the Sámi Medical Association, Sámi Nurses Association, and Sámi Social Workers Association demanded that health services to the Sami population in Finnmark County must be developed in accordance with the “distinctive Sami cultural and linguistic characteristics” (Severinsen, 1986, p. 59). The requirement for cultural and linguistic facilitation of health services for the Sami is based on an understanding that health is not only a subjective state. The ILO Convention emphasizes that in order for the health services to contribute to good health for users, they must be developed in accordance with the economic, geographical, social and cultural conditions. The Convention also points out that the health service and its users may have different disease understandings and health practices, and that the users' traditional preventative care, healing practices and medicines should be taken into account. Moreover, the Convention also comprise a political dimension whereby indigenous peoples participate in the planning and administration of health services that apply to them. Furthermore, the Convention emphasizes the recruitment and education of health professionals among the peoples concerned (ILO No. 169, 1989).

The development of health services specifically targeted at the Sami started with the establishment of mental health facilities in Finnmark County where the majority of the northern Sami-speaking population reside. The “Plan for Mental Health Services in Finnmark” referred to the term “Sami psychiatry”, defining it as mental health services located in the Sami core areas, provided in Sami by Sami professionals. Moreover, Sami psychiatry referred to mental health care which, in its approaches and treatment methods, is adapted to the Sami culture, way of thinking and way of life (Finnmarks fylkeskommune [Finnmark County Authority], 1994). The Finnmark mental health plan was followed by the governmental “Plan for Health and Social Services to the Sami Population in Norway, NOU 1995:6” and the action plan “Diversity and Equality. The Government's Action Plan for Health and Social Services for the Sami Population in Norway 2002-2005” (Ministry of Health and Care Services, 2002-2005; NOU 1995:6, 1995). The plans aimed to ensure equitability, defined as equal access to health services and equally good treatment results for Sami patients independently of geography and the patients' linguistic and cultural

backgrounds. A follow-up document to the plan for health services to the Sami population stated that the lack of Sami-speaking health professionals is the main cause of the lack of culturally adapted health services to the Sami (NOU 2016:18, 2016).

In 1985, two mental health facilities in Finnmark County, the child and adolescent psychiatric outpatient clinic (BUP) in Kárásjohka/Karasjok and the adult psychiatric outpatient clinic (VPP) in Leavdnja/Lakselv, were assigned the responsibility to develop mental health services to the Sami population in Mid Finnmark. In 1994, the two institutions were merged to become the Mid Finnmark District Psychiatric Centre (DPC), and the responsibility was expanded to provide services to the Sami people all over Finnmark. Since 2002, the Mid Finnmark DPC has become SANKS, which is integrated into Finnmark Hospital Trust, under the North Norway Regional Health Authority. The Sami have, due to the right of all patients to choose their treatment centre (Direktoratet for E-helse [The Norwegian Directorate for eHealth], (2017), the right to request treatment at SANKS regardless of where they live in Norway. SANKS has a national responsibility to offer mental health services to the Sami throughout Norway, as well as providing such services to all inhabitants in the catchment area of Mid Finnmark, regardless of ethnic and cultural background. SANKS is located in the inland of Finnmark, but has established decentralized offices in several other places in the Sami regions, and employs both Sami and non-Sami-speaking staff (Finnmarkssykehuset [Finnmark Hospital Trust]). The vision of SANKS is to help to ensure that the Sami population receives an equitable offer in mental health care and substance abuse. The aims are to develop treatment methods that are culturally adapted to the Sami and to enhance research and education concerning the Sami language and cultural understanding (Finnmarkssykehuset [Finnmark Hospital Trust]).

In addition to Sami-speaking clinicians and courses in “cultural competence”, the family ward at SANKS has included a “culturally adapted” form of treatment, that is, the use of *meahcceterapiija* (“treatment out in nature”) where the clinicians and the family spend some days out in the nature as the context for the treatment. The *meahcceterapiija* is a standard part of the family treatment package for both Sami and non-Sami families (Finnmarkssykehuset [Finnmark Hospital Trust]). SANKS and the Saami Council have initiated the development of a “Plan for Suicide Prevention among Indigenous Sami in Norway, Sweden, and Finland”, including an 11-point strategy to prevent suicides (SANKS & Saami Council, 2017). The strategy is broad, including social, medical and political aspects such as Sami self-determination, historical trauma, ethnic discrimination, equitable mental health care and

internal problems in Sami communities involving violence and denunciation of homosexuality and transsexuality. However, the strategy is questioned because of limited evidence supporting the suggested measures. So far, the strategy is neither implemented nor evaluated.

The development of targeted health services for the Sami in Norway was based on clinical experiences narrated by Sami and non-Sami health professionals, and political visions among local, regional and state politicians. According to several governmental plans and propositions, lack of Sami linguistic and cultural competence among health professionals can cause communication problems, misinterpretation of symptoms and failed treatment, especially in relation to mental health. A recommendation common to the various government documents is to prioritize the education of health professionals in “Sami language and cultural competence” (Ministry of Health and Care Services, 2002-2005, 2006, 2009; NOU 1995:6, 1995; NOU 2016:18, 2016). Since the 1960s, to increase the number of Sami health professionals, there has been a Sami quota in health education, aiming to serve Sami communities with Sami and Sami-speaking staff. M. Gaski, Abelsen, and Hasvold (2008) examined the effects of the admission policy for Sami medical students. However, the authors were not able to conclude whether the special grounds for admission led to more Sami doctors working in the Sami areas.

3 Previous research

Worldwide, indigenous peoples' culture and different (sic) language are assumed to be explanations for the high rates of mental health problems and poorer access to health services among indigenous people (Gracey & King, 2009; Kirmayer, 2012; Leske et al., 2016). According to Kirmayer (2012, p.149), [c]ulture influences the experience, expression, course and outcome of mental health problems, help-seeking and the response to health promotion, prevention or treatment interventions." Consequently, cultural adaptation of health services and cultural competence among health professionals have been promoted as measures to improve health services and reduce health disparities of indigenous peoples (Browne & Varcoe, 2009; King, Smith, & Gracey, 2009; Kirmayer, 2012). However, indigenous peoples are heterogeneous; they live in "extremely varied local environments and national [and cultural] contexts with important consequences for their health" and living conditions (Kirmayer & Brass, 2016, p. 105). As previously mentioned, this study does not investigate mental health *per se*, but focuses on how Sami culture and language affects mental services. The main focus in this chapter is therefore on how language, culture, ethnicity and living conditions influence the use of health services among the Sami, and I will only briefly refer to relevant research on mental health and living condition.

3.1. Sami culture, ethnic identity, living conditions and mental health problems

In general, research indicates that the Sami in Norway have overall favourable health indicators and that there are minor mental health differences between the indigenous Sami and the Norwegian majority population (Bals, Turi, Skre & Kvernmo, 2010; Hansen & Sørli, 2012; Hassler et al., 2008; Kvernmo, 2004; Møllersen, Sexton, & Holte, 2005; Silvikén & Kvernmo, 2008; Sjölander, 2011; Turi, 2011). However, some exceptions are reported: more Sami than Norwegians have died in suicide in a certain time period (Silvikén, Haldorsen, & Kvernmo, 2006), the Sami experience ethnic discrimination, influencing negatively on their mental health (Hansen, 2015; Hansen & Sørli, 2012), and more Sami have reported interpersonal violence than the Norwegians (Eriksen 2017). Moreover, the work-related mental stress reindeer husbandry is found to be alarmingly high, implying a risk of mental distress, however, the reindeer-herders report high levels of well-being despite work-related stress (Hedlund & Moe, 2000; Møllersen, Stordahl, Eira-Åhren, & Tørres, 2016; Silvikén, 2011).

Moreover, Sami ethnic identity is referred to as a stigma, particularly in the low Sami density areas, such as the coastal areas and other communities outside the Sami core areas, where the assimilation process has had the greatest impact. Sami individuals with a strong ethnic identity living in minority position (in low Sami density areas), are associated with psychological stress and discrimination (Bals, Turi, Skre, & Kvernmo, 2010; Hansen, 2011; Hansen, Minton, Friborg, & Sørli, 2016; Kvernmo, 2004; Silviken & Kvernmo, 2008). Also, according to Bals et al. (2010), Sami youth who have not learned their native language at home are more vulnerable to experiencing internalizing symptoms than Sami youth who have learned the Sami language at home. According to Silviken and Kvernmo (2008, p. 372), “The process of revitalization has resulted in the Sami enjoying a much greater extent of cultural equality and less socio-economic disadvantage compared with other indigenous peoples, which is also reflected [positively] in their health status”. M. Gaski, Melhus, Deraas, & Førde (2011, p.7) have suggested that the small health differences between the Sami and the Norwegian majority population are “consequences of [the] assimilation”, as if the lack of differences were positive side effects of the assimilation (Blix, 2013, p.13).

3.2. Use of health services among the Sami

A pioneering study from the 1970s reported that the Sami consulted the doctor less often than Norwegians, the Sami had more undiagnosed illnesses, and when illnesses were diagnosed, they were not followed up by the health services (Fugelli, 1986). Fugelli explained these results with the lack of decentralized medical services, long distances to medical facilities, and Sami cultural issues such as problems with making and keeping appointments because of the unpredictable lifestyle of reindeer herding, linguistic communication problems, and extensive use of traditional medicine and local healers (Fugelli, 1986).

More recent research on health services use among the Sami is limited, and the results are ambiguous and inconclusive. Hedlund and Moe (2000) stated that the southern Sami make limited use of health services because of the historical relationship between the Sami and Norwegians and the assimilation process. According to the authors, the southern Sami are less likely to seek help, they only approach the health care system when there are serious problems, they have little confidence in health care, and they feel that health professionals do not understand them. The authors state that the southern Sami, living in low-density Sami areas, do not report health problems because the health workers are Norwegians.

Another study found that specialized mental health facilities located in high-density Sami areas offer more consultations to patients than those in low-density Sami regions (Møllersen et al., 2005). Overall, equally frequent use of health services was found among Sami and non-Sami youth but the authors found associations between health services use and ethnic identity and living in more or less assimilated contexts (Turi, Bals, Skre, & Kvernmo, 2009).

A study on admissions and inpatient stays in mental health facilities in northern Norway found no differences between the Sami and the control groups (Norum, Bjerke, Nybrodahl, & Olsen, 2012). However, the study by Norum et al. (2012) has been criticized for using municipalities with a significant proportion of Sami for control groups, and for mistaking the concept of equitability with equity (NRK Troms og Finnmark, 2011). Another study in a mental health facility compared treatment, treatment satisfaction and recovery among Sami and Norwegian patients receiving treatment from Sami and Norwegian clinicians (T. Sørлие & Nergård, 2005). The results of the study indicated that the Sami patients were less satisfied with contact with clinicians, had received less information and experienced less user participation than Norwegian patients. In the study by T. Sørлие and Nergård (2005), the Sami patients were identified and recruited on the basis of “stable ethnic self-definition of the patient, use of the Sami language (their own, their parents, grandparents, among friends, at school), and selected Sami cultural traditions related to the use of names, clothes, food, upbringing of children, Sami song or yoik, use of traditional helpers, and so on. [Moreover, it was the project’s] Sami co-workers [who] made the final determination of patient ethnicity at the end of the hospital stay” (T. Sørлие & Nergård, 2005, p. 299). The study could be criticized for using essentialist cultural traits when identifying Sami patients, and for allowing co-workers to determine study participants’ ethnic identity. Also, a study investigating hospital use in six municipalities in the Sami administrative area (inhabited by both Sami and non-Sami individuals) indicated that hospital expenditure in the “Sami municipalities” was similar to corresponding municipalities in the same geographic area but higher than the national average (M. Gaski et al., 2011, pp. 1-2). Although both the “Sami municipalities” and the corresponding municipalities are inhabited by people of diverse ethnic backgrounds, M. Gaski et al. (2011) concluded that no ethnic barriers prevented Sami inhabitants from utilization of somatic hospital and specialist services. M. Gaski et al. (2011) did not discuss other possible reasons for higher consumption of health care, such as more health problems, or health providers experiencing communication problems and misunderstandings leading to problems with diagnosis and more admissions/check-ups during treatment.

3.3. The impact of Sami culture on the use and delivery of health services

Research results indicate that, despite minor differences in health status and health services use, the Sami are less satisfied with the health services, presumably because of linguistic and cultural barriers (Møllersen et al., 2005; Nystad, Melhus, & Lund, 2008; T. Sørli & Nergård, 2005). Several Sami cultural factors and *changes* in Sami culture have been attributed as reasons for the dissatisfaction with health services. In a study from the Lule Sami region, Olsen and Eide (1999) explored how cultural differences influenced the relationship and cooperation between Sami users and health professionals in primary health care. A particular Sami health and illness perception is referred to as the major cultural difference between the Sami and health professionals (Bongo, 2006; Kuperus, 2001; Olsen & Eide, 1999). Olsen and Eide (1999, pp. 16, 48) stated that the Sami relate to illness as a collective rather than an individual matter, so that illness in a person concerns the community the individual is part of. Olsen and Eide (1999) included a focus on the culture of the health care system, emphasizing that illness perceptions are present in patients, clinicians and the health care system. Some authors have stated that the Sami use traditional healing methods in addition to public health services and wish traditional healing methods could be integrated in the services (Larsen, 2018; Sexton, 2009).

Some researchers have reported that health service use among the Sami with is related to the Sami language and communication style. Researchers have stated that the Sami communicate in indirect non-verbal ways, that they do not talk about illness or talk about illness in different ways (Bongo, 2012; Hedlund & Moe, 2000; Kuperus, 2001; Mehus, Bongo, & Moffitt, 2018). According to Bongo (2012), the Sami included in her study, influenced by the Sami norm of *ieš birget*, coped with illness in silent and indirect ways, and requests for help and offers of health care were communicated indirectly. Other authors have described the phenomenon of *ieš birget* as idealizing autonomy, a preference for managing on one's own and the avoidance of seeking help from both family members and mental health services (Kaiser, N., Ruong, T., & Salander Renberg, E., 2013; Silviken, 2009; Stoor, J. P., Berntsen, G., Hjelmeland, H., & Silviken, A., 2019). The *ieš birget* phenomenon might influence Sami health professionals as well as the users of the health services. Dyregrov et al. (2014) suggested that local health professionals "themselves may have internalized the cultural norm *Ieš birget*, which can completely reinforce [...] expectations [that Sami users fend for themselves] and subsequent practices [of leaving it to the users to initiate help] (Dyregrov, Berntsen, & Silviken, 2014, p.

56). Dyregrov et al. (2014, p. 54) demonstrated that the bereaved after sudden death found “the absence of an outreach approach and passive helpers to be the most important barrier to adequate help”. Another assumption about the “Sami way” is that “the Sami take care of their own”, which is referred to as an important social and cultural support system. However, as demonstrated by Blix and Hamran (2017), this is not always the case. Sami service users may not get the help they need because health care professionals attribute the service users’ reluctance to seek and accept help to their culture. The multicultural competence of the Sami is also described as having a positive impact on their use of the health services. As mentioned above, Turi et al. (2009) found that Sami youth used health services just as much as non-Sami. The author attributed this finding to the multicultural competence among the Sami youth, ascribing them the cultural skills to manage the meeting with Norwegian health professionals without “emotional discomfort or communication barriers” (Turi et al., 2009).

3.4. Cultural adaption of mental health services to the Sami

Research on culturally based interventions is limited. Ethnic match between the patient and the therapist and the cultural competence of the therapists are described as factors that can be of importance for enhancing cultural facilitation. Ethnic match between clinicians and patients is assumed to improve the quality of health care (Kirmayer, 2012). Some studies have investigated the effect of ethnicity, and clinicians’ treatment strategies towards Sami and non-Sami patients (Møllersen et al., 2005; Møllersen, Sexton, & Holte, 2009; Møllersen, Sexton, & Holte, 2010). In these studies, clinicians’ ethnicity and ethnic match predicted the choice of treatment strategy. According to Møllersen (2005), Sami clinicians possibly chose verbal therapy less often than medication because Sami clients may have been perceived as less introspective and less verbally oriented than clients of non-Sami background. However, in another study, the authors stated that deeper communication is likely to be eased in ethnically matched treatment pairs. Compared to non-Sami clients, the treatment outcome for Sami clients was equally good with less use of verbal therapy, fewer sessions and shorter treatment durations (Møllersen et al., 2010). I have not found any research that has reproduced the Møllersen studies or whether this has been explored further.

Sami cultural competence is perceived as vital for the use of health services by southern Sami. Kuperus (2001) stated that the southern Sami do not use and do not trust the mental health services because of the lack of Sami cultural competence among the health professionals.

Southern Sami are assumed to be afraid to be perceived as “crazy” when telling about experiences of “cultural phenomena” (Kuperus, 2001). The author suggested that the mental health services should employ a Sami-speaking cultural broker (interpreter), who could act both as an interpreter and as a lecturer in southern Sami culture. Research concerning the use and effect of Sami cultural brokers has not been found. According to Kuperus (2001, p. 34), therapists must have some “specific knowledge” of Sami patients’ different and culturally-based perceptions of illness and “normal behaviour”.

T. Sørli and Nergård (2005) suggested that to improve the services, the health professionals and mental health units serving Sami patients should know about Sami cultural traditions, offer therapy in the Sami language and co-operate with traditional helpers. Sexton (2009) suggested that health professionals should expand the [Western psychiatric] treatment paradigm and include traditional healing methods in public mental health treatment.

Moreover, Sexton (2009) stated that health providers with a Sami background could adapt mental health care and work from “within the Sami world-view” (Sexton, 2009).

According to Redvers, J., Bjerregaard, P., Eriksen, H., Fanian, S., Healey, G., Hiratsuka, V., . . . Chatwood, S. (2015), there are few programmes or interventions concerning mental well-being among the circumpolar indigenous populations. This also applies to the Norwegian Sami context, and the few existing measures have not been investigated in research. One master’s thesis reports that the users of the *meahcceterapiija* evaluated the context as positive, allowing for more free talk, an informal conversation style and not limiting the talk to consultations at specific times (Skårland, 2017).

Intervention studies investigating the effect and/or experience of “cultural competence” or “culturally adapted services” regarding the treatment of Sami patients have not been found.

3.5. The use of Sami language in mental health services

As mentioned in Chapter 2.3.1, the Sami in Norway have a right to speak Sami when in need of health services. Also, the need to speak the Sami language has been a major argument for establishing specifically targeted health services to the Sami. The use of the Sami language is described as crucial to enable Sami patients to be understood and correctly diagnosed and treated (Kuperus, 2001; Olsen & Eide, 1999, p. 51). It has also been reported that although the Sami can speak Norwegian well in everyday situations, they sometimes only speak Sami when they are ill and weak (Hedlund & Moe 2000). Kuperus (2001, p. 115) stated that to be

able to understand the underlying cultural meaning in communication, therapists need not only language skills but also knowledge of Sami patients' culture.

I have only been able to identify two research studies that investigated language use in health care. Nystad et al. (2008) demonstrated that Sami-speaking patients were less satisfied with general practitioners' services because of the lack of opportunity to speak Sami and the more frequent occurrence of linguistic misunderstandings. A study in a specialized mental health hospital indicated that Sami-speaking patients were not always identified as Sami speakers and only occasionally received therapy in Sami (T. Sørli & Nergård, 2005). Research investigating possible consequences of the lack of possibilities to speak Sami in therapy has not been found. As noted in Article 1, language surveys of the use of the Sami language show considerable variation in opportunities to use Sami in local health care, and there is a lack of Sami-speaking health professionals. Health services in the Sami majority regions have more Sami-speaking health personnel, but even there service users are dissatisfied with the possibilities to speak Sami when receiving health care (Angell, Balto, Josefsen, Pedersen, & Nygaard, 2012; Skålnes & M. Gaski, 2000; Solstad & Balto, 2012). The results of the studies of language concur with the research results in Nystad et al., (2008) and T. Sørli & Nergård (2005).

In sum, research on the impact of Sami culture and language regarding health services use is limited. Most studies focus predominantly on clinicians' experiences and assumptions of the impact of Sami culture. There is limited knowledge about the preferences, and needs of the Sami patients and users of the health services as described by themselves. There is also limited research on how to incorporate knowledge about Sami culture into clinical health care practice. Moreover, the varied and unsystematic definition of ethnicity makes it difficult to conclude on health status and health service use among the Sami people. The results in studies of mental health and health services use refer to ethnic identity in a variety of ways. According to Pettersen (2015, p. 1), health research studies "tend to apply a variety of Sami inclusion criteria and categories". Information on Sami ethnicity in research can be obtained either through direct questions about ethnic affiliation (self-identification and/or language fluency), or through residence in a geographical area (Senter for samisk helseforskning (SSHF), 2015). In the Sami statistics provided by Statistics Norway, the Sami settlement areas are based on geography, and limited to the scope of the Sami Parliament's grant schemes for business development, the STN area, which lies north of the Arctic Circle

(Saltfjellet), consisting of both Sami and non-Sami inhabitants. As of 2018, the STN area accounts for 14 per cent of the population north of the Arctic Circle. The Sami settlement area does not include towns in the STN area (Sámi allaskuvla [Sami University of Applied Sciences], 2018). The Sami populations south of the STN area are not included in the Sami statistics (Sámi allaskuvla [Sami University of Applied Sciences], 2012). Pettersen (2015) stated that the varied use of Sami ethnicity registration may give rise to uncertainty regarding the trustworthiness of the research results about Sami health issues and complicate comparisons between studies. I have not investigated or compared the Sami inclusion criteria and categories in the research studies mentioned in this chapter. However, I find it difficult to draw conclusions on the impact of Sami culture and language on mental health and health services use on the basis of the identified studies.

4 Aims

The overall aim of the thesis was to explore, identify and describe the significance ascribed to culture and language in mental health care by clinicians and Sami patients in order to enhance the understanding of cultural and linguistic adaption of mental health services to the Sami.

The thesis is based on three articles that address the overall aim from different perspectives.

Article 1:

The aim of this article was to explore the significance of language and culture in communication about mental health topics as experienced by Sami patients receiving mental health treatment. The research questions were:

- In what way and in what language do Sami patients talk about mental problems in therapy?
- How do Sami patients experience and handle cultural norms in a mental health treatment setting?

Article 2:

The aim of this article was to explore how clinicians identify and respond to Sami patients' language data, as well as how they experience provision of therapy to Sami-speaking patients in outpatient mental health clinics in Sami language administrative districts. The research questions were:

- How do the clinicians identify and respond to Sami patients' language data?
- How do the clinicians experience provision of linguistically appropriate therapy to Sami-speaking patients?

Article 3:

The aim of this article was to explore clinicians' assumptions about Sami culture, and if and how assumptions of culture influenced their understanding of and interaction with Sami patients in mental health therapy. The research questions were:

- What do the clinicians refer to as Sami culture?
- How do they consider that clinical encounters with Sami patients are influenced by Sami culture?
- How do the clinicians transform assumptions about Sami culture into mental health care towards Sami patients?

5 Theoretical framework

5.1 The concept of culture

As noted in Article 3 (in press), culture is a complex concept, definitions are many, and theories are innumerable. Attempts at answering the ontological question of what culture “is” have resulted in hundreds of definitions of culture (Kroeber & Kluckhohn, 1952). According to Sobo (2009), when talking about culture, the definition in Tylor’s book “Primitive cultures” from 1871 is often highlighted: “Culture, or civilization [...] is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (cited in Sobo, 2009, p. 107). Tylor’s and similar definitions demonstrate that culture has been categorized on different levels, ranking from civilization down to inferior culture belonging to “primitive” people (Sobo 2009). The racial connection between groups of people and culture was, as described in Chapter 2.2, the ideological basis for the assimilation policy, aiming at “elevating” inferior, indigenous peoples of primitive cultures to a more civilized level. An essentialist understanding of culture has been criticized by Barth (1994, p.177), who stated: “... empirical variations in culture form a continuum that cannot be divided into clearly distinct and internally unified ‘cultures’, belonging to distinct ethnic groups.” Categorizing and dichotomizing culture as primitive or civilized implies ranking, simplifying and essentializing not only culture, but also the (ethnic) group associated with the cultural traits. Cultural essentialism implies “othering” and culturalism, i.e. anticipating that the culturally different “others” think, feel or act in certain ways due to their culture (Vandenberg, 2010). When focusing solely on the culture of the assumed different “others”, our own culture appears as the “neutral position” and remains unexplored (Johnson, J.L., et al., 2004).

This thesis is based on a constructivist view of culture as patterns of shared, acquired values, habits and behaviour co-occurring in particular groups and dynamic in nature. Culture is fluid and shifting, continuously negotiated, and cultural ideas and perceptions can be contradictory, dysfunctional, and differently distributed among people (Barth, 1994; Hastrup, 2004; Sobo, 2009). Moreover, ideas about culture must be seen in relation to social, historical and political processes, including power structures within societies (Vandenberg, 2010; Kirmayer, 2012). Although individuals may be more or less influenced by culture and in different ways, culture does not *determine* individuals’ mindsets and modes of living. Barth (1994, p.177) argues that “although we mainly learn cultural ideas - our basis for interpretation and action in the world -

from others, culture is built up in each of us as a deposit of our own experiences.” Moreover, “[i]t is therefore necessary to observe and analyse the experiences that shape ethnic identities - it is not enough to make a list of objective cultural traits and say that they define ethnic identity” (Barth, 1994, p. 177).

Culture relates to “processes of meaning making” (Vandenberg, 2010, p. 240). In a health context, focusing on culture and meaning making can shed light on cultural ideas about illness perceptions, ideas about effective treatment methods and help-seeking behaviours (Kirmayer, 2012; Kleinman & Benson, 2006). Descriptions of what culture “is” may serve as a starting point; however, understanding the impact of culture in a health context is not a straightforward task. Culture is negotiated and made more or less relevant in interaction between individuals in social situations. Predicting how culture will unfold in clinical encounters is difficult, given that culture is constantly negotiated between the patient and the clinician in the interaction and communication in clinical encounters.

5.2 Cultural adaption and cultural competence

Although many anthropologists have become more reluctant to use the concept of culture in recent decades, the concept has strengthened its position in the health care disciplines (Blix, 2014; Schackt, 2009). As mentioned in Chapter 3, indigenous peoples’ culture often serve as explanations of why they have poorer health status and use the health services less often than do the majority populations. When targeting patients’ culture as the cause of inequities, cultural competence emerged as an approach to overcome the patient bias (Sobo, 2009). Increased cultural competence among health professionals has been promoted as a measure to improve health services and reduce health differences among indigenous peoples (Browne & Varcoe, 2009; King, Smith and Gracey, 2009; Kirmayer, 2012; Sobo, 2009). Cultural competence has been criticized for its underpinning of essentialism and “othering” practice in focusing solely on the culture of the culturally different “others”. Cultural competence is introduced as the competence necessary to provide health care in accordance with the culture of the indigenous patients. In this sense, the significance of the cultures of health services and clinicians is ignored.

Cultural competence has been defined as skills, behaviour and attitudes that enable systems or professionals to work effectively in cross-cultural situations (Kirmayer, 2012; Sobo, 2009, p.

106). More specifically, cultural competence “describes the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt, Green, & Carrillo, 2002, p. v). According to Adamson, Warfa and Bhui (2011), cultural competence training focuses on “cultural difference [in the other] and encompasses a wide range of activities designed to improve cultural awareness, knowledge and understanding” among health practitioners. Moreover, the authors stated, “cultural competence training focuses less on cultural considerations and adaption of specific clinical practices or procedures”. According to Betancourt et al. (2002) and Kirmayer (2012), cultural competence can be addressed at three levels; “the organization of health systems and institutions, the training and composition of the health work force, and the specific models of care or types of intervention” (Kirmayer, 2012, p. 151). With regard to the latter, cultural adaption of interventions involves adjusting style of interaction and communication to the patient, or referral to other sources of help or healing. However, in terms of interventions, there is a lack of evidence as to whether cultural adaption results in improved health or increased use of health services (Betancourt et al, 2002; Alizadeh & Chavan, 2016; Browne & Varcoe, 2009; Kirmayer, 2012; Kleinman & Benson, 2006). Organizational cultural competence involves institutional policies of equity and cultural diversity awareness. Adamson et al. (2011) stated that there is a relationship between the cultural competence (CC) of health practitioners and the cultural competence of the organization: “organizations that incorporate CC into their strategic planning and operational policies are more likely to develop health practitioners and leaders that are culturally competent”. Clinical cultural competence in health professionals refers to training of professionals in cultural knowledge, skills and attitudes. Cultural competence among health professionals is most often referred to as the measure to achieve culturally adapted health services to indigenous patients.

Many models of cultural competence, textbooks and teaching material have been developed to improve clinicians’ “cross-cultural” skills to enable them to care for culturally different patients. However, the culture theorizing underpinning cultural competence is increasingly being questioned and debated (Browne & Varcoe, 2006; Gray & Thomas, 2006; Sobo, 2009; Vandenberg, 2010). Culture theorizing refers here to theories about the relationship between culture, mental health and mental health care (Vandenberg, 2010)³. Therefore, the ontological

³ Vandenberg (2010) originally refers to nursing; however, I find the theory transferable to mental health care.

question of what culture “is” will be crucial to the understanding of what cultural competence is. The cultural competence concept has been criticized for being based on an essentialist view of culture, presupposing that individuals of a certain (particularly cultural or ethnic) group think, feel or act in certain ways due to their culture. This implies that cultural competence means to learn about “the culture of the cultural others”. When cultural essentialism underpins cultural competence in health care, it may involve a risk of failing to consider the individual patient’s preferences, life history and broader social context (Browne & Varcoe, 2006; Kirmayer, 2012; Kleinman & Benson, 2006). Moreover, cultural essentialism has been criticized for ignoring complexity and the impact of other significant factors such as gender, education, class, economy and geographical location (Kirmayer, 2012; Sobo, 2009). As mentioned, cultural competence has been criticized for “othering”, i.e. focusing solely on the culture of the culturally different “others”. Othering practice refers to the question of who has culture and the distinction between the “civilized” and the “other”, “cultural” people. When focusing on the other, cultural competence practice tends to ignore the significance of the cultures of health services and clinicians (Sobo, 2009). Additionally, there are limited descriptions of how to operationalize cultural competence in clinical practice without reducing holistic care to “technical skills for which clinicians can be trained to develop expertise in how to treat a patient of a given ethnic background” (Kleinman & Benson, 2006, p. 1673; Browne & Varcoe, 2009; DelVecchio, Good, & Hannah, 2015; Kirmayer, 2012; Kleinman & Benson, 2006; Sobo, 2009).

The Sami anthropologist Stordahl (1998) has, based on her work in a Sami mental health facility, developed a model of cultural understanding, illustrating key concepts that need to be analysed to achieve an understanding of the impact of culture in clinical practice. The model illustrates the complexity in the process of integration of cultural aspects into clinical practice. It shows how clinical practice is an ongoing dynamic process involving “contextual knowledge”, assessment of applied “explanatory models”, as well as “cultural self-reflection”. *Contextual knowledge* implies knowledge about culture, history, politics and minority issues in the local community, acknowledging that the contexts in which the patients live influence their experiences and expressions of mental health problems and the treatment process. Contextual knowledge might serve as background knowledge for clinicians, informing them about local conditions possibly relevant in clinical encounters. *Cultural self-reflection* implies that clinicians need to reflect on their own cultural and professional backgrounds, values and categories and how these influence their understanding of and interaction with patients.

Explanatory models refer to the ways clinicians understand and explain the phenomena appearing in clinical encounters, e.g. explanatory models of perceptions of illness. Health professionals are educated and trained in a cultural system with its own terms for health and illness (Sobo, 2009). For the health professional, it is crucial to reflect on the explanatory models underpinning one's understanding of patients and on one's own impact. Stordahl (1998) distinguishes between the cultural knowledge one acquires by being a member of a community (both private and professionally), and the analytical competence needed to identify and understand the impact of culture in clinical practice. Stordahl compares this with linguistic competence, distinguishing between the ability to speak a language and academic, theoretical linguistic competence (Stordahl 1998). According to Stordahl (1998), analytical competence is not an innate capacity; therefore, ethnic match does not necessarily imply cultural understanding. Consequently, both Sami and non-Sami health professionals must acquire professional analytical expertise. Analytical competence is needed to assess the impact of culture and other contextual factors on clinical practice. However, as Stordahl (1998) states, there is a lack of culture analytical competence among health professionals. To my knowledge, Stordahl's model has not been integrated or tested in clinical units providing mental health care to Sami patients.

5.3 Language use and bilingualism

The understanding of language applied in this thesis is based on insights from the field of sociolinguistics. Sociolinguistics recognizes that individuals can use different languages in their everyday lives across a variety of life events, in different social contexts and in interaction with different people (Deckert & Vickers, 2011). The use of different languages implies bilingualism, defined as individuals having more than one language in their linguistic repertoire and alternating the use of the languages in their daily lives (Grosjean 2015; Outakoski 2015). Language use is not random; individuals use their languages "for different purposes, in different domains of life, with different people" (Grosjean 2015, p. 574). Different aspects of life often require different languages, for example whether the discourse situation is private or public, and whether the role relationship between the interlocutors is intimate or not. In a study on language use among the Sami, Helander (1984) found coherence between language, relationships and spheres. The Sami spoke Sami language with Sami individuals (intra-ethnic, intimate relation) in the private sphere, but used the majority language while communicating with non-Sami individuals in non-intimate relationships in

public. Moreover, language use varies with “topical regulation”, implying that some topics are better handled in one language than in the other (Fishman, 1965; Grosjean, 2015). As noted in the first article, bilingual speakers may acquire the habit of speaking about a certain topic in one language, because the other language lacks specific terms, or the speaker is not familiar with the terms. Language choice may be influenced by cultural norms of what is considered appropriate to talk about. Consequently, bilingual speakers may choose different languages and different spheres to enable communication about norm-regulated topics.

Language use is a social and cultural activity, where people who speak the same language communicate and interact with each other. Grosjean (2015) reminds us that being bilingual implies being more or less familiar with the cultural contexts in which the languages are used. Bilinguals may adapt, at least in part, their language use to the ongoing interaction and communication in different sociocultural contexts. The study of language use in social contexts includes focusing on the close coherence between language, culture and identity. In addition, language competence and language use are influenced by historical and political factors. Language is closely connected with ethnic identity; therefore, at times, the use of the Sami language in public has been controversial. The Norwegian anthropologist Harald Eidheim wrote a landmark article about language switching among Sami in a small village in a sea Sami area in the 1960s. Eidheim (1971) described how the Sami spoke Sami in the private sphere where “outsiders” were not present and spoke Norwegian in the public sphere. Eidheim related the language use to the stigmatized Sami ethnic identity at the time. The assimilation policy resulted in perceptions of Sami identity as a disgrace, a stigma and a hidden identity. Many Sami lost their Sami language competence, and those who did speak Sami, spoke Sami only among other Sami-speaking “allies” (in the private sphere/back stage (cf. Goffman)). Eidheim (1971) illustrated the close relationship between language use and identity in a socio-cultural context in a particular historical time and political circumstances.

The manner in which a person has become bilingual may influence the person’s identification as a Sami speaker or a Norwegian speaker. Forced assimilation, being denied the use of the Sami language and the stigma associated with Sami language and culture have caused many Sami to hide their Sami identity and hide, or forget, their Sami language competence. Consequently, many apparently Norwegian citizens may have a hidden or forgotten Sami family and language history. On the other hand, people who speak more than one language may not accept being labelled bilingual nor identify with more than one of the language

societies in which the languages are being used (Grosjean, 2015). In the Sami context, many Sami may identify solely as Sami and Sami-speaking although they also speak Norwegian and live in Norwegian society. This may, according to Outakoski (2015), explain why research on language skills among the Sami has focused predominantly on *Sami* language skills, and not bilingualism and skills in other languages. Although Sami language revitalization has been the official Norwegian policy since the 1970s and 1980s, Sami languages have remained the language of the ethnic minority, the Sami. Only a few Norwegian-speaking individuals have acquired Sami language competence, which means that Norwegian is used in most situations where Norwegian speakers are present (Helander 2009). Research on the impact of speaking Sami or Norwegian in therapy has not been identified.

6 Methodology and methods

Qualitative research involves “the systematic collection, organization, and interpretation of textual material derived from talk or observation. It is used in the exploration of meanings of social phenomena as experienced by the individuals themselves.” (Malterud, 2001, p. 483). A constructivist approach implies that knowledge is socially, historically and culturally positioned, acknowledging that individuals’ subjective meanings are negotiated and formed by various factors (Creswell, 2013). A constructivist perspective acknowledges the dynamics in the interview situation and the analysis, and that knowledge production is the “situated and temporary outcome of dynamic interpretations of several possible versions of reality” (Malterud, 2012, p. 812). Therefore, research “findings” are not identified and interpreted in an “epistemological vacuum” (Braun & Clarke, 2006), free of theory or unaffected by the researcher’s preconceptions. A constructivist, interpretive perspective acknowledges and requires reflection on the researchers’ preconceptions, and what they bring to the inquiry (Alvesson & Sköldbberg, 2009; Creswell, 2013).

6.1 Sampling and recruitment

6.1.1 Choice of geographical area

Seven mental health clinics located in the Sami language administrative district in Lule, Southern and Northern Sami areas⁴, and in areas known to include Sami communities, were invited to participate in the study. These clinics were selected based on my assumption that this would facilitate the inclusion of both Sami patients and clinicians with experience of providing mental health care to Sami patients. After receiving formal approval from the Regional Committee for Medical and Health Research Ethics (Appendix 1), I sent information about the study to the directors of the seven clinics (Appendix 4). In the letter, I asked permission to come to the clinics to inform about the study and to distribute invitations to participate in the study to clinicians and patients. I followed up by making telephone calls to the directors or named contact persons to offer additional information and answer questions. The clinics in the Lule and Southern Sami areas declined the invitations, stating “we do not have Sami patients”, “we do not prioritize spending time and resources on this

⁴ Within the geographical area of responsibility of the Regional Health Authorities in Northern Norway

subject” or “this is not relevant for us” (discussed in Methodological considerations). The three clinics that consented to participate were all located in the Northern Sami area.

6.1.2 Recruitment and sample of clinicians

I attended staff meetings at the three participating clinics, where I described the study and distributed letters of invitation containing information and consent forms (Appendix 5), in pre-paid envelopes. The invitations to participate were distributed to 60 clinicians in August 2012-November 2013. I decided that the single inclusion criterion was having experience with providing mental health care to Sami patients. Clinicians interested in participating submitted the consent form to me, and I contacted them and made appointments for interviews.

Participating clinicians

A total of 20 clinicians were included in the study, nine males and eleven females. Their ages varied from the mid-20s to the mid-60s. Their vocational backgrounds were: ten qualified nurses, social workers, physiotherapists or occupational therapists, while the remaining ten were psychologists, clinical psychologists or psychiatrists. Three of them had some form of specialized training in cultural studies. They had lived in the Sami area between one and about 60 years, and their work experience from mental health services ranged from two to around 40 years. Eleven participants self-identified as Sami and nine as non-Sami. Five spoke Northern Sami fluently and could provide treatment in Sami, whereas 15 were unable to provide treatment in Sami.

6.1.3 Recruitment and sample of patients

The study aimed at including men and women 18 years or older in ongoing outpatient treatment who self-identified as Sami, regardless of Sami language skills. Inclusion was not restricted by diagnosis, treatment duration, previous treatment or reason for seeking help. Letters containing information about the study, an invitation to participate, and a consent form (Appendix 6), were available to all patients in the arrival area/receptions and waiting rooms in the clinics, and were meant to be distributed to all patients by the clinicians in the therapy room. The letter confirmed that their clinicians would not be informed about the study participation, and in case of post-interview reactions, they could ask to have their next consultation soon afterwards. Persons interested in participating submitted the consent form

with their phone number or e-mail address, and the interviewer contacted them for an appointment.

Participating Sami patients

Five patients submitted the consent form and participated in interviews. One of these was excluded because of non-consistent Sami self-identification. This person initially self-defined as a Sami but denied it during the interview. However, I proceeded with the interview, and the decision to exclude this interview from the data was made after the interview. Two women and two men aged 21-50 years were included. The participants lived in small communities, three in majority Sami-speaking inland communities, and one in a predominantly Norwegian-speaking coastal community. One was married and had children, while the other three were unmarried without children. They were all recruited while in treatment, and three of them had previously received mental health treatment. Three participants were bilingual; two of them had Sami as their mother tongue and Norwegian as a second language, one was bilingual from birth with one Sami-speaking and one Norwegian-speaking parent, and one participant was a Norwegian speaker but had spoken (some) Sami in childhood.

6.2 Data material

6.2.1 Interviews

The participants were invited to choose the interview site themselves. The clinicians chose to be interviewed in their offices and the patients chose to be interviewed at their treatment locations. The interviews lasted for 50-140 minutes and were digitally recorded. Initially, before starting the digital recorder, I noted the following background data for the clinicians: age, vocational background, work experience, training in cultural studies, years of living in Sami areas, ethnic self-identification, and language competence. Background data for the patients were place of residence, marital/family status, ethnic self-identification and language competence. I repeated the information provided in the invitation letters about the study aim and interview topics at the beginning of the interviews.

I invited the clinicians to reflect on their assumptions about Sami culture, how they integrated Sami culture in their clinical work and whether Sami culture was a topic of discussion at their workplaces (Thematic interview guide, Appendix 7). The patients were invited to tell about how they experienced the treatment, their thoughts about having mental distress,

communication with the clinician, and their thoughts about possible impacts of culture on their experiences of mental distress and receiving therapy (Thematic interview guide, Appendix 8). Initially I did not specify what I meant when asking about “Sami culture” because I wanted to hear the participants’ own reflections on what they understood by, or included in, the concept of Sami culture. In spite of some thematic preparation, I strove to keep the questions open-ended. The interviews were conducted as conversations in which the participants were encouraged to talk freely. However, since I do not speak Sami sufficiently well to conduct interviews in the Sami language, the interview language was Norwegian. In the information letter about the study, I provided information about the interview language, and I offered to use an interpreter when we made the interview appointments. This offer was declined by the participants, as they stated that they were fluent in Norwegian. The interview guide was used as a “memory note” and finally as a “checklist” at the end of the interviews. Towards the end of the interviews, I asked the participants about how they had experienced being interviewed and if they wanted to add anything, and I repeated the possibility to withdraw their consent.

After the interviews, I wrote field notes about my thoughts, impressions, sense of surprise and reflections on the interviews.

6.3 Analysis

I chose to use thematic analysis, inspired by the procedure of systematic text condensation (STC) as described by Malterud, who states that STC is well suited for novice researchers (2011, 2012). Thematic analysis is appropriate for “identifying, analyzing, and reporting patterns within data” (Braun & Clarke, 2006). STC has an “explorative ambition” in identifying, presenting and describing significant, although not exhaustive, aspects of a phenomenon as narrated by the study participants (Malterud, 2012).

The analysis process starts when planning the study, in the choice of study aims, theoretical perspectives and development of the interview guide, and continues through the interviews, the analysis of interview texts and in the writing of articles and discussion about the study results in the light of selected theory. The practical process of analysis involves transcription of audio files from the interviews, organization of data, reading and re-reading of the data, coding, organization and formulation of themes, and finally, interpretation of identified

themes (Creswell, 2013; Malterud, 2011). I analysed the data from interviews with individual participants, aiming at identifying diversity as well as contradictions through a cross-case analysis.

Transcription: Seven of the audiotaped interviews were transcribed by me and the remainder were transcribed by two secretaries, who signed a confidentiality statement. The decision to hire transcription services was made because the project was delayed, although it is recommended that researchers transcribe all interviews themselves as part of the analysis (Malterud 2011). The interviews were transcribed verbatim, initially retaining pauses, dialect words, crying, laughter, and fillers such as er, mmm, sort of, etc. However, when preparing parts of the interview texts for citation, the texts were slightly modified. For example, long sentences were shortened and the fillers were for the most part excluded from the citations. Moreover, the citations were changed from dialect to standard Norwegian before being translated to English. Transcriptions are abstractions and the result of the transformation of face-to-face communication to written text where body language, non-verbal communication and emotions are excluded (Kvale & Brinkmann, 2009). The transcripts from the secretaries were proofread and edited by me while listening to the interviews. I have read the transcripts and listened to the audio files several times throughout the research process. Processing the transcripts has been an important part of the analysis. Listening to the audio files brought me closer to the interview situations, reminded me of the atmosphere and allowed me to re-contextualize the de-contextualized written versions of the interview conversations (Kvale & Brinkmann, 2009).

Analysis of transcriptions: The (first) challenge was to approach the analysis of interviews in a way that goes beyond the preconceived plan and the themes in the interview guide.

The transcribed texts were analysed thematically using an inductive approach, inspired by systematic text reduction (Malterud, 2011; Malterud, 2001, 2012), as follows:

All transcripts were read several times to obtain a general impression of the whole. Then the same procedure was performed by reading all transcripts one by one, followed by reading the texts in relation to the aims of each study. Preliminary themes were noted by identifying possible topics, or “key words” and marking them with different colours to visualize where the participants talked about the different topics, in which context and connected to which other topics.

The texts were then systematically examined and meaning units (small text elements) relevant to the research question were identified. The meaning units for each interview were condensed and coded, with the aim of compressing the text without losing the meaning. The codes were systematized and categorized, and related codes were sorted into themes and subthemes. Finally, short texts were formulated, summarizing the interpretations of each theme. These texts formed the basis of the content in the presentation of the results.

The analysis process of the texts was performed in co-operation with my supervisors, primarily my main supervisors. I read all the interview texts and selected half of the interviews for my main supervisor to read. Furthermore, I formulated code groups and themes, which were introduced to the co-authors along with selected quotations. The code groups and themes were modified and further developed cooperatively by the supervisors. The analysis was a process of reading and rereading, formulation and revision of themes and subthemes, and selection of quotations representative of the participants' stories. We selected quotes until we found them suitable to illustrate the participants' stories, answer the research question and illustrate and uphold the diversity and complexity in the material.

6.4 Ethical considerations

The study, including methodological changes, was approved by the Regional Committees for Medical and Health Research Ethics (REC) (Appendix 1 and 2).

The participants, both clinicians and patients, were assured of confidentiality and the right to withdraw from the study at any time without stating a reason.

Invitation letters to the clinicians were distributed in their mailboxes at their workplace. I was the only person with information about which clinicians consented to participate. Letters to patients with invitations to participate in the study were available in the waiting areas, receptions and in clinicians' offices. Receptionists and clinicians had no information about which patients consented to participate. Clinicians and patients were interviewed separately, and the study had no information about which clinicians the patients were seeing. The patients were informed that they would be asked about their experiences of receiving treatment, but that their clinician would not be informed about it. No information about the patients' diagnoses or other medical information was recorded.

The interviews addressed the patients' experiences of receiving mental health treatment, and their cultural affiliation, due to the aim of the study. Patient's vulnerability regarding mental health problems has a bearing on the researcher's thinking with regard to research ethics (Hem, 2015). The participants were free to limit what they wanted to talk about and what they did not want to respond to. However, people may disclose more than intentionally planned in an interview situation. Moreover, people in a mentally distressing or vulnerable situations may be strongly affected by seemingly "neutral" topics during the interview or may have regrets in retrospect (Hem, 2015). The patients were informed that refusal to participate would not have any consequences for their treatment. In the agreement with the mental health institutions, the patients were informed that they could request a follow-up consultation very soon after the interview. I have no information on whether any of the participants did so.

Participation in the study was voluntary and based on informed consent. All participants were competent to consent. If anyone withdrew their consent, the interview data would be deleted immediately, unless it had already been published. No participants withdrew their consent. At the end of each interview, I asked the participants how they felt about the interview situation and invited them to contact me if they had questions or second thoughts concerning participation in the study. No participants contacted me.

Personal information about the participants was replaced with a number which referred to a name list that was kept separate from the other material in the Department of Social Medicine at UiT The Arctic University of Norway. Tape recordings were kept as digital, coded files in a locked area of a university computer. The tape recordings and the name list were deleted when the approval date expired. Interview texts were anonymized when transcribed by removing names of persons and places and details about their experiences that might be identifiable. In the dissemination of the results, no information about name, place, age, gender or occupation was linked to citations.

This study aimed to identify aspects relevant to the provision of culturally adapted mental health services to the indigenous Sami population. According to Ingierd and Fossheim (2016), the indigenous ethnic Sami population is a potentially vulnerable group. The question of ethnic vulnerability is "whether researchers carry a special responsibility given the darker sides to the history of this research with respect to conclusions motivated by racism; and the complex political aspects of ethnicity" (Ingierd & Fossheim, 2016). Historically, the Sami

people have been subjected to skull-measurement research aiming at proving the racial inferiority of the Sami. According to Stordahl, Tørris, Møllersen, and Eira-Åhren (2015), “research can be associated with colonialism and racism and that the historical power imbalance between the scholarly world and indigenous communities is still in existence”. For decades, the Sami have been defined as a vulnerable group, demanding special ethical protection in research. The ethical principle of vulnerability concerning research on indigenous groups is discussed in the Helsinki Declaration, which defines *some* (unspecified) ethnic minority groups as vulnerable. The declaration states that “medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research.” (The Declaration of Helsinki, 1964). In addition to the Helsinki Declaration, the Sami Parliament in Norway has developed suggestions for ethical guidelines for research on the Sami population (Sametinget [Sami Parliament], 2017). The guidelines were not established when this study started, and the status of the guidelines is at present not clarified.

The aim of this study was to identify issues of importance concerning mental health services to Sami patients. I do not consider this study to be stigmatizing or harmful for the patients. However, the clinicians could potentially discover a lack of competence or maltreatment of Sami patients during the interviews but the results in the study are anonymous and impossible to trace to named individuals. Some clinicians were very self-critical concerning their care for Sami patients and shared some, to them, sensitive and emotional stories of what they called “sins of omission”. I offered these participants to contact me if they needed to talk more about their reactions to the interview, but none of them contacted me about these issues.

The study was delayed, and I applied to the REC for extended permission to finish the study. The REC approved (Appendix 2) prolongation but instructed me to inform the participants about the delay, which I did, to the addresses they had given me when first consenting. The letter to the patients included repeated information about the right to withdraw from the study as well as an invitation to contact me if needed (Appendix 3). No patients contacted me nor withdrew from the study.

7 Results

7.1 Article 1

This article is based on interviews with Sami patients, and explored in what way and in what language Sami patients talk about mental health problems in therapy, and how Sami patients experience and handle cultural norms in a mental health treatment setting. Three of the four participants in the present study defined themselves as Sami speakers and bilinguals, mastering Sami and Norwegian language equally well. The results were analysed thematically and discussed in the light of sociolinguistics and theory about cultural norms.

The results showed diversity in preferences for language use in therapy and indicate more complex language choices than shown in previous studies on language use among Sami individuals.

The participants reported extensive use of language switch both in everyday life and in therapy. The patients' choice of communication language was based on a combination of their language competence, to whom they were talking and what they were talking about. If all communication partners spoke Sami, they spoke Sami. Different languages were used also within the closest relations in the intimate family sphere. Family members may have different mother tongues; thus, some family members spoke Sami together and spoke Norwegian with others. However, the language choice among the participants was even more complex. Their language competence about certain topics depended on whether they were used to talking about the topic or not, and whether the language contained words to describe the phenomenon. Examples mentioned were the Sami speakers' shortage of Sami words for feelings, and paucity of Norwegian words to explain about reindeer herding. The participants primarily spoke Norwegian in therapy, either because of habit, lack of offer to speak Sami or their own choice to see a Norwegian/non-local clinician to avoid seeing a clinician with whom they could not have a strictly professional relationship. Finally, the Norwegian-speaking participant stated that her lack of Sami language competence hampered adequate expression of her sense of identity and state of health.

Moreover, the results showed that cultural norms may influence 1) what was considered an acceptable or unacceptable topic to talk about, 2) the way to talk about the topics "one is not supposed to talk about", and 3) with whom one can talk about topics "one is not supposed to talk about". All participants had experienced communication problems with the health services and considered cultural differences between themselves and the clinicians to be the

reason. The results illustrated that patients may feel the need to change the “Sami way” of talking and “use more fancy words” to make the clinician understand. They described the “Sami way of communicating” as less verbal, more indirect, using hints and body language. The results indicate that language choice in different communication situations is influenced by a complex combination of various social, cultural and individual factors.

Contribution: The results illustrate the complexity in Sami patients’ language choices and emphasize that the question of speaking Sami or not is not always a matter of either-or. Most Sami speakers are bilingual, but it may be difficult to predict their language needs and language use. Sami patients may have a varied family language history and cultural background that influences the way they talk, or do not talk, about mental distress. More research is required on Sami patients’ language use and the impact of culture in therapy.

7.2 Article 2

This article was based on interviews with clinicians and explored how they identify and respond to Sami patients’ language data, and how they provide linguistically appropriate therapy to Sami-speaking patients.

The results showed that Sami patients’ language data were randomly identified, before, during or after therapy. Available institutional systems for language identification were rarely used. Patients’ language data was usually not known prior to admittance and was therefore identified ad hoc, by using various individual approaches. Language was identified by asking all patients about language competence and preferred therapy language, or by asking only the patients with particular, visual cultural markers. Often clinicians assessed patients’ Norwegian proficiency as good and did not ask about language data. Consequently, they did not identify Sami language competence, did not offer language choice and they trusted the patients to address language problems. The results also showed that some clinicians were satisfied with the communication if they understood what the patient said, irrespective of the patient’s understanding of the clinician.

Linguistic match between clinician and patient may have increased the possibility for language choice in therapy. The Sami-speaking (both Sami and non-Sami) clinicians claimed to always identify the patient’s language proficiency and offered to speak Sami in therapy. In their experience, Sami-speaking patients benefited from using the Sami language in therapy because they communicated more easily in Sami. Nonetheless, some Sami-speaking patients

chose to speak Norwegian or switch between languages during therapy. Moreover, the clinicians reported that patients' responses to an offer of language choice depended on when the offer was given, whether an interpreter was available, and whether they could choose a clinician with whom they could have a strictly professional relationship, which may be a challenge in small communities. The results indicated a need to improve language identification and systematize the offer of language choice in therapy. However, despite available Sami-speaking therapy, Sami-speaking patients may reject an offer of a Sami-speaking clinician. This illustrates that the question of language-appropriate mental health care is defined by the patients themselves.

Contribution: The results indicate that despite legal rights and decades of increased focus on Sami language use in health services, a systematic choice of language is lacking and knowledge about the impact of language in clinical practice appears to be limited. Systematic language identification, continuous language awareness and an active offer of language choice are all needed to improve language-appropriate services to Sami patients. However, in the end, the choice of therapy language is for the patient to decide. Both patients and clinicians may switch between languages. More research is required on the impact of therapy language on treatment effect.

7.3 Article 3

This article was based on interviews with clinicians and explored assumptions of culture and the incorporation of culture into health care practice. We investigated what the clinicians referred to as Sami culture, how they considered that clinical encounters with Sami patients were influenced by Sami culture, and how they transformed their assumptions about Sami culture into mental health care for Sami patients.

The clinicians referred to Sami culture as distinct cultural traits and the "Sami way" of being and living. Their notions of culture also comprised aspects of history and politics. Sami culture and the Sami people were defined by virtue of "difference". However, the basis of comparison remained transparent and was an unspoken norm of "normality". Despite many assumptions about Sami culture, descriptions of the impact of the Sami cultural traits on clinical encounters with Sami patients were limited. The cultural traits described as influencing clinical work were the "Sami way" of communicating and Sami patients'

experiences with talking with the deceased. The patients' experiences of talking with the deceased were assessed whether they were normal cultural behaviour or delusional symptoms. Moreover, clinicians' assumptions about Sami culture did not always correspond with their experiences from clinical encounters with Sami patients. The results indicate that reflections about the clinical impact of the culture on mental health as well as cultural self-reflection among most clinicians were limited. Moreover, the participants described how incorporation of cultural aspects in therapy was for the most part a "private matter", because clinical integration of Sami cultural issues was seldom a part of professional team discussions at their workplaces.

Contribution: The results of this study demonstrate the need for professional development and discussions of how to define Sami culture and how to integrate it into mental health care services.

8 Discussion

8.1 Discussion of methods

This thesis is positioned within a social constructivist paradigm. According to Creswell (2013, pp. 24-25), “[i]n social constructivism, individuals seek understanding of the world in which they live and work. They develop [varied and multiple] subjective meanings of their experiences [...]” Moreover, Creswell (2013, p. 25) states that individuals’ subjective meanings are not simply imprinted, but negotiated historically, socially and culturally, formed through interaction with others. In this research, I aimed to explore the meanings of social and cultural phenomena as experienced by the individuals themselves, and to rely as much as possible on the individuals’ views of the situation. Further, I have looked for complexity of views (Creswell, 2013; Malterud, 2012). A social constructivist perspective acknowledges the dynamics in the interview situation and the analysis, and that knowledge production is the “situated and temporary outcome of dynamic interpretations of several possible versions of reality” (Malterud, 2012, p. 812). Therefore, research “findings” are not identified and interpreted in a “epistemological vacuum” (Braun & Clarke, 2006), free of theory or unaffected of the researcher’s preconceptions. A social constructivist, interpretive perspective acknowledges and requires reflection on the researchers’ preconceptions, and what they bring to the inquiry (Creswell, 2013). In this chapter, I will discuss the methods, aspects of reflexivity and my role as a researcher, and the transferability of the results.

8.1.1 Changing the method

Undertaking qualitative research involves willingness to change the initial research plan during the research process when complications, obstacles or new insights require a shift in focus or procedures (Creswell, 2013). That was also true of this study; during the research process, some changes were made in the methods. Initially, I had planned to do non-participatory observations of consultations through video recordings followed by interviews with the participants. Consequently, I planned to invite patients in ongoing treatment through the clinicians who had accepted to participate in the study. However, I did not succeed in recruiting clinicians to participate in a study that included video recording, so I had to change the method of conducting interviews. Due to this change, I could have changed the patient inclusion criteria to also include persons who had previously received mental health therapy. However, I did not. In hindsight, I realize that changing the inclusion criteria could have resulted in more participants. It is difficult to say why so few patients participated, but being

in vulnerable and challenging life situations and receiving mental health treatment might be reasons. Another possible reason might be that those invited considered the focus of the study (questions about culture and how it affects them) as irrelevant or difficult to answer. Also, the low number of patient participants might possibly be a result of the recruitment strategy. Invitation letters were distributed through clinics and clinicians. Although the information letter stated that participation in the study would not affect treatment and that their clinicians would not know if they participated in the study, the persons invited might still consider this as a risk. I do not know the exact number of information letters distributed by the clinicians and what additional information they might have provided to the patients. Several clinicians did express concerns about handing these letters to patients. They stated that they were not aware of their patients' ethnic identities, and they were concerned that passing on the invitation could "insult" the patients by "accusing" them of being Sami. I informed them repeatedly that they should offer the envelope to all patients, not ask anyone about their ethnic identity, and let the patients decide whether they fulfilled the inclusion criteria. However, I acknowledge that the clinicians' main responsibility was to safeguard the therapeutic relationships with their patients. The recruitment strategy may have contributed to the relatively low number of patients consenting to participate in the study. Preferably, information about the study should have been available for persons both in ongoing treatment as well as post-treatment, and through other channels than via clinicians and clinics. It is however thought-provoking that invitations to research participation might be considered insulting because the study concerns Sami issues.

8.1.2 Reflexivity

The process of doing qualitative research is strongly influenced by the researcher. According to Malterud (2001, p. 483), "a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the results considered most appropriate, and the framing and communication of conclusions". Therefore, reflexivity is an important measure to assess the influence of the researcher in the research process and scientific rigour in research (Malterud, 2001; Pelias, 2011). Included in the process of reflexivity are reflections about preconceptions brought into the project by the researcher, representing previous personal and professional experiences.

Altheide and Johnson (2011, p. 591) reflect on the “concept of knowing”, stating that knowledge about “social reality is constructed by human agents—even social scientists—using cultural categories and language in specific situations or contexts of meaning”. Qualitative research aims to acquire knowledge by exploring and interpreting how the study participants experience and perceive the topic of interest within a specific setting (Malterud, 2001); in this case, mental health care services. My knowledge of psychiatry and the provision of mental health therapy is limited. I have not explored psychiatric diagnoses or treatment regimens in this study. Possible aspects relevant to psychiatry as a field of study have therefore only to a limited extent been identified and included in the analysis. The therapist participants in the study referred to “Sami ways” as a “different” cultural perspective, implicitly contrasted with the generally unspoken culture of mental health care, which to a large extent provides guidelines on what is “normal” and what a symptom, a diagnosis and the right treatment are. According to Altheide and Johnson (2011, p. 581), “all knowledge is contextual and partial, and other conceptual schemas and perspectives are always possible”. Hence, a researcher with background and experience from mental health care could have provided a different understanding of the importance of cultures in mental health care.

Reflexivity requires researchers to examine their own influence and acknowledges that the researcher cannot be separated from the research (Pelias, 2011). As stated in the introduction, I have been engaged in issues about health and Sami culture for a long time as a nurse, advisor and lecturer. I also identify as a Sami. My Sami background has probably influenced the choice of topic, the angle of the project, the interviews and the selection and presentation of themes, in fact, the entire research process. However, it is difficult, not to say impossible, to fully recognize and describe the significance of one’s own self in a research process. The question of whether a researcher can research his/her own society, culturally and academically, raises questions about the consequences of being in an insider position in research. An insider position might allow the insider “to have insights that outsiders could not or, conversely, that their insider status may have kept them from seeing operative cultural logics.” (Pelias, 2011, p. 663). As an insider, I believe that I have a pre-understanding based on, for example, my nursing qualifications and my long clinical experience from somatic hospitals. I am also an outsider in relation to clinical psychiatry, the Sami-speaking community, and I am (relatively) new to the academic world. My preunderstanding is also coloured by the fact that I have worked mainly in towns in northern Norway, grew up on the

coast of Finnmark, am a woman, middle-aged and politically positioned. Which of these aspects of my insider/outsider background were significant in the research, at what time and in what way, is almost impossible to grasp. Dwyer and Buckle (2009, p. 55) noted the paradox of being “tuned-in to the experiences and meaning systems of others [...] and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand”. Dwyer and Buckle (2009, p. 59) stated that it is restrictive, and simplistic, “to lock into a notion that emphasizes either/or, one or the other, you are in or you are out”. I agree with the authors when they state: “[h]olding membership in a group does not denote complete sameness within that group. Likewise, not being a member of a group does not denote complete difference” (Dwyer and Buckle, 2009, p. 29). The authors acknowledged the fluidity and multi-layered complexity of experience, arguing for the notion of the space in between, challenging the dichotomy of insider versus outsider status. In qualitative research, the positions as insider and outsider cannot be finalized once and for all. Rather, the researcher's and the participants' positions are negotiated in every situation.

Whether the position is that of an insider, outsider or in between, the influence of the researcher is an ever-present and essential aspect of the research (Dwyer & Buckle, 2009). However, I have attempted to explain my academic approach, how I recruited and interviewed participants, the analytical method I used, and the theoretical positions involved in the discussion and presentation of the results. There is no doubt that my previous experience, my assumptions about the Sami language and my own position and experience as a Sami helped to change the focus of the study. Initially, the overall study aim was to explore *cultural* aspects, and language was not explicitly included other than in mapping the participants' language competence. The reason for that decision was partly that governmental and health documents distinguish between language and culture, partly that I do not speak Sami sufficiently well to perform interviews in Sami myself, and partly because of my narrow preconceptions of language. My preconceptions concurred with the statement in NOU 2016:18 (2016) that Sami speakers prefer to speak “the language of the heart”, particularly when in need of health services. However, my preconceptions were challenged early on in the study. In one of the first interviews, an emotional episode took place where the participant cried and struggled to talk and said it was difficult for him to talk about the problem (the episode is described in Article 1. I immediately interpreted what was “difficult to talk about” as concerning language and the lack of possibility to speak Sami in the interview. I suggested taking a break, postponing the interview, or using an interpreter, but the participant declined

the offer. So I suggested to him that it perhaps was easier for him to speak about these issues in Sami. Further, because I speak some Sami and thought I might understand a little, or at least wanted to hear how he expressed the issues in Sami, I said: How would you say this in Sami? But it turned out that it was difficult to talk because he had never talked about such issues before, but most importantly and surprisingly for both of us, he stated that he was unable to talk about them in Sami although Sami was his mother tongue. This incident expanded my knowledge about bilingualism and language switch in therapy, and I started to “listen for it” in the following interviews with both clinicians and patients. I found the participants’ stories about bilingualism and varied language use in general to be of such importance that I, supported by my supervisor, decided to include an explicit focus on language in the interview guide and in the study as a whole. This shift in focus resulted in the first article of this thesis. The patient participants’ stories about bilingualism raised new questions regarding how clinicians deal with the fact that some of their patients might be bilingual. These questions resulted in the second article of this thesis. Obviously, the separation between language and culture is not so evident in the real world as in theory. One could say that despite being an insider in Sami communities, I was an outsider in relation to Sami-speaking society. Moreover, despite having to some extent observed that Sami speakers switch between languages all the time, I was not aware that patients and therapists might also switch between languages in therapy. However, an equally important lesson is that to be able to speak about and negotiate concepts and ways to talk about health problems in Sami, research participants must obviously be allowed to speak Sami, or switch between languages. Clearly, the interview language may have been a barrier for Sami-speaking participants. Ideally, interviews focusing on the impact of the Sami language in therapy should be conducted by bilingual interviewers. I had stated in the information letter that the interview language was Norwegian, but still, I offered to use an interpreter when we made the interview appointments. The offer to use an interpreter was declined by the participants, as they stated that their fluency in Norwegian was good. However, the participants may have declined because they had to do so face to face with me. Therefore, the offer of an interpreter should have been given in the invitation letter. The importance of “free talk” about what comes to mind is of vital importance to identify, and understand, the impact and meaning of culture. However, in the light of the study results, it might not have been solely a disadvantage that I did not speak Sami fluently.

Another question when assessing reflexivity is whose voice is heard in the research when produced and presented (Altheide & Johnson, 2011). The knowledge produced in this thesis is interpreted on the basis of my preconceptions, knowledge and choice of theoretical framework, what was discussed in the interviews with the participants, their emphasis on certain issues and how I interpreted their reactions as well as my own moments of surprise. In the presentation of results, I have striven to ensure diversity of preferences in the participants' stories (Altheide & Johnson, 2011, p. 114). Requirements for user participation were not present when this study started, and I did not include user representatives in the planning, designing and implementation of the study. I have not discussed my interpretations and results with the participants or other user representatives. Consequently, the experiences narrated in the interviews are selected and presented by me, aiming at representing the complexity and multiple voices of the participants. More comprehensive user involvement might have influenced the interpretation and presentation of what was agreed upon as the results.

8.1.3 Interviews

In the information letters, I explained that I wanted to explore the impact of Sami culture in a mental health context, but I did not describe what I meant by "Sami culture". Previously, I have positioned this study within a social constructivist paradigm, based on a dynamic notion of culture. As noted in Chapter 5.1, culture is often described both as external cultural traits and as unconscious, taken for granted and implicit ways of being and living. One's own culture is difficult to describe explicitly. In an interview that aims to explore and illuminate culture, the challenge is to find a way to talk about the presumed "unconscious matters". How could one ask about a phenomenon that is more or less unconscious and fluid? I did not limit or define the concept of culture. Rather, I wanted to allow free associations of what culture in a mental health context might comprise. Creswell (2013) suggested that interview questions should be as open-ended as possible. I developed a thematic interview guide and prepared for how I could ask open-ended questions about culture. For example, I asked: "What comes to your mind when you hear the term Sami culture?", "How you would describe Sami culture?", or "What do you think about the expression 'the Sami way?'" However, I had also prepared some more specific questions to investigate the participants' thoughts about some common statements about Sami culture, such as: "They say that within Sami culture, people perceive illness and reasons for being ill in a "Sami way", or "use their own methods to get better from illness and health complaints - what do you think about that?" These questions were meant to

be used in the end of the interviews in case the participants did not talk about these issues themselves. I did not ask about this in many interviews, because most participants mentioned the topics themselves. However, in the analysis, I found other topics to be discussed more and of greater interest. Perhaps direct questions about culture are a barrier to achieving knowledge about culture in any other form than as lists of cultural traits. When the participants talked freely about their thoughts and experiences *regarding other issues*, they told me about language use and cultural norms, indirectly, and interpreted by me. For example, the insights on the lack of Sami words to express emotional issues and how cultural norms affect what could be talked about in therapy were developed in the communication between me and the participants about experiences of health and health problems rather than responses to direct questions about culture. This demonstrates that culture is present in many ways in communication and interaction, and that culture, more than anything, is an analytical concept. It has been stated that knowledge production in research should be developed from “systematically obtained material” (Malterud, 2001, p. 484). The knowledge resulting from moments of surprise can hardly be said to be “systematically obtained”; rather, this demonstrates the value of luck, and of participants answering questions that were never asked.

8.1.4 Transferability

Qualitative research does not aim at producing knowledge that can be generalized, or is universally transferable. Rather, such research is intended to elucidate the particular and specific (Creswell, 2013). Transferability refers to external validity, i.e. to what extent the results can be applied and provide meaning in other contexts (Malterud, 2001).

For how long are research results valid and relevant? The interviews in this study were conducted in 2012-2013. The project was delayed because of recruitment problems, changes in methods, and other unforeseen, personal incidents. However, I consider the results to be relevant and valid today because the politics, laws, health professional knowledge and visions for health services to the Sami have not changed markedly since 2012. Moreover, I have presented and discussed the study in various contexts, and the responses indicate that the study results are recognizable and still relevant.

The study sample included four patients and in the articles, I have referred to the sample size as a possible limitation, stating that “A different and/or broader demographic sample might have resulted in different results but require a broader sample and different methods”. A larger sample and different methods would no doubt allow the researchers to answer different

questions. The low number of patient participants could be considered selection bias, making the results valid only within the specific context in which they were constructed. However, the concept of theoretical sampling emphasizes information power, stating that the number of participants is less important than what they can contribute (Malterud, Siersma, & Guassora, 2016). The patients who participated in the study added considerable varied and new knowledge that I would argue has broadened our understanding of what Sami language and culture may mean in clinical encounters. This knowledge is transferable to other health and social care settings. However, the knowledge developed on the basis of the participants' stories should be further explored, in larger samples, in other geographical areas, using different methods and with multilingual researchers.

8.2 Discussion of results

Culture matters in healthcare services because people's experiences and expressions of mental health problems, as well as their health-related beliefs and help-seeking behaviours and their responses to and the outcomes of treatment, are influenced by culture (Kirmayer, 2012; Kleinman & Benson, 2006). Moreover, as noted by Kirmayer (2012), clinical encounters are "shaped by differences between patient and clinician in social position and power, which are associated with differences in cultural knowledge and identity, language, religion and other aspects of cultural identity" (Kirmayer, 2012, p. 149). Culture matters because people make culture matter and because they live and work in sociocultural contexts to which they ascribe meaning.

The Sami in Norway are entitled to receive health services that take into account the Sami language and culture. The reason for developing health services specifically adapted for the Sami is that the Sami language and culture are perceived as barriers to access to and benefit from health services (Ministry of Health and Care Services, 2009; NOU 1995:6, 1995; NOU 2016:18, 2016).

The overall aim of this thesis was to explore the significance of Sami culture and language in mental health care in order to enhance the understanding of cultural and linguistic adaptation of mental health services to the Sami. Despite legal rights and decades of focusing on the need for adapted health services, the results indicate that language-appropriate services are lacking, and professional knowledge about the impact and incorporation of Sami culture and language in clinical practice is limited. Nonetheless, it should be noted that after conducting

this study, my impression is that most clinicians participating in this study found it difficult, but did their best, to provide culturally and linguistically appropriate mental health care for their Sami patients, within the frameworks and with the knowledge available.

The results of this study indicate that it is difficult to offer linguistically and culturally adapted mental health services. The question remains: why is this the case? The answer to this question is complex. Therapists' perceptions of Sami people, Sami culture and Sami language may hinder the development of culturally and linguistically adapted services. Furthermore, therapists work within systems and structures that make it difficult to develop, integrate and share knowledge about the importance of culture when dealing with Sami patients. Few, if any, interventions have been developed on the basis of Sami language and culture. The answer to the question of why linguistic and cultural adaptation of mental health services is difficult is thus likely to be found at the system level, in the encounter between the therapist and the individual patient and at the intervention level. Hence, I find the levels of cultural competence described by Kirmayer (2012) and the model of "cultural understanding" described by Stordahl (1998) to be suitable to frame the discussion of the study results and ways forward in the process of providing culturally and linguistically adapted health services for the Sami. In the following section, I will discuss possible reasons why the provision of such services to Sami patients is challenging, with reference to 1) Sami culture as policy and practice, 2) cultural and linguistic adaption at the institutional level, 3) cultural and linguistic adaption at the practitioner level, and 4) cultural and linguistic adaption at the intervention level.

8.2.1 Sami culture as politics and practice

The results of this study indicated a tendency among clinicians to refer to Sami culture as distinct cultural traits and the "Sami way" of being and living, including aspects of history and politics, particularly the assimilation process. Sami culture and the Sami people were defined by virtue of "difference". Although transparent and unspoken, the basis of comparison is the Norwegian majority population. The essentialist descriptions of the Sami and the Sami "cultural traits" have a historical basis. As mentioned in Chapter 2.2, during the process of Sami cultural revitalization, the Sami movement aimed at establishing a new, positive comprehension of Sami identity and culture. Eidheim (1971, p. 68) referred to the revitalization as an ethnic incorporation process, "by which ethnic membership is made relevant to the mobilization of group spirit and joint political action vis-à-vis the majority

population”. According to Eidheim, idioms are terms “to which culturally defined ethnic meaning is ascribed” (Eidheim 1971, p. 75). Idioms concur with the concept of cultural traits, and I will employ the concepts interchangeably. According to Eidheim (1971), to achieve “group spirit” and political mobilization, a re-codification of the idiomatic repertoire representing “Sami-ness” was required. Renewed idiom representation of the Sami was critical for the process of ethnic incorporation in order to achieve equality and complementarity with the Norwegian majority population. In the Sami revitalization process, the Sami political movement re-codified the descriptions of the “inferior Lapps” to become symbols for the Sami nation, a people sharing a dignified culture complementary to Norwegian culture. In order to achieve recognition of the Sami language at the Norwegian state level, the Sami movement re-codified it as “mother tongue”: “a cultural trait which people speaking other mother tongues should respect” (Eidheim 1971, p. 75). The Sami proclaimed national unity through the use of national symbols such as *Sámi soga lávlla* (the Sami national anthem) and *Sámi leavga* (the Sami flag) (Sørensen, 1998). Moreover *dáidda* (art) and *duodji* (handicraft) became expressions of Sami aesthetic and practical skills (H. Gaski, 1997). Another example of an idiom representing the Sami people is the *juiggos* (yoik), which was recodified from sinful drunken silliness to traditional folk music (Minde, 2003). Health-related concepts, such as Sami illness perceptions, healing traditions and folk medicine, have been subject to similar re-codification processes. The process of re-codification of idioms representing “Sami-ness” was based on dichotomization and complementarity, that is, underlining the differences between the Sami and the Norwegians, and at the same time emphasized that the cultures were of equal value. A re-codification of Sami ethnic identity was also required intra-ethnically, to “lead [Sami] individuals to embrace a [Sami] identity” (Eidheim, 1971, p. 76), after a century of assimilation and downgrading of the Sami. Hence, the process worked internally to create unity and externally in the struggle for equality. The cultural traits that people themselves use as signs of difference are important, not because they are the most original or genuine, but because they are identity markers for the culture in question (Barth 1994). One problem with dichotomization is that the idioms, representing one or the other group, must be mutually exclusive. Consequently, the idiomatic repertoire representing the Sami had to contrast with the Norwegian, which could result in quite narrow and essentialist descriptions. Although the re-codification was advocated from the “inside”, by emphasizing traits contrasting with Norwegian ones, the Sami stereotyped themselves in order to achieve complementarity (Barth, 1994). Sissons (2005) has noted that essentialist cultural representations may result in expectations about indigenous peoples’ “authentic identities”

[...] “associated with cultural purity”, which is “racism and primitivism in disguise” and may result in expectations about indigenous peoples looking and behaving in an “indigenous way” (Sissons, 2005, p. 37).

In the present study, the clinicians’ descriptions of Sami cultural traits concur with the descriptions of the Sami advocated by the Sami movement in the 1950s-60s. Also, some patients referred to “the Sami way”, stating that they do something in a “non-Sami way” (seek help and talk about emotions and mental problems), or that they lack a certain competence (Sami language) to be a Sami and to process mental problems in a proper way (because problems cannot be processed in the Sami language). Hence, the assimilation policy and revitalization strategy still have an impact on the descriptions of the Sami, Sami culture, and the sense of individual identity. Narrow assumptions of Sami culture and Sami people influence the development of “culturally adapted” health services.

Notions of culture and cultural competence are highly politicized concepts also in health policies (Kirmayer, 2012). Stereotypical representations of the Sami have become an integral part of both Norwegian and Sami political discourses, and serve as arguments for, among other things, special attention within the health services. Sami cultural traits, as described in NOU 1995:6, are still the main reference point in many governmental health documents and strategies (Blix, Hamran, & Normann, 2013). As a political strategy, essentialist cultural descriptions may serve to maintain attention on the obligation and responsibility to ensure equitable health services to the Sami. Moreover, idiomatic descriptions may strengthen the internal sense of Sami collective identity. However, for the health services, such idiomatic descriptions are not necessarily useful “tools” in the provision of culturally and linguistically appropriate care for Sami patients.

8.2.2 Cultural and linguistic adaptation at the institutional level

The experiences of the Sami patients and clinicians in this study are a call to health institutions to work on the way they provide and organize their services. As noted by Kirmayer (2012, p. 149), “the dominant culture, which is expressed through social institutions, including the health care system, regulates what sorts of problems are recognized and what kinds of social or cultural differences are viewed as worthy of attention”. Hence, attention to organizational cultural competence is important to provide cultural and linguistic adaptation on the institutional level. Organizational cultural competence implies e.g.

policies of equity, enabling ethnic matching by employing staff representing the ethnocultural and linguistic composition of the communities served, and relevant training and education of staff (Kirmayer, 2012).

Regarding policies of equity, Norwegian health policies are based on the right of the population to receive equitable health services, including the duty for health institutions to provide health services adapted to the needs of the Sami population and in accordance with Sami culture and language (Helseforetaksloven [Regional Health Authorities Act], 2001; Ministry of Health and Care Services, 2009; Ministry of Labour and Social Affairs, 2008; NOU 1995:6, 1995). However, policy documents have been criticized for representing Sami culture in essentialist ways (Blix et al., 2013). For example, the Coordination Reform states that lack of Sami linguistic and cultural competence may result in failures in diagnosis and treatment, especially in mental health care. According to the document, “The health and care services are unable to help Sami speakers [...]. Many are reluctant to say that they do not understand or need an interpreter. Some Sami therefore fail to seek out the health and care services, even when they have significant help needs” (Ministry of Health and Care Services, 2009. My translation). These are serious assertions, however, the evidence base is weak. So far, the evidence indicates minor health differences between the Sami and control groups (see Chapter 3.1). Research on health services use among the Sami is limited and ethnic categorization of the Sami varies. However, the research results available indicate similar, or higher consumption of health services among the Sami compared to the Norwegian population (M. Gaski et al., 2011; Møllersen et al., 2005; Norum et al., 2012; Turi et al., 2009). On the other hand, higher consumption of health services might indicate language or communication problems or more health problems among the Sami than reported through the present research. The severity of the assertions demonstrate the need for more research to develop solid knowledge about health and health services use among the Sami, identify possible barriers for the use of health services and to develop strategies to improve the services.

Although similar of higher use of health services, research indicates that Sami users are less satisfied with the health services than non-Sami users (Nystad, 2008, T. Sørli & Nergård, 2005). Kirmayer (2012) suggested that ethnic and linguistic match might improve health services to minority patients. Ethnic match at the institutional level implies that health care institutions are planned, governed and run by the Sami. Sami governance of health institutions

would be in accordance with §25 of the ILO Convention No. 169 (cited in Chapter 2.3.1) (ILO No. 169, 1989). According to this convention, health services should be “planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions”. Patients have the right to choose their treatment center (Direktoratet for E-helse [The Norwegian Directorate of eHealth], 2017), and Sami patients throughout the country can ask to be referred to Sami health institutions. However, the Sami live in all parts of Norway. The localization of Sami health institutions solely in the Sami core areas would imply long distances to travel for many Sami patients. This would be a potential barrier for the use of such health services. However, a decentralized model, such as the Sami-run SANKS (described in Chapter 2.3.2) may improve access.

In a Master’s thesis, Heatta (2007) interviewed two administrative leaders (one working for the Regional Health Authorities and one in Finnmark County Hospital), and one GP about the challenges health institutions may face when attempting to offer equitable health services to the Sami. According to Heatta, there is a need for more Sami-speaking clinicians, cultural competence among clinicians and leaders, information material in Sami, extra pay for Sami-speaking clinicians, and enhanced IT services that include Sami fonts. Heatta (2007) stated a need to develop concrete, targeted measures and suggested conducting a comprehensive user survey on satisfaction with the health services among the Sami population. However, an evaluation of SANKS, conducted by the Norwegian Directorate of Health (2018), indicates that developing a Sami institution within a Norwegian health system is not necessarily an easy task. The report from the Directorate found that the organization of SANKS did not fit into the system of national centres of competence, and that there was a lack of specific, targeted measures and objectives for cultural and linguistic adaptation of the services. The lack of specific measures concurs with the problem related to cultural competence, namely, the difficulties in incorporating assumed knowledge about culture into clinical health care. Moreover, the Directorate found a lack of documentation of the effect of the services provided by SANKS on the targeted part of the population, concurring with Heatta’s (2007) request for a comprehensive user investigation. However, documenting the effect of measures aimed at the Sami population meets the challenges of lack of ethnic registration of Sami individuals.

Education and training of staff is one of four main tasks of the specialist health services in Norway (Ministry of Health and Care Services, 2014). Also, training and employment of

local community health workers is in accordance with the ILO convention (ILO No. 169, 1989). The results from the present study indicate that discussions about cultural matters were not integrated in clinical team discussions, but rather addressed in separate meetings. The clinicians in the present study suggested that health institutions should organize training and professional team discussions about the coherence between health issues and cultural perspectives. Professional team discussions including culture in clinical meetings might be a way forward in the development of knowledge about mental health issues in the light of cultural diversity.

Linguistic match facilitates communication and mutual understanding, therefore, employing staff representing the linguistic composition of the communities served is crucial (Kirmayer, 2012). However, health institutions are not obliged to hire staff of diverse backgrounds, nor are they required to offer Sami-speaking staff to Sami-speaking patients. As mentioned in Chapter 2.3.2., concerns about the lack of Sami-speaking health personnel have been expressed in several governmental plans and propositions, illustrating the need for human resources to fulfil Sami patients' rights to speak Sami when receiving health services. A joint recommendation in the previously mentioned governmental documents is to prioritize the training of health professionals in "Sami language and cultural competence" (Ministry of Health and Care Services, 2002-2005, 2006, 2009; NOU 1995:6, 1995). Regarding linguistic adaptation of mental health services to the Sami, the results of the present study indicate a random identification of Sami-speaking patients. As noted in Article 2, although institutional systems for language identification were available, they were not frequently used. In the referral and medical history forms, there were columns for language registration. However, filling in these columns was not mandatory. Also, the electronic patient records lack Sami fonts, and consequently, many Sami names and addresses cannot be written correctly in these systems. According to the Sami Act, applications by letter in Sami languages must be answered in Sami. However, since the medical record must be written in Norwegian (Forskrift om pasientjournal [Regulations on patient medical records], 2001), transcripts of the medical record to patients were also given in Norwegian if the institutions had not established practices for Sami-speaking doctors to review the record with Sami patients. In sum, there were several challenges for the provision of language-appropriate services to Sami-speaking patients at the institutional level, and the provision of such services appeared to be random. Insufficient registration of patients' language data and non-systematic organization of language-appropriate services before admission left the responsibility to

identify the patients' language data and offer language choice to the individual clinician. The provision of an interpreter is considered sufficient to fulfil the obligations to provide linguistically appropriate health care (Ministry of Local Government and Modernisation, 2014; Skogvang, 2009). However, the use of an interpreter is also left to the individual clinician to decide.

More Sami speakers in educational programmes in health care would improve the situation, but probably not guarantee the possibility to see a Sami-speaking therapist everywhere in Norway. Reorganization of the Sami-speaking staff, ambulatory Sami-speaking health care professionals, and the use of video consultations (e-health), which are already in use⁵ in Norwegian and Sami health services, are other measures that to some extent may compensate for the lack of Sami-speaking personnel. Moreover, institutional systematic recording of patients' language preferences and a systematic offer of language-appropriate services are vital to fulfil Sami patients' rights to receive linguistically appropriate services.

8.2.3 Cultural and linguistic adaption at the practitioner level

Health care encounters between clinicians and patients are always "filled with culture", in the way people talk and interact, and in how the communication partners experience, understand and interpret the situation. As noted in Chapter 5, increased cultural competence among health professionals has been promoted as a measure to improve health care services (Browne & Varcoe, 2009; King et al., 2009; Kirmayer, 2012; Sobo, 2009). Cultural competence among health professionals is assumed to ensure the provision of culturally adapted and clinically effective health services to indigenous patients. According to Kirmayer (2012), cultural competence at the practitioner level implies for example ethnic matching of clinician and patient, training of health professionals in cultural knowledge, or use of culture brokers. In addition to shared cultural knowledge, ethnic matching between clinician and patient might facilitates trust and mutual understanding (Kirmayer, 2012). In the Norwegian Sami context, ethnic matching of clinicians and patients is not a straightforward task. First of all, recording of patients' ethnic identity is prohibited. Ethnic match can only be organized if the health professional already knows the patient and "knows" that he/she is Sami. Second, ethnic match may not be preferred by the patient. The present study concurs with Kemi (1998), who demonstrates that users of health and social services might prefer not to see a Sami therapist if

⁵ <https://finnmarkssykehuset.no/nyheter/pasienter-far-tettere-oppfolging-gjennom-skype>

this is a person they know from the community. Third, ethnicity and culture do not necessarily coincide (Barth, 1969). The assumption that common ethnic identity and/or cultural background equates with mutual understanding involve the risk of ignoring individual patients' preferences, life histories and broader social contexts (Browne & Varcoe, 2006; Kirmayer, 2012; Kleinman & Benson, 2006). Particularly persons with ambiguous Sami identities and Sami language histories are at risk for "going under the radar".

Stordahl (1998) argued that since cultural knowledge is not an innate capacity, clinicians must acquire analytical cultural competence, regardless of ethnic identity. Stordahl differentiated between the cultural knowledge acquired as a member of a society, and the analytical competence needed to identify and understand the impact of culture in clinical practice. Moreover, Stordahl (1998) recommended that health professionals, both Sami and non-Sami, must exercise cultural self-reflection and reflect on the importance of their own cultural background, while also considering the importance of the structural frameworks in which they work. However, cultural and professional (self-) reflections are difficult to perform individually, especially when they involve implicit, unconscious and taken for granted cultural aspects. The clinicians expressed the need and desire for their employers to arrange team discussions where culture was part of the regular meetings, and where cultural aspects were considered as part of the assessment of e.g. a patient case or the design of services. Team discussions are crucial for developing knowledge of how cultural aspects can be integrated into practice. Hence, the development of cultural competence at the practitioner level is closely associated with opportunities for training organized at the institutional level.

As noted in Article 3, there are limited descriptions of how to operationalize culture into clinical practice without reducing holistic care to "technical skills for which clinicians can be trained to develop expertise in how to treat a patient of a given ethnic background" (Kleinman & Benson, 2006, p. 1673). The clinicians included in the study reported a lack of professional discussions about ways to incorporate Sami culture into mental health care and to decide whether the interventions were appropriate or not, in other words, to figure out "what to *do* with the patients' culture". Although the clinicians referred to several Sami "cultural traits", few of them referred to specific experiences in which "Sami culture" had mattered in clinical encounters. Cultural adaptation is challenging to realize in practice. As noted in Chapter 3.1, the Sami cultural norm of *ieš birget* and avoidance to talk about mental problems have been referred to as having a negative influence on the health of the Sami and their use of health services (Kaiser et al., 2013; Silviken, 2009; Stoor et al., 2019). Some participants in the

present study also referred to this norm, stating that they preferred to conceal their mental problems. However, they did in fact seek help, and did talk about their problems. Boine (2007) has nuanced the term *ieš birget*, arguing that dialogue is meant to be a central part of *ieš birget*, but that it often takes place in a “*bálddalagaid*” (side by side) conversation instead of an “eye to eye” contact and a “*njunnàlagaid*” (facing each other) conversation; this can hamper good contact and communication, particularly about topics perceived as “sensitive”. Boine (2007) shows that talk about what is perceived as a sensitive topic may take place in a more indirect manner and in carefully selected situations. *Meahcceterapijja* at SANKS, presented in Chapter 2.3.2, has also been described as providing better and more open communication because the talk takes place outdoors in natural surroundings (Skårland, 2017), and in a flexible and *bálddalagaid* manner. The results in the first article in this thesis indicate that talk about difficult topics depends not only on the mode of communication and the situation, but also on whom one is talking to and on the chosen language. The results further suggest that cultural phenomena must not be taken literally or as truths, as they can be considerably more complex than they appear to be.

In the worst case, attempts at cultural adaptation may degenerate into sins of omission. Moreover, regard for cultural adaption may conflict with health-related knowledge and professional guidelines for therapy that emphasize talk as the central aspect of therapy (Johnson, Y.M. & Munch, 2009). If clinical work is based on essentialist perceptions about Sami culture such as Sami people’s reluctance to talk about illness and their desire to manage by themselves, this may result in a lower level of care and treatment for Sami patients than for others. In its utmost consequence, cultural adaptation in this context can be understood as “the patient’s way must be respected”, resulting in the therapist also not talking about what the patient finds difficult to talk about, or they may fail to offer help because they expect patients to prefer to cope themselves (Blix & Hamran, 2017, Dyregrov et al., 2014).

Cultural adaptation does not mean consideration for Sami language and culture, but for the individual Sami patient’s needs and preferences. The Sami have experienced different degrees of assimilation, they may have different perceptions of their Sami identity and varying degrees of fluency in the Sami language, but still have an important Sami-language family history. Cultural norms may be beneficial in one context, but contra-productive in another. Sami culture and other factors have different meanings in patients’ perception of their situation. It is therefore crucial to have what Stordahl (1998) refers to as contextual knowledge as one’s background knowledge, but it is through dialogue with the patient that a

clinician must find out how the patient experiences his/her situation. In clinical encounters between therapists and patients, culture is continuously negotiated through interaction and by talking, or not talking, about life, emotions, identity and experiences of mental health. Culture is thus being articulated all the time, but apparently it is only when recognizable “Sami cultural traits” are manifested in the talking that therapists register this as culture, and then as the patient’s culture.

Linguistic adaption at the practitioner level implies linguistic match between clinician and patient, or the use of an interpreter. Shared language is a prerequisite for effective verbal communication between clinicians and patients in mental health encounters. Effective communication is vital for quality care and is considered an essential element of safe health care (Cioffi, 2003; Irvine et al., 2006; Misell, 2000; Roberts et al., 2007; Sobo, 2009). As noted in Chapter 8.2.2, documentation of patients’ language data is random. This study demonstrates that the clinicians were seldom aware of patients’ language needs prior to consultations. Hence, clinicians’ language competence and language awareness strongly affected patients’ possibilities to use their preferred language in health care encounters. Language awareness includes identification of patients’ language history, competence and preference, the offer of language choice prior to therapy and awareness of language switch and needs in therapy (Drolet et al., 2014; Hudelson, P., Dominicé Dao, M., & Durieux-Paillard, S., 2013; Kale & Syed, 2010; Roberts & Burton, 2013). In Article 2, I used the phrase “continuous language awareness” to emphasize that language preferences are not identified “once and for all” on admittance but are an ongoing process. According to the clinicians in the present study, “you never know who are Sami or speak Sami”. Bilingualism and language switch were commonly used in everyday communication as well as in clinical communication. For monolingual Sami speakers, it is absolutely critical for communication, trust and treatment results to receive therapy from clinicians who speak their language or to use an interpreter. The possibility to choose language in therapy is also important for Sami-speaking patients who speak Norwegian fluently. However, Sami-speaking patients cannot take for granted that they can speak Sami in therapy. There is a lack of Sami-speaking clinicians. Even in the municipalities in the Sami core regions, people are not satisfied with the possibilities to use Sami when in need of health services (Nystad et al., 2008). The close, multiplex relationships in small communities are also a challenge for the provision of Sami-speaking services, because patients might prefer to see a therapist with whom they have a strictly professional relationship.

Language barriers in clinical communication may have several undesirable effects, such as “a tendency for the patient to be less compliant; less contact with services/preventative care; increase in the number of tests/visits; negative impact on health; serious incidents; lower satisfaction in terms of the patient and the provider, and higher costs.” (Welsh Language Commissioner, 2014, p. 35). Consequently, communication in a common language or via an interpreter facilitates mutual understanding, correct diagnosis and treatment. In the present study, very few clinicians had offered to use a Sami interpreter, and none had actually used one in clinical communication with Sami patients. Mehus et al. (2018) explored how Sami-speaking patients experienced communication with healthcare providers and found that they communicated indirectly, and perceived provision of health services in Sami to be a confirmation of their Sami identity, which was crucial for the patients’ experiences of comfort, safety and respect. The authors recommended that healthcare providers should use “a professional interpreter who possesses the linguistic and cultural insight that allows them to reconcile direct and indirect forms of communication” (Mehus et al., 2018, p. 297), and thereby “bridge the gap between Norwegian caregivers and Sami patients and make the stay in hospital safe for the patients” (Mehus et al., 2018, p. 297). Kuperus (2001) also suggested that the mental health services should employ an interpreter who could also act as a culture broker. These recommendations are not in accordance with the ethical guidelines for interpreters in Norway, which clearly state that interpreters are obliged to interpret the content of everything that is said, and not add or change anything (Ministry of Justice and Public Security, 1997). The suggestions to use a culture broker to interpret Sami patients’ “indirect communication” underline the ethical challenges in ensuring that Sami-speaking patients receive high quality language-appropriate and safe health services.

Adding to the complexity is the fact that, although health professionals speak a language, they may not be “trained to use [the language] professionally [about health related topics] within medical consultations” (Deckert & Vickers, 2011, p. 142). In the present study, some Sami-speaking clinicians described situations in which they had to switch to Norwegian because they lacked professional concepts in the Sami language(s). Moreover, the present study indicates that the cultural language of the health culture also influences the way the patients communicate their problems. As demonstrated in Article 1, one patient reported having to change her way of communicating and use more “fancy words” in order to get help from the psychologists. The patient suggested that the clinicians should learn about “the Sami way to communicate”. Moreover, this participant stated that in therapy with a Sami therapist there

were no communication problems. Møllersen's studies (2005, 2007) found that Sami therapists used less verbal therapy than non-Sami therapists, suggesting that Sami therapists possibly "intuitively understood" the Sami patients. However, as noted by Stordahl (1998), ethnic match does not necessarily imply mutual understanding. A more analytical approach as outlined by Stordahl could include a focus on various factors: the importance of the clinician's way of talking, the possible constraining effect of the therapist's office and the framework for the talk, a therapy situation may be a new experience, the patient may feel insecure in the relationship, and the patient may be a Sami speaker. Contextual knowledge of history and assimilation can reveal that Sami speakers have had few opportunities to speak Sami in encounters with public services, including the health service. Both clinicians and patients may therefore lack terminology for talking about phenomena in Sami. On the other hand, patients may well speak in a "Sami cultural way". In the present study, some clinicians claimed that "the Sami communicate in a different way", for example, that they speak indirectly, and so slowly that "you have to drag the words out of them". Understood as a cultural trait, this may merely appear as a statement such as "That's the way Sami are", almost as a culturally deterministic explanation of the reason (Sobo 2009). By explaining the patient's behaviour as a result of the patient's culture, other factors of importance may be overlooked, such as the clinician's own cultural way of communicating, the relationship between the clinician and the patient, and the degree of trust between them.

8.2.4 Cultural and linguistic adaptation at the intervention level

According to Kirmayer (2012, p. 151), cultural adaptation at the intervention level means for example to develop "culturally adapted interventions, or offer patients interventions drawn from their own cultural traditions". According to the clinicians in this study, there are few, if any, culturally adapted interventions targeting Sami patients. They had no guidelines or tools in their efforts to provide "culturally adapted" mental health care to their patients. Most clinicians would have preferred to have such guidelines or tools. A few clinicians had heard about cultural interview guides, but had never used such guides. They stated that some tests had been translated into (northern) Sami, but they questioned whether tests and other diagnostic tools were adapted in accordance with Sami culture. Recently, T. Sørli et al. (2018) reported that Sami and non-Sami individuals understood questions about mental health in the same way. I have not been able to identify studies involving Sami individuals that examine the effect of culturally adapted or culturally based interventions.

However, I did ask the therapists for examples of how they had culturally adapted their work. One example was a story about the use of music and poetry in group therapy, including Sami versions, because “this is the landscape we work in”. In every group, one or more patients eventually talked about how they spoke and were Sami. Expressions of Sami culture may have inspired Sami patients to “admit” their Sami identities and Sami language competence. This example indicates that the use of Sami cultural expressions might have signalled acceptance and respect for Sami culture, and thereby facilitated trust (Kirmayer, 2012). According to this clinician, acceptance of Sami cultural expressions in a therapeutic setting often led to more open communication about identity and other aspects of their perception of mental health problems.

A few clinicians stated that patients occasionally told them that they used traditional healers (“readers”) in addition to the therapy sessions. The clinicians found this unproblematic, but had no further information about the topic. According to Sexton (2009), Sami patients would like to see the integration of Sami traditional (healing) methods into mental health clinics. According to §25 of ILO Convention No. 169, health services to the Sami in Norway should take into account traditional preventative care, healing practices and medicines. However, according to Kvernmo (1997, p. 140), designing health care services “based on the Sami people’s needs, way of thinking, and traditions [...] could come into conflict with the views that [health] professionals have acquired through training and [health education] as well as rules and regulations that apply to the health services”. The treatment provided in Norwegian mental health services is to be in accordance with national treatment standards (Ministry of Health and Care Services, 2017). Health institutions and health personnel will thus not normally be able to offer their patients treatment options that are based on “cultural conditions” and “traditional preventive care, healing practices and medicines”. Also, Norwegian health institutions are subject to legislation that regulates “alternative treatment methods” (Alternativ behandlingsloven [Act on Alternative Treatment], 2004). Moreover, cultural adaption of interventions may have potential side effects and reduce the benefits and clinical efficacy of a program (Kirmayer, 2012, Kleinman, 2005). Thus, according to the authors, cultural adaptation of interventions must be implemented with caution, and new programmes or methods should be followed by evaluation procedures to generate knowledge about the usefulness and limits of new practices. If cultural adaptation of standardized interventions is adopted, it faces some challenges; it must be discussed to what extent and in what ways cultural adaptation can take place; it must be in accordance with Norwegian

legislation and comply with the rules for standardization of methods in the health care system. In addition, changes in interventions must be followed up with evaluation. Perhaps could the asymmetrical power relationship between a public mental health institution and Sami cultural phenomena suggest that two so widely different meaning systems and understandings of reality are better off without being combined?

The only cultural phenomenon that the clinicians in this thesis thought might interfere with therapy was the Sami custom of talking with the deceased (described in Article 3). A few clinicians talked about the phenomenon, stating that they knew and accepted that this could be common or “normal” in Sami culture. In their clinical approach, they considered whether or not this was a symptom, i.e. auditory hallucinations. Assessing this phenomenon could be a balancing act. The clinicians acknowledged the patient’s experience and a “form of Sami cultural expression”, but at the same time they had to assess whether this was a symptom and an expression of mental illness. It was important for them not to preclude either possibility until they had assessed the possible pathology. The Sami are not alone in experiencing communication with a person that others cannot see. Kalhovde (2015) has shown that it is relatively common for people without a psychiatric diagnosis to “hear voices” and many people do not find this problematic or troublesome. According to Stordahl (1998), explanatory models influence how clinicians seek to explain the phenomena they meet in their clinical work. Kleinman (2005, p. 17) notes that the “*Explanatory Model* approach is what the clinician needs to make use of in order to further the cultural assessment, [asking questions such as] What do you call this problem? What do you believe is the cause of this problem? [How] do you think this problem affects your body and mind? [and] What do you fear about this condition [and] treatment?” Experiences of talking to the deceased can be explored by asking, for example, who do they talk to, is it someone they have had a relationship with in their life, in what language do they talk, what do they say, is it unpleasant or helpful, do they want to get rid of the voices or not? (Kalhovde 2015). There is a lack of research-based knowledge about the extent and significance of experiences of talking to the dead, or hearing voices, in a Sami context.

According to Kleinman (2005, p. 17), exploring the patient’s explanatory models may “open conversation on cultural meanings that may hold serious implications for care”. Moreover, he states that sensibility is “a primary requirement for training and practice of *culturally informed interventions*” (Kleinman, 2005, p. 23. My italics). I would suggest to broaden the

concept to imply a “culturally informed approach” in all clinical encounters. However, this necessitates allowing the patient to speak in his/her preferred language, with the right person and in the right way. The contribution of health institutions is to train and employ clinicians with the necessary language skills, local knowledge, and knowledge of history and cultural phenomena. Clinicians must acknowledge their position of power, and that their therapeutic work is influenced by their own cultural background, attitudes to and knowledge of culture, and their educational explanatory models, understandings of disease and treatment regimens. One might say that the assessment and use of cultural aspects in therapy is not a question of either-or. Rather, used wisely, it is possible to integrate cultural aspects in therapy and simultaneously acknowledge the significance of individual preferences.

The art of culturally adapted mental health care could be said to be figuring out; what is at stake and what is important to the patient.

9 Concluding remarks

The overall aim of this thesis was to explore, identify and describe the significance ascribed to culture and language in mental health care by clinicians and Sami patients in order to enhance the understanding of the cultural and linguistic adaptation of mental health services to the Sami.

The results in this research indicate that the incorporation of language and culture into mental health care is a complex process involving strategies at three levels: institutional systems and structures, health professionals' cultural assumptions and analytical competence, and cultural assessment of interventions in mental health treatment.

The results indicate that despite legal rights and decades of increased focus on Sami culture and language in health services, systematic language identification and offer of language choice in therapy is lacking, and knowledge about the impact of language and language switch in clinical practice appears to be limited. The results also indicated that cultural aspects were to a limited extent incorporated in clinical practice and professional team discussions. Moreover, the results indicated that Sami patients have different preferences and needs concerning culturally and linguistically adapted services. A complex combination of linguistic and cultural factors influenced what they talked about, in what language, in what way and with whom. Exploring what the patients are talking about and why they occasionally need to switch language might be useful to enhance understanding of patients' experiences and problems. Cultural and linguistically adaptation of health services are politicized concepts in health policies, but are to a limited extent developed to health professional competence, and few, if any, culturally adapted interventions targeting Sami patients are available.

Approaches to culturally adaptation of health services depend on the underpinning notions of culture. In this study, essentialist, stereotypical descriptions of Sami culture dominated. However, stereotypical portrayals of Sami culture narrow the understanding of Sami identity, delimit the identification of Sami speakers and simplify possible impacts of culture within health care. A more dynamic understanding of culture as a continuum between collective cultural patterns, and individual experiences and preferences can increase the understanding of the individual patient's situation. Therefore, the question is not what culture "is", but how culture unfolds in human encounters.

Kleinman's advice of training and practice of culturally informed [approaches] is transferable beyond "culturally adapted services" and can be used advantageously in encounters with all patients. Knowledge of the particular elucidates the general; the study of the possible impact of Sami culture and language in therapy can thus provide general insight into being a patient in need of health care.

9.1 Implications for practice and research

This thesis provides arguments for organizational routine identification and documentation of patients' language preferences for therapy. The offer of a Sami-speaking therapist or the use of an interpreter should be standardized. Moreover, patients should be allowed to choose to see a therapist with whom they will have a strictly professional relationship. There is a need for more Sami-speaking clinicians, development of culturally informed mental health services, and more written information and essential IT services in Sami. A further need is a comprehensive user survey on the use of and satisfaction with the health services among the Sami population.

Further research on culturally informed approaches and cultural adjustments of clinical interventions is needed. There is limited knowledge about the experiences of Sami patients and users of health services. The patients who participated in this study added new information that has expanded the understanding of what Sami language and culture can mean in clinical encounters. This knowledge is transferable to other health and social work settings. However, the knowledge developed based on the participants' narratives should be further explored, in a larger sample, in other geographical areas, with different methods and with multilingual researchers. More research is required to develop solid knowledge about health and health services use among the Sami, identify possible barriers to the use of health services and develop strategies to improve the services.

Stronger user involvement is recommended to enhance perspectives, understandings, interpretations and presentation of results. A number of young Sami men have appeared in the media to request more openness about mental health in Sami society⁶. They refer to the

⁶ The Sami have to be more open: <https://sverigesradio.se/sida/artikel.aspx?programid=2327&artikel=6652608>
Sami men have to talk about emotions: https://www.nrk.no/sapmi/_-unge-samiske-menn-snakker-ikke-om-folelser-1.14289945

phenomena also referred to in this thesis; namely “*ieš birget*” and the “culture of silence” among the Sami and call for more openness and acceptance for mental disorders within Sami society. The significance of such phenomena should be further explored, and qualitative studies in particular seem to be appropriate to enhance knowledge of the aspect of meaning and its importance for health and health services use.

Research in the field of cultural and linguistic adaptation of health services is complex and implies a need for a multidisciplinary approach, and competence within health, history, anthropology and culture theory, and linguistics and sociolinguistics. Multidisciplinary and multilingual teams should conduct further research in this field.

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Article 1

Article 2

Article 3

Appendix

List of articles

Article 1

Dagsvold, I., Møllersen, S., & Stordahl, V. (2015).

What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment.

International Journal of Circumpolar Health, 74:1.

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Article 2

Dagsvold, I., Møllersen, S., & Stordahl, V. (2016).

"You never know who are Sami or speak Sami." Clinicians' experiences with language-appropriate care to Sami-speaking patients in outpatient mental health clinics in Northern Norway.

International Journal of Circumpolar Health, 75(1), 32588.

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Article 3

Dagsvold, I., Møllersen, S., Blix, B.H.

Clinicians' assumptions about Sami culture and their experiences with providing mental health services to indigenous Sami patients in Norway.

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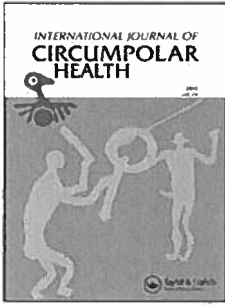
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ORIGINAL RESEARCH ARTICLE

What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment

Inger Dagsvold^{1,2*}, Snefrid Møllersen¹ and Vigdis Stordahl^{1,2}

¹Sámi Norwegian National Advisory Unit on Mental Health and Substance Use, Finnmark Hospital Trust, Hammerfest, Norway; ²Centre for Sami Health Research, The Faculty of Health Science, UiT The Arctic University of Norway, Tromsø, Norway

Background. The Sami in Norway have a legal right to receive health services adapted to Sami language and culture. This calls for a study of the significance of language choice and cultural norms in Sami patients' encounters with mental health services.

Objectives. To explore the significance of language and cultural norms in communication about mental health topics experienced by Sami patients receiving mental health treatment to enhance our understanding of linguistic and cultural adaptation of health services.

Method. Data were collected through individual interviews with 4 Sami patients receiving mental health treatment in Northern Norway. A systematic text reduction and a thematic analysis were employed.

Findings. Two themes were identified:

(I) Language choice is influenced by language competence, with whom one talks and what one talks about. Bilingualism was a resource and natural part of the participants' lives, but there were limited possibilities to speak Sami in encounters with health services. A professional working relationship was placed on an equal footing with the possibility to speak Sami.

(II) Cultural norms influence what one talks about, in what way and to whom.

However, norms could be bypassed, by talking about norm-regulated topics in Norwegian with health providers.

Conclusion. Sami patients' language choice in different communication situations is influenced by a complexity of social and cultural factors. Sami patients have varying opinions about and preferences for what they can talk about, in which language, in what way and with whom. Bilingualism and knowledge about both Sami and Norwegian culture provide latitude and enhanced possibilities for both patients and the health services. The challenge for the health services is to allow for and safeguard such individual variations within the cultural framework of the patients.

Keywords: Norway; Sami; mental health; qualitative; experiences; language; culture; cultural norms

Responsible Editor: Rhonda Johnson, University of Alaska Anchorage, USA.

*Correspondence to: Inger Dagsvold, Duevn. 16, NO-9015 Tromsø, Norway, Email: inger.j.dagsvold@uit.no

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Cultural difference often serves as one among other explanations of why indigenous people have poorer health and are less satisfied with health services than majority populations, and cultural adaptation of health services and cultural competence in health providers are assumed to improve health services and reduce health differences (1–5). In Norway too, cultural and linguistic differences have been an explanation of the differences found in health status between Norwegians

and the indigenous people, the Sami. Thus, after the Second World War, two strategies were attempted to reduce the health gap: the welfare state model ensuring equal access to decentralized health services and the occasional recognition of the significance of Sami language and culture in health services for the Sami (6–11). Recent research indicates minor differences in health status and use of health services between Norwegians and Sami (12–16). However, Sami identity can still be a

stigma and some studies indicate a correlation between discrimination and mental health problems (17). In spite of minor differences in health status¹ and in use of health services, studies indicate that the Sami are less satisfied (18–20) and have greater communication problems (21) with the health services than Norwegians because of linguistic and cultural differences. This is the point of departure in the present study, which explores the significance of linguistic and cultural aspects in interaction and communication about mental health topics, as experienced by Sami patients.

The Sami population resides in Norway, Sweden, Finland and the Kola Peninsula in Russia and is estimated to number about 100,000.² The majority of the Sami, roughly 40,000, live in Norway,³ maintaining their own language and culture. Historically, from the middle of the nineteenth century, the Sami in Norway experienced a 100- to 150-year-long period of harsh assimilation policy, leading to a stigmatized view of Sami identity, culture and language as inferior. The idea of belonging to an inferior race gave rise to shame and self-hatred in the population, which made a great many Sami hide their identity and speak Norwegian rather than Sami (22). The Sami-policy in Norway has gradually changed from assimilation towards cultural safeguarding and a revitalization of Sami society. Norway formally approved the Sami as an indigenous people in 1990. The prevailing understanding is that to achieve the goal of equitable health services for the Sami people, such health services should adapt to Sami language and culture (6,21,23).

Health services for the Sami are integrated in the public welfare state system in Norway. As Norwegian citizens, the Sami are legally entitled to public health services, and as an ethnic minority⁴ and indigenous population,⁵ to culturally and linguistically adapted health services. The Sami Act of 1987, § 3–5, regulates the right to use Sami to protect his or her own interests vis-à-vis local, regional or national public health and social institutions if their services cover parts of the Sami Language Administrative District. In addition, The Sami National Centre for Mental Health and Substance Abuse (SANKS) was established in 2002. SANKS is integrated into Finnmark Hospital Trust and serves the whole population in the Mid-Finnmark area, but holds a special obligation to

develop mental health services for the Sami throughout Norway.⁶

The Sami in Norway speak 3 main Sami languages, following the borders in Northern, Lule and Southern Sami settlement areas, with several dialects within each language (24). The number of Sami speakers (and the number of Sami-speaking therapists⁷) in Norway is unknown. However, an estimate indicates that more than half of the Sami population in Norway is bilingual in Norwegian and Sami, while the rest have limited or no knowledge of Sami (25,26). Four criteria determine bilingualism: (a) speaking the language of origin, (b) linguistic competence, (c) the function (use) of language and/or (d) attitude (identity and identification with language and/or culture) (27). The latter is important because it includes bilingualism as “cultural identity and identification” irrespective of reduced language competence, which is relevant for the predominantly Norwegian-speaking Sami. The linguistic competence and function criteria emphasize flexibility and a variety of language choice in different situations (28). Bilinguals may talk about mental distress in different languages, in different ways, with different people, within different spheres, such as (a) intimate sphere (family), (b) personal sphere (friends), (c) social sphere (colleagues and acquaintances), and (d) public sphere (public authorities including health services⁸ (28–30)). Clusters of interaction and communication situations may occur between Sami patients and their interlocutors⁹ (29), in this case meaning family/friends or therapists. A limited possibility to speak Sami in their interaction with health services may be a reason for Sami patients’ reduced satisfaction with health services (18,20).

Another assumed reason for reduced satisfaction with health services is that cultural differences between Sami patients and therapists lead to interaction and communication problems (31–34). The concept of culture is a wide and complex concept with hundreds of definitions (35). We have not restricted our theoretical frame to one specific definition; our understanding of culture is a complex, dynamic, socially acquired pattern of behaviours that *influences*, but *does not determine*, peoples’ mindsets and modes of living. Culture often serves as essentialized explanations for what people do and how they “are,” as if culture defines one specific phenomenon and delimits specific “cultural traits” as belonging to one group of people exclusively. However, culture does not *act* or *cause*

¹Health status is outside the scope of this article and will not be further discussed.

²This study is limited to Sami patients in Norway.

³There are no census data on the number of Sami inhabitants because it is prohibited to register individual ethnicity data in Norway.

⁴The Patient Rights Act, § 3–5 regulates all patients’ right to information, adapted to individual qualifications, age, maturity, experience and cultural and linguistic background.

⁵The ILO Convention, Article 25 ensures the Sami people’s right to be involved in formulating relevant health services and reaffirms Sami users’ right to adequate health care.

⁶In addition, SANKS and Finnmark Hospital Trust have made agreements to serve the Sami population in the counties of Lapland in Finland and Jämtland in Sweden.

⁷Health institutions are not obliged to include Sami-speaking staff even though Sami patients have the right to speak Sami; it is sufficient to offer interpretation service.

⁸For our purpose, we find it useful to define (a), (b) and (c) as “private/intimate,” in contrast to health services in the public/non-intimate sphere.

⁹Communication partners.

anything in itself, nor is it a static set of characteristics describing or explaining what groups of people think or do.

Culture serves as a foundation for our understanding of and acting in the world and is shaped by individual experiences in a socially positioned, political and historical context, as well as being influenced by new generations, gender, educational level, economy and geographical location (1,36,37). Culture is reproduced through a process where individuals learn its norms and values from others. Cultural norms are, often unconscious, guidelines for behaviour, interaction and communication in a group, and when internalized by individuals, norms are taken for granted and appear as “the normal way” to behave (30,38,39). People are influenced by cultural norms in what they consider as acceptable or usual topics to talk about, in what way and with whom (29,30). Culture is relevant for health services because patients are influenced by culture in how they experience, handle and express their mental health problems, as well as their help-seeking behaviour and response to treatment interventions (2). Describing and working towards understanding patients’ cultural backgrounds may help to illuminate the health issues as people experience them, and to do so without essentializing culture. This study explores how patients¹⁰ experience and handle cultural norms in a mental health treatment setting.

The aim of this study is to explore the significance of language and cultural norms in communication about mental distress, as experienced by Sami patients receiving mental health services. We will discuss how these experiences might enhance our understanding of linguistic and cultural adaptation of health services.

Method and material

Design

This explorative study investigated the significance of language choice and cultural norms in Sami patients’ encounters with mental health services.

A qualitative method was chosen as most suitable for exploring issues of which we have limited knowledge and for gathering information as experienced and narrated by the individuals themselves (40,41).

Data collection

Data were collected through individual interviews with Sami patients in outpatient mental health treatment. The semi-structured interview guide included the recording of demographic data¹¹ and questions about the significance of language and culture for mental health problems, treatment and communication with the therapist/

health services. The first author conducted the interviews, which lasted for 60–165 minutes each. The participants chose their treatment locations to be the place for the interviews.

The interview language was Norwegian, as proposed in the invitation letter, since the interviewer did not speak Sami sufficiently. The participants were encouraged to talk freely, draw on their own experiences and raise issues relevant to them. However, such free talk may have been limited because of the lack of a Sami-speaking interviewer. An interpreter was offered but rejected by the participants, as they felt their fluency in Norwegian to be adequate. A bilingual interviewer might have accessed more stories about other experiences. The interviews were audiotaped and transcribed.

Recruitment procedure

The study aimed to include men and women over 18 years in ongoing outpatient treatment from Northern, Lule and Southern Sami regions. We requested 7 mental health clinics in Northern Norway for permission to recruit from their patients. These institutions were chosen because they serve patients from the Sami Language Administrative District. Three of the 7 outpatient clinics, all in the Northern Sami region, permitted recruitment of their patients.

Explicit Sami self-identification was an inclusion criterion, independent of mother tongue or Sami language skills. Recruitment was not restricted by diagnosis, treatment duration, previous treatment series or reason for seeking help.

Letters containing information about the study, including the interview topics and an invitation to participate, were available to all patients in the arrival area visiting the clinics, or were distributed by their therapist from February 2012 to February 2013. Persons interested in participating submitted the consent form and left their phone number or e-mail address, and the interviewer contacted them for an appointment.

Sample

Five patients submitted the consent form and participated in interviews. One of these was excluded because of no explicit identification as Sami. Two women and 2 men, aged 21–50 years were included.

The participants were born and lived in small communities, three in majority Sami-speaking inland areas, and one in a predominantly Norwegian-speaking coastal area. One was married and had children, while the other three were unmarried without children. Three had previously received mental health treatment. Three participants were bilingual; two of these had Sami as mother tongue and Norwegian as second language, while one was bilingual from birth with one Sami-speaking and one Norwegian-speaking parent. One had Norwegian as mother tongue and spoke some Sami.

¹⁰In this study, we focus on the experiences of patients, not therapists, but we do realize that culture influences health providers to the same extent and should be equally examined.

¹¹Age, occupation, mother tongue, Sami language competence, cultural/family background.

Analysis

To identify elements of meaning from the texts, we conducted a thematic text analysis, using an inductive approach and systematic text reduction (41–43).

A stepwise analysis was performed:

- 1) Reading all the interview texts and identifying those parts related to the research questions.
- 2) Meaning units, that is, fragments of text containing information about the research question were identified. The meaning units were condensed and coded, thus reducing the amount of text without losing the meaning.
- 3) Related code groups were categorized into themes.¹²
- 4) Based on the code groups, short analytical texts were formulated, elaborating the understanding of the themes and reflecting the essence of meaning in the original text (43).

Findings

The presentation of findings is based on the analysis of the texts together with selected quotations. Table I presents examples of the analysis. From the analysis, we identified two themes: (I) Language choice is influenced by language competence, to whom one talks and what one talks about and (II) Cultural norms influence what one talks about, in what way and to whom.

Theme I

The participants' choice of language in different situations was influenced by language competence. The bilingual participants claimed to speak Norwegian and Sami equally well, and stated that being unable to use Sami consistently would not pose a problem. Switching between Sami and Norwegian was a normal part of everyday life and a natural way to relate to the world. One participant expressed it like this:

My mother tongue is Sami, but for me it doesn't make any difference whether I speak Sami or Norwegian. I have no difficulty expressing myself in Norwegian, I must say I think equally clearly in both languages, I can find the right words and talk about things in the same way in Norwegian as in Sami.

The Norwegian-speaking participant, however, described her lack of competence in Sami as a loss. She said that her mother tongue should have been Sami instead of Norwegian, but because of the assimilation process, the Sami language was not spoken in her family. As a child, she had tried to learn Sami to be able to speak with her grandparents, but gave up because they got angry with her for speaking Sami to them. She said that "*the Sami way of thinking*" influenced the way she talked, and

¹²Malterud calls this "category and sub-category headings"; here, we use the term theme.

that language was a matter of identity. She felt that her lack of fluency in Sami prevented her from adequately expressing her sense of identity and state of health.

That Saminess is very strong inside me [...] I feel that Norwegian, well it's not my language, and it feels very good to get into a Sami milieu where people speak Sami. It's very much ... the way of thinking, the way of talking So it's not only people with another language who need an interpreter. So therapists have to understand that even if someone is only speaking in Norwegian, it might not be Norwegian, the thing is that you don't have the words you need.

Language choice also varied with the person with whom they spoke. If both/all spoke Sami, they also spoke Sami. If one non-Sami speaker was present, they spoke Norwegian, which everybody understood. In the intimate family sphere, some spoke Sami with some family members and Norwegian with others. Two participants had siblings with different mother tongues; some had spoken Sami and others Norwegian since childhood. However, in the non-intimate health care sphere, all usually spoke Norwegian with their therapists.

It doesn't matter which language we talk, I would really have preferred Sami in fact, but if that's not possible, I speak Norwegian. That's no problem. But when we just speak among ourselves, we Sami speakers, we very readily shift to Sami, as it's easier, more natural. The psychologist I go to now is the first person to ask whether I'd prefer to speak Sami or Norwegian. I told him it really didn't matter, but I also told him that I once had a Sami-speaking therapist and it felt easier because we spoke in Sami.

Finally, language choice varied with different topics, in this case emotions and reindeer herding. Some had difficulty in communicating in Sami about "sensitive" topics such as emotions and mental health problems. One expressed it like this:

Just now, I can't think of any words to describe how I feel, in Sami. [...] So, emotionally, to explain my situation ... I express myself better in Norwegian [...]

Even with their closest relatives with whom they normally spoke Sami, some did not talk in Sami about all topics. One participant spoke Sami with her parents, except about feelings, as she explained:

When I try to explain to my mother how I feel, I can't quite manage to do it in Sami; I don't know how to say it in Sami. Sami is a rich language, but it's easier to talk in Norwegian about feelings. I also write my diary in Norwegian, it's easier.

This participant preferred to speak in Sami about reindeer herding. She described reindeer herding as a specific Sami mode of living, as only Sami are allowed to

Table 1. Examples of analysis with meaning units, codes, code groups and themes

Meaning units: citations from the interviews	Codes	Code groups	Themes
I: In your communication with the therapist, can you express yourself equally well in Norwegian as you do in Sami? I mean, do you have better words for feelings in Sami than in Norwegian? Pa4: What do you mean? I: Do the Sami words describe how you are doing in a better way? Pa4: No. We don't have words like that in Sami. So emotionally, I think I express myself better in Norwegian, describe the situation ... Just now, I can't think of words to describe what I feel. In Sami. I: What do you think about that? Pa4: It was thought provoking, what you said. But of course, we do have words for some states of feelings, such as pain. Such simple words we do have, but not deep ... emotional ... But wait, in fact, if I think about it, we do have that kind of word. But it's sort of not used, I don't think I've said that, ever, don't think so. So it came as a shock when you asked. I had to start thinking, although my mother tongue is Sami, it's maybe not used so often, but you have sometimes heard it. But it's not something you use every day. I think Sami society doesn't talk much about feelings and problems.	Emotionally I express myself better in Norwegian. I cannot think of words to describe what I feel, in Sami. We have simple words for feelings such as pain in Sami, but not for deep emotions. If I think about it, we have such words for emotions, but they are so rarely used you forget about them. Sami society does not talk about feelings and problems.	Express emotions more easily in Norwegian. Lack of Sami language competence for emotions. Sami society does not talk about feelings and problems.	Theme I: Language choice is influenced by language competence, to whom one talks and what one talks about. Theme II: Cultural norms influence what one talks about, in what way and to whom.

own reindeer and the Sami language dominates this aspect of Sami society. Her need to explain the context for her mental health problems in her reindeer herding life to the therapist was complicated by lack of language. She said:

Sometimes it would be better if my therapist was a Sami ... I've had to spend some time explaining things about reindeer herding so that [the Norwegian therapist] could understand how it works, because I can't find the Norwegian words, those kinds of words don't exist in Norwegian.

Theme II

The participants were influenced by cultural norms in what they considered acceptable or unacceptable to talk about. They described 3 topics as not usual or acceptable to talk about in the Sami community: emotions, mental health problems and physical/sexual abuse.

One participant was rather shocked to find that he had never talked about his feelings in Sami, when during the interview he was asked whether Sami words worked better to describe how he was doing. He said:

No. We don't have words like that in Sami. So emotionally, I think I express myself better in Norwegian, describe the situation ... Just now, I can't think of words to describe what I feel. In Sami. [...] of course, we do have words for some states of

feelings, such as pain. Such simple words we do have, but not deep ... emotional ... But wait, in fact, if I think about it, we do have that kind of word. But it's they're sort of not used, I don't think I've said that, ever, don't think so. So it came as a shock when you asked. I had to start thinking, although my mother tongue is Sami, [such words] are maybe not used so often, but you have sometimes heard it. But it's not something you use every day. I think Sami society doesn't talk much about feelings and problems.

Some participants said they did not talk about these topics because one is not supposed to have mental problems, and not complain about them if one does, as one participant put it:

For a reindeer herder it's almost shameful, you're not supposed to speak out loud about having mental problems, because you can't have them. "There are no mental problems in reindeer herding, it's just something people have invented to have something to complain about," that's what people say about it.

Several of the participants had experienced violence and/or sexual abuse in different ways, as victims or as abusers, but they had not talked about it before they started therapy.

I suffered violence and abuse, but it wasn't something I thought about then. And we didn't talk about it

either. My mom is a Sami and I've probably taken after her in a way . . . I haven't talked about it as an adult either.

The participants were also influenced by cultural norms in their way of talking. All participants had experienced communication problems with the health services and considered cultural differences between themselves and the therapists to be the reason. They described the "Sami way of communicating" as a norm as being less verbal, more indirect, using hints and body language and not complaining. This was in contrast to the straightforward/confrontational way health providers communicate. One said it like this:

And then there's the thing that we don't like to talk much about personal stuff. To keep things to yourself is typically Sami. I don't talk much, I've never been a person who said much, and when I need to react to something, I go off by myself. Because that's a typical Sami thing, you tend to spend a long time working through things, and you don't talk.

The participants said that the "Sami way of communicating" influenced the way a Sami expresses a need for help or support.

The Sami way to ask for help is by hinting . . . because you don't want to force your needs on anyone. The way to tell others you're having a hard time is very indirect, cautious, roundabout, maybe as a joke . . .

You don't say you're in a crisis . . . because people don't say that. Everyone understands . . . everyone understood . . . if you just said . . . a little . . . and then . . . you almost didn't need to say anything, and people understood . . . in your family . . . they can tell by looking at you . . . how you are. I think body language is widely used in the Sami culture. Health providers should know about the Sami way of telling, the way a Sami asks for help.

The findings indicate that the participants were highly motivated for treatment, and decided to change their "Sami way" of communicating to get help. As one put it:

We don't talk so much about feelings and problems in Sami society, but I decided I had to be open about this, try to get help because I couldn't take it anymore. "Why am I here, is this anything to live for?" – at the end it was sometimes kind of that I wanted to get away, to the hereafter. Then I decided this can't go on. I can't manage this on my own.

Another said it like this:

So I actually had to change . . . I'm no longer like my parents, I use so many fancy words. I've had to change to get ready for . . . to enable me to get some actual help from psychology, in fact. Health providers should know about that, how Sami express things.

The participants' choice of whom they talked to about sensitive topics was partly also influenced by cultural norms. Initially, the participants described the topics as "what we don't talk about" or "what we keep in the family," but eventually they said that they do talk about them but only with selected trusted persons in whom they could confide. Some talked about emotions and mental health problems in the nuclear family but not in the extended family.

You can't talk about mental health problems in the reindeer herding society [. . .] but as for me and my mom, we can talk about what we talked about [in treatment] and dad can also ask: Well, how did it go? But it's not like we go and tell others in the "siida."¹³

Others had family members who did not accept communication about these topics and expected them to deal with the problems by themselves, expressed like this:

I told my mother I went to see a psychologist, but she just said, "What? A shrink? Can't you even cope with that thing?" We never talked about that again.

Some did not talk with anyone in the family but had one or two close friends as interlocutors.

However, when the mental problems had become so severe that the participants had difficulties functioning in daily life, for example, insomnia, feeling isolated, depressed or suicidal, they said communication only with family and friends was insufficient. The only option was to find someone outside to talk to, and they turned to the health care system.

[. . .] to come here [to the therapist], that's what was needed, I had no choice. You think you can deal with it on your own, but you can't, you need help. My God, where would I be if I hadn't gotten help? It was like my life was nothing, I was playing with my life.

Some preferred a local therapist who, sharing their cultural and/or ethnic background, was assumed to understand them better.

Because I come from the Sami culture I have trouble communicating with doctors from the south. They don't understand the nuances unless they happen to have that kind of personality that makes them realize . . . I haven't met many who come from other places who understand. When I went to a Sami therapist, it worked well; there wasn't much misunderstanding between us.

Others preferred to talk to a non-local therapist as they felt they could talk more freely with someone they were unlikely to encounter in a private context. They found it

¹³Reindeer herding society, usually including members of the extended family.

unpleasant that relatives and acquaintances worked in the institution where they received treatment. They did not want people they knew to learn about their mental problems, because as previously mentioned, one is not supposed to have mental problems in the Sami society. Although they had faith in the therapists' confidentiality, they were afraid of being thought of negatively or perhaps as crazy. One said it like this:

Emotionally it would have been easier to talk to someone I don't know in private. I think it would have been easier if I'd lived in a city, where you don't meet them [therapists] in the street or anywhere. My therapist is leaving, and when he leaves, there are only people I know left working as therapists, that's a crisis for me.

Discussion

Sami language and culture are described as critical factors in health care for the Sami population, especially mental health (6,23,44,45). This has brought about legislation that entitles the Sami to use their language and receive culturally adapted health care services. This study shows that the issue of linguistic and cultural adaptation of health services is more complex than the question of health policies and a legal right to receive adapted services. Sami patients are not one cultural group with common needs, rather they have individual preferences concerning choice of language and communication partners as well as how they view and handle cultural norms.

According to Helander (46), several factors influence language choice: whether the discourse situation is public or private, whether the role relationship between the interlocutors is intimate or not and whether the interlocutors are Sami or not. Helander (46) found coherence between language, relationships and spheres, in that Sami (intra-ethnic) interlocutors in intimate relationships in the private sphere spoke Sami, while inter-ethnic interlocutors in non-intimate relationships in the public sphere spoke the majority language.

The present study indicates that language choice does not necessarily follow relationships and spheres, but varies within both the private and public sphere, as well as in intimate and non-intimate relationships. Our participants interact and communicate in or across spheres, in one or the other language. Within intimate relations in the private sphere, members of a nuclear family do not necessarily share one common language. A person might speak Sami with one sibling or parent and Norwegian with the other, depending on each person's language competence. However, as in Helander's study (46), our findings show that the majority language, Norwegian, is the most common language in encounters with the health services, and most participants say they accept and handle that without problems. The one person who expresses language problems is actually the predominantly Norwegian-speaking participant. Her reflections about her lack of the right

language to express the sense of Saminess inside her emphasize how important it is to explore patients' linguistic and cultural background. A large proportion of the Sami population are Norwegian speakers but may still experience a lack of the Sami language to express their sense of cultural identification with language and/or culture (27). This suggests the possibilities of exploring non-verbal experiences and raises the question of whether the treatment language influences the treatment result, which should be further investigated.

Our findings suggest that language choice also depends on the topic and cultural norms that guide how and with whom certain topics are appropriate to discuss. Language choice is influenced by what Fishman (29) calls "topical regulation," which implies that some topics are better handled in one language than the other. The variety of topics may lead bilingual speakers to acquire the habit of speaking about a certain topic in one language, because the other language or the individuals lack specialized terms or because it is considered strange or inappropriate to talk about it in the other language (29). In our study, the lack of specialized terms in Norwegian about reindeer herding hindered a satisfactory conversation about it with a Norwegian-speaking therapist. The lack of knowledge on specialized terms for emotions in Sami influenced some participants to use Norwegian with their therapists, but also with their closest relatives with whom they usually spoke Sami. Within a private sphere and in reindeer herding societies, the large number of Sami speakers would be expected to favor the use of Sami (46). However, a lack of terms or habit to talk about emotions influenced them to talk about it in Norwegian both in their families and in Sami society.

Pedersen (47) describes a similar finding: Sami participants attending an anxiety group said they lacked Sami terms about anxiety and were not habituated to talking about such issues. However, given this opportunity to talk about it, they managed to help each other to find the right Sami words to describe their emotions and anxiety problems. Historically, the Sami have had limited opportunity to develop terminology related to mental health because of the lack of a Sami-speaking health service, and according to our results, also because of the absence of the topic in Sami society and mass media and the influence of cultural norms (47).

People are influenced by cultural norms in what they consider acceptable and especially *unacceptable* actions and topics for conversation (39). Several authors refer to Sami norms influencing people to hide mental distress, manage on their own, not show weakness, keep problems such as depression to themselves or within the family and avoid seeking help (31,47–50). Culture is often used to explain human actions, assuming that people act as they do because of their culture. In such a deterministic perspective, culture appears as personal characteristics

and cultural norms appear as “rules”, applicable to all Sami people (51). Discussing norms in a deterministic, generalized way involves the risk of creating essentialized myths about populations, such as “Sami do not talk about emotions.” However, norms are not static and unalterable, rather as culture they are relational, social constructions in continuous change. Our participants stated that they were aware of, but had chosen to bypass, the cultural norms of not talking about emotions and mental distress by doing just that – starting to talk about them. They described “the Sami way” of talking as using indirect communication, body language or hints and a lack of habit to talk about mental distress within Sami society. Our participants also changed their way of communicating to be able to receive the therapists’ treatment. They said that the open, public way of discussing mental health in Norwegian society enhanced their linguistic competence and possibilities to communicate their mental distress, in Norwegian. They could not cope alone and therefore sought help from the health services, which for them represented an arena for open-hearted communication about topics regulated by Sami norms. Our findings raise questions as to how health services should deal with such cultural nuances and balance respect for cultural norms with appropriate individual health care.

A study of bilingual public services in Sami-language administrative areas concluded that health services is the sphere where most people prefer to speak Sami but where the possibility is the poorest, because health providers are mostly monolingual Norwegian speakers (44). Norway has 2 official languages, Norwegian and Sami, but very few Norwegians have learnt to speak Sami (52). The limited number of Sami-speaking therapists reduces the possibility for Sami patients to choose one and speak Sami in their therapy.

In addition, even if therapists speak Sami, another challenge arises in the relationship to therapists as fellow villagers. The institutions in this study are located in small communities in Sami areas. Professional work in such communities raises challenges of proximity and distance between therapists and patients. Holding local and cultural knowledge could be an advantage for the therapist but might also imply a lack of necessary distance. Patients might have multiple social relationships with therapists as kinsmen, neighbours or acquaintances in the private spheres (53). A relative, neighbour or acquaintance will, as a health provider, access sensitive information that he/she might not have accessed through their private relationship. Some of our participants preferred to see a local and/or Sami therapist, assumed to have knowledge about Sami culture and the Sami way of communicating, while others saw this as raising dilemmas that overshadowed the language barrier. Most of these participants preferred a professional and

non-intimate relationship to a therapist, where they meet exclusively in the public sphere; this was thus more important than the possibility to speak Sami with a local therapist.

Helander’s study from 1984 revealed a tendency to use the majority and minority languages together in many situations. Now, 30 years later, we find the same tendency. Living as bilingual implies that language choice in different communication situations is influenced by a complex combination of various social and cultural factors (46). Our participants’ experiences reveal the importance of health care professionals learning about indigenous peoples’ history, politics, language and culture but ensures the individual perspective (54). Different patients have individual needs, varying opinions about and preferences for what they can talk about, in which language, in what way and with whom. The challenge for the health services is to allow for and safeguard such individual variations within the cultural framework of the patients.

Limitations

The number of participants in this study was small and our findings are not valid for the entire Sami population. All participants were born and lived in the Northern Sami area, but other Sami, for example, from Lule or Southern Sami populations might have other experiences due to demographic, linguistic, individual and contextual differences, as well as differences in health services. The sample is especially limited in age, marital status and parenthood and these factors have not been considered, nor have other factors such as gender, class, education, occupation, living in rural/urban or Sami- or Norwegian-dominated areas. Finally, only participants attending therapy were included in this study. Persons whose treatment had terminated or those with no experience of treatment may have other issues, reflections and priorities associated with mental health services. A different demographic sample might have resulted in different findings.

The study was conducted in Norwegian. As the results show, the participants were fluent in Norwegian but expressed some things in Norwegian and others in Sami. A Sami-speaking interviewer could have explored and discussed Sami expressions in more detail with the Sami-speaking participants.

A broader sample and interviews in both Sami and Norwegian might reveal a broader range of meaning units associated with the significance of language and culture in mental health topics. An exploration of the participants’ experiences and reflections in both languages, and in both cultural perspectives, might have led to more or different findings.

Concluding remarks

The present study indicates a complex situation where Sami patients’ choice of language and ways of communicating

with mental health services are influenced by their language competence, cultural norms, the topic of conversation and their relationship with the interlocutors.

Most participants in this study perceive themselves as bilinguals, speaking Sami and Norwegian equally well. They consider bilingualism to be a resource and a natural part of their lives. Bilingualism enables flexibility and choice of language. There is a tendency to perceive the Sami as synonymous with Sami-speaking people (6,55), but many Sami people speak only or predominantly Norwegian. The participants' language competence is even more complex; some might speak Norwegian fluently but still lack specialized terms for certain topics, such as reindeer herding, in Norwegian. Others, with Sami as their primary mother tongue, might still lack Sami terminology for mental distress and emotions. Individuals may be influenced by Sami cultural norms, which prevent a habit of talking about emotions and mental health issues, in families or in broader Sami society, inducing silence around such topics. Some Sami patients choose to bypass certain norms if they appear as obstacles to their well-being. Finally, language choice and the extent to which they speak about sensitive topics such as mental health also depend on the person with whom they speak. Some prefer a local/Sami and/or Sami-speaking therapist because of an assumed cultural competence. Others prefer a non-local therapist to keep professional distance, even though that means speaking Norwegian during therapy.

The discourse of cultural adaptation of health services to indigenous people is highly politicized, tending to essentialize the culture. Indigenous patients are often assumed to share certain cultural norms, values and beliefs to which health services have to adjust (2). Our study indicates a variety of language use and cultural influence. Patients are influenced by both Sami and Norwegian culture in their interaction and communication with health services. Bilingualism and knowledge of both Sami and Norwegian culture provide latitude and enhanced possibilities for both patients and the health services.

Clinical implications

Access to useful mental health services for the Sami population may expand if patients can choose or switch between Sami or Norwegian language in therapy. They should also be able to choose between a local or non-local therapist. It is therefore important that health care facilities as well as health educational institutions recruit Sami-speaking health providers and students. Therapists and students should hold linguistic and analytical cultural competence and explore bilingual experiences and the diversity of cultural influence in handling and expressing mental health problems, without essentializing culture and stereotyping Sami patients.

Further research

The number of participants in this study is small and should be followed up with a broader demographic sample to portray experiences of the Sami population in Norway as well as in other nations.

Sami-speaking researchers should conduct further research to explore Sami-speaking patients' language competence and preference in communication about mental health topics. The meaning of language and culture in relation to professional contact about mental health issues in monolingual Sami-speaking populations, and in the Lule and Southern Sami populations where the minority-majority situation is different will probably add important understanding to the topic. It is important to include both individual and group variations when changes in health service programmes are to be discussed to prevent actions based on incomplete or biased knowledge.

This study has focused on Sami patients' experiences, and further research should include exploration of the significance of therapists' linguistic and cultural background and competence.

The focus and findings in this study are transferable, but must be contextualized, when exploring experiences of indigenous people in other countries.

Ethics

The study was approved by the The Regional Ethical Committee (REK-number delivers on demand) and was conducted in accordance with the Helsinki Declaration of 1975, revised in 2008.

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ORIGINAL RESEARCH ARTICLE

“You never know who are Sami or speak Sami” Clinicians’ experiences with language-appropriate care to Sami-speaking patients in outpatient mental health clinics in Northern Norway

Inger Dagsvold^{1,2*}, Snefrid Møllersen¹ and Vigdis Stordahl^{1,2}

¹Sami Norwegian National Advisory Board on Mental Health and Substance Abuse (SANKS), Finnmark Hospital Trust, Karasjok, Norway; ²Centre for Sami Health Research, Department of Community Medicine, Faculty of Health Sciences, UiT – The Arctic University of Norway, Tromsø, Norway

Background. The Indigenous population in Norway, the Sami, have a statutory right to speak and be spoken to in the Sami language when receiving health services. There is, however, limited knowledge about how clinicians deal with this in clinical practice. This study explores how clinicians deal with language-appropriate care with Sami-speaking patients in specialist mental health services.

Objectives. This study aims to explore how clinicians identify and respond to Sami patients’ language data, as well as how they experience provision of therapy to Sami-speaking patients in outpatient mental health clinics in Sami language administrative districts.

Method. Data were collected using qualitative method, through individual interviews with 20 therapists working in outpatient mental health clinics serving Sami populations in northern Norway. A thematic analysis inspired by systematic text reduction was employed.

Findings. Two themes were identified: (a) identification of Sami patients’ language data and (b) experiences with provision of therapy to Sami-speaking patients.

Conclusion. Findings indicate that clinicians are not aware of patients’ language needs prior to admission and that they deal with identification of language data and offer of language-appropriate care ad hoc when patients arrive. Sami-speaking participants reported always offering language choice and found more profound understanding of patients’ experiences when Sami language was used. Whatever language Sami-speaking patients may choose, they are found to switch between languages during therapy. Most non-Sami-speaking participants reported offering Sami-speaking services, but the patients chose to speak Norwegian. However, a few of the participants maintained language awareness and could identify language needs despite a patient’s refusal to speak Sami in therapy. Finally, some non-Sami-speaking participants were satisfied if they understood what the patients were saying. They left it to patients to address language problems, only to discover patients’ complaints in retrospect. Consequently, language-appropriate care depends on individual clinicians’ language assessment and offering of language choice.

Keywords: Sami; mental health; qualitative study; language-appropriate services; language switch; equitable health services; Norway

*Correspondence to: Inger Dagsvold, Duevn. 16, 9015 Tromsø, Norway, Email: Inger.j.dagsvold@uit.no

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The Indigenous population in Norway, the Sami, living in Sami language administrative districts¹, have since 1990 had a statutory right to receive equitable health care, including an extended right to speak and be spoken to in the Sami language when receiving

health services (1). Shared language is a prerequisite for verbal communication, and it is well recognized that when patients speak their preferred language in therapy, it enhances mutual understanding, a good therapeutic relationship between patient and clinician, and may improve the quality of therapy (2–7). Language barriers are common causes of communication problems and clinicians’ failure to understand minority-language patients (6,8–11). Therefore, clinicians’ ability to assess language needs, offer

¹Sami language administrative districts include the municipalities Tana, Nesseby, Porsanger, Karasjok and Kautokeino in Finnmark; Kåfjord and Lavangen in Troms; Tysfjord in Nordland; and Snåsa and Røyrvik in Nord-Trøndelag.

a language choice and evaluate the impact of language in therapy is vital in the provision of language-appropriate care. However, language assessment is complex; language proficiency and level of fluency are not easily defined and may vary whether it is clinician- or patient-assessed. Furthermore, patients' language use and preferences may vary with relation to interlocutor or topic of conversation (7,12). The purpose of this study is to explore how clinicians deal with language-appropriate care with Sami-speaking patients in specialist mental health services.

Language-appropriate health care for immigrants in southern Norway and for minority-speakers in other countries, for example, Canada, Wales and the USA, is reported to be insufficient. Identification of patients' language data and offers of language-congruent services or interpretation are poorly implemented (2,5,9,13,14). In a Sami context, there is limited knowledge about clinicians' experiences with provision of language-appropriate care within specialized mental health services towards Sami patients. Language surveys show considerable variations in the possibilities to use Sami in local health care. Sami majority areas have more Sami-speaking health personnel, but even there service users are dissatisfied with the possibilities to speak Sami when receiving health care (15–17). The lack of Sami-speaking clinicians and professional Sami interpreters is reportedly the main challenge, both in local and specialized health services (15,16,18–21). We have identified two studies of language-appropriate health care for Sami patients. The first, a study of general practitioners (GP) practices, indicates that Sami patients are not offered GP services in Sami (22). The second, a study of specialized mental health services in a psychiatric hospital in Northern Norway, showed that Sami-speaking patients are not always identified as Sami speakers and only occasionally receive therapy in Sami (23). Reports and research to date are limited but indicate that language-appropriate health care for the Sami in Norway is inadequate.

This study aims to explore how clinicians identify and respond to Sami patients' language data, as well as how they experience provision of therapy to Sami-speaking patients in outpatient mental health clinics in Sami language administrative districts.

The Sami

The Sami population resides in Norway, Sweden, Finland and the Kola Peninsula in Russia, and is estimated to be about 100,000 people.² The majority, roughly 40,000, live in Norway.³ From the mid-19th century⁴, the Sami in Norway experienced a 100–150-year-long period of

linguistic and cultural oppression and harsh assimilation policy, leading to among other things language shift among many Sami (2,5,24). The Norwegian Sami policy has gradually shifted from an assimilation ideology, and Sami society is now being revitalized. In Norway, the Sami were formally acknowledged as an Indigenous people in 1990 and they have a constitutional right to maintain and develop their language, culture and way of life (25).

Sami languages in Norway

The Norwegian Constitution section E, Human Rights, §108⁵ gives Sami and Norwegian languages equal worth and status. There are three main Sami languages: Northern Sami⁶ (26), Lule Sami and Southern Sami, with several dialects within each language (27). The exact number of Sami speakers is unknown; estimates vary between 23,000 (18) and 35,000 (21,28). Furthermore, the exact number is difficult to determine because "Sami-speaking" is not defined in terms of fluency (21,28). Sami language competence varies between generations, family members and locality, since the intensity of assimilation varied in periods and between Sami areas. Most Sami speakers are assumed to be bilingual (29–32). The number of monolingual Sami speakers is assumed to be small, predominantly pre-school children, persons with intellectual or cognitive disabilities and senior citizens (33).

Language rights in health care for the Sami

Health care for the Sami is integrated in the Norwegian public welfare state system, where they are entitled to receive equitable health services⁷ (34). Several national laws, notably the Patient Right Act and the Sámi Act, confirm Sami patients' right to speak Sami in health care settings. The Sámi Act stipulates an extended right to use Sami in local, regional or state public bodies (here: health institutions) in the Sami language administrative districts (1,18). The Health Trusts Act emphasizes that specialized health services are responsible for safeguarding Sami patients' extended right to use Sami in specialist health care (18). However, health institutions are not obliged to employ Sami-speaking clinicians; it is sufficient to offer an interpreter (35,36). According to the Health Personnel Act, clinicians are responsible to fulfil the Patient Rights Act (13,18,21).

Material and method

Design

We chose a qualitative design with individual interviews to explore issues of which we have limited knowledge, narrated by clinicians with relevant experience (37).

²This study is limited to Sami in Norway.

³There are no census data on the number of Sami inhabitants because it is prohibited to register individual ethnicity data in Norway. The estimate of 40,000 has remained unchanged since 1970.

⁴The process of Christianization and assimilation started even earlier, in the 17th and 18th centuries, in the south Sami areas.

⁵Former § 110

⁶Northern Sami is the language spoken by most Sami in Norway.

⁷Equitable services include equal access to treatment and equal treatment outcomes in health care, irrespective of place of residence, economy, social status, age, sex or ethnic affiliation.

Recruitment procedure

The study aimed to include clinicians providing care to Sami patients in outpatient mental health clinics. We requested seven mental health clinics serving patients within Sami language administrative districts⁸ in Northern Norway for permission to recruit participants among their clinicians. Three clinics consented, all located in the northern Sami area. Information meetings and letters containing information about the study, including the interview topics and an invitation to participate, were distributed to 60 therapists in August 2012–November 2013. An inclusion criterion was experience with provision of mental health care to Sami patients. Clinicians interested in participating submitted the consent form directly to the first author, who contacted them for an appointment.

Sample

A total of 20 clinicians⁹ participated in the study, of which 9 were men and 11 were women. Participants' age varied from mid-20s to mid-60s. Of the participants, 10 were qualified nurses, social workers, physiotherapists or occupational therapists, and another 10 were psychologists or psychiatrists. Their experiences from mental health care ranged from 2 to about 40 years. Three had some kind of specialized training in cultural studies. Eleven participants identified as Sami and nine as non-Sami. Residency in the Sami area ranged from 1 to approximately 60 years. Five spoke Sami fluently and could provide treatment in Sami, while 15 were unable to provide treatment in Sami because of no (n = 10) or limited (n = 5) Sami language competence.

Data collection

The interviews, conducted by the first author, took place at the participants' chosen location; their workplaces, and lasted from 50 to 140 minutes. The semi-structured interviews were based on a thematic interview guide including topics relevant to the aim of the study: participants' language awareness with Sami-speaking patients, experiences of provision of language-appropriate mental health care to Sami-speaking patients and the use of Sami in therapy. The questions were open-ended and the order was flexible. The participants were encouraged to talk freely, draw on their own experiences and discuss issues that interested them. All interviews were in Norwegian because the interviewer did not speak Sami fluently. For Sami-speaking participants, the use of Norwegian may have limited free talk. A bilingual interviewer might have accessed other stories about their experiences. The interviews were audiotaped and transcribed verbatim. To safeguard participants' confidentiality, their name, age,

occupation and other personal¹⁰ details were not included in the transcripts or the presentations of findings.

Analysis

The transcribed texts were analysed using an inductive approach, according to thematic text analysis inspired by systematic text reduction (37–39), as follows:

- a. All transcriptions were read several times to obtain an overall impression of “what they were talking about,” followed by reading of the texts in relation to the aim of the article: exploring how clinicians identify and respond to Sami patients' language data, as well as how clinicians experience provision of therapy in Sami or Norwegian in outpatient mental health clinics in Sami language administrative districts.
- b. Meaning units were identified representing aspects relevant to the research question. The meaning units for each participant were condensed and coded, which reduced the amount of text without losing the meaning.
- c. The codes were systematized and categorized across the sample. Related codes were sorted into themes and subthemes.
- d. Finally, we formulated short texts, summarizing our interpretations of each theme.

The first author read all the interview texts, and selected half of the interviews for the last author to read. The first author formulated code groups and themes, which were introduced to the co-authors, along with selected quotations. The code groups and themes were modified and further developed by all authors in cooperation. The analysis was a process of reading and re-reading, formulation of themes and subthemes and selection of quotations suitable to enlighten the themes and represent the participants' stories about their experiences.

The findings are presented as experienced by participants who could and those who could not provide therapy in Sami. In both groups, there were differences regarding participants' characteristics, such as gender, age, education, language, ethnic background and time of residency in Sami- or Norwegian-dominated areas. Characteristics other than Sami language are not mentioned here due to the small number of participants and confidentiality. A different and/or broader demographic sample might have resulted in different findings but require a broader sample and different methods.

Ethical approval

The research protocol was approved by the Regional Committees for Medical and Health Research Ethics (REC)¹¹ and was conducted in accordance with the Helsinki Declaration of 1975, revised in 2008.

⁸Where the Sámi Act gives Sami patients an extended right to use Sami.

⁹We refer to them as participants.

¹⁰All clinicians are named as she or her, and all patients as he or his.

¹¹REK-number delivers on demand.

Results

The presentation of findings is based on the text analysis and illustrated by selected quotations. From the analysis, we identified two main themes and five subthemes (see Table I).

Identification of Sami patients' language data

The findings in this study showed that the participants identified Sami patients' language data (language proficiency and/or preferred therapy language) either through health institutions' standardized routines, by varied individual approaches, randomly or not at all.

When is Sami patients' language data identified?

Prior to treatment start, referrals from GPs are, according to seven participants (four Sami speakers), the only tool that occasionally informs them about Sami language data, at least when the referring doctor is a "Sami-speaking doctor". However, most participants (13, including one Sami speaker) found that referrals have no information about Sami patients' language proficiency or preferred therapy language.

Language-appropriate services, particularly interpreter services, were not organized prior to admission. Sami-speaking patients were most often not assigned to Sami-speaking therapists prior to admission, as stated by one:

Patients don't get the chance to choose a Sami-speaking therapist [...] Never seen anything about that in referral letters, I've been involved in admissions and I've never seen anything like that.

Most of the participants were not aware of Sami patients' language data and had not prepared for a language choice prior to initial contact. Consequently, the participants could decide for themselves whether to identify language or not when they met the patient.

At the outset of therapy, the anamnesis is an institutional tool that can identify language proficiency, according to five participants (one Sami speaker). However, the anamnesis is not obligatory to use. One non-Sami-speaker stated that:

We do ask about the language in the anamnesis [...] but with Sami, I don't know if it's always so much emphasized because it's so obvious that they speak Norwegian. If they come in here speaking Norwegian, we presume they speak Norwegian well, like most Sami.

Table I. Results

I Identification of Sami patients' language data
• When is Sami patients' language data identified.
• Approaches for Sami language identification.
II Experiences with provision of therapy to Sami-speaking patients
• Provision of therapy in Sami
• Offering referral to Sami-speaking services
• No offer of language choice

Another non-Sami-speaking participant emphasized that, since the institution serves a multilingual population, it should routinely identify all patients' mother tongue and preference for therapy language:

[...] it's quite incredible that it's possible to take a whole anamnesis without asking about [which language they prefer in the therapy] [...] when we live here in the north, and everyone knows there are so many people with Sami as their mother tongue [...] and when the patient is in a crisis [...] it's quite natural that what we speak then is the mother tongue, it's what lies deepest in a person, isn't it? [...]

These participants reported that even if institutional systems for language identification are available, they are not always used. The participants used various individual approaches to identify language data in the beginning of therapy, or discovered it by chance during treatment.

Approaches for identification of Sami patients' language data

All five Sami-speaking participants reported that they always identified Sami language proficiency and preferred therapy language. Among the 15 non-Sami-speaking participants, nine reported that they always identified, six occasionally identified – and two did not identify Sami patients' language proficiency. As for preferred therapy language, nine reported that they always identified, two occasionally – and four never identified it (two of them had and two had not identified language proficiency). Identified language proficiency was not always followed up by an identification of preferred therapy language.

The Sami-speaking participants identified language proficiency by asking all patients, alternatively identified themselves as a Sami speaker by greeting in Sami or using their Sami name during the first consultation. Sometimes they knew the patient as a Sami speaker from the local community and therefore asked about the preferred therapy language. Some participants simply started to talk in Sami to a patient they believed to be a Sami speaker and left it to the patient to choose language in replying. The patients' responses when being spoken to in Sami determined the therapy language to be either Sami or Norwegian. However, Sami-speaking patients could change their mind and prefer to switch to another, or between, language(s) during therapy.

The non-Sami-speaking participants identified language proficiency by asking all, or some, patients in the beginning of therapy. Some asked about Sami language proficiency if they observed, what they considered typical Sami characteristics: the patient had a Sami name, "looked like a Sami", spoke imperfect Norwegian with a "Sami accent" or if a patient lived in a "Sami area" (Karasjok or Kautokeino¹²). One participant admitted that if patients lived in non-typical Sami area, she might forget:

I certainly know which patients speak Sami. There aren't so many [...] I usually ask what their mother tongue is, but it does happen that I forget, it's easier to forget it if they come from the coast.

Some non-Sami-speaking participants said that they might discover both language proficiency and preferred therapy language by chance later in the therapy. One said: "I ask about language if I get a hunch," without being able to define "a hunch". Another participant related how the use of Sami poetry and music during group therapies may identify hidden or even forgotten Sami language proficiencies among patients:

[...] we always use poetry and music [in group sessions], in Sami too [...] and then there are some [patients] who suddenly think of Sami words they didn't know they knew, they remember they heard them, used them, in childhood [...] and while we were listening to a Sami song, there were suddenly others in the group who [said they] understood what the song was about, but they didn't say it at first. Two understood the language, but they couldn't speak it, and another could also speak [Sami] [...].

This participant emphasized the importance of language awareness when serving the population in Sami areas because "you never know who are Sami or speak Sami."

Among the non-Sami-speaking participants, there were also reports of no identification of Sami language proficiency. One stated that:

I don't ask about their mother tongue. As long as the patient speaks a kind of Norwegian that I think of as quite normal Norwegian, it's not an issue.

Those participants who did not identify patients' preferred therapy language reported that they have assessed the patients' Norwegian proficiency as satisfactory for communication. They spoke Norwegian without asking the patient about preferences and claimed that they have never experienced language problems during therapy. They trust their patients to address language problems:

[...] I tend to say if you don't understand me, please tell me, so I can use other words in a way that you can understand what I'm saying [...] it's very important to have them realize that I have some limitations too, I can't speak their language. [...] I want to try to help them and if they want help, they have to help me to help them, you could say, if they can.

The findings indicate that, in most cases, the participants identified language data, ad hoc, by using various individual approaches. A few participants assessed patients'

Norwegian proficiency as good and did not ask Sami patients about language data. They trusted the patients to address language problems.

Experiences with provision of therapy to Sami-speaking patients

Most of the participants offered a language choice for therapy at treatment start or later in therapy. The Sami-speaking participants offer therapy in northern Sami themselves. The non-Sami-speaking participants reported having three options: referring the patient to a Sami-speaking therapist, using an interpreter or providing therapy in Norwegian without offering a language choice.

Provision of therapy in Sami

The five Sami-speaking participants offer to provide therapy in northern Sami at treatment start. In their experience, most Sami-speaking patients are bilingual and respond differently to the offer. Many of their Sami-speaking patients prefer to speak Sami, but some also say it does not matter because they speak both languages equally well or prefer to speak Norwegian with therapists out of habit.

When Sami-speaking patients chose to speak Sami, the participants found communication to be more profound and openhearted. One participant stated:

I think it's an advantage to know the language because to speak Sami with those who prefer that opens up in a completely different way than talking in a second language, and I think that when people can think aloud and hear themselves talk, it can be a good help.

However, all the Sami-speaking participants also experienced that many Sami-speaking patients may reject the offer to speak Sami in therapy. One participant reported:

[...] I've wondered sometimes, because some have been talking Norwegian to me, but I know they can speak Sami. But it hasn't happened, then we don't speak Sami even though I know they speak Sami, so it's strange. But I tell them you can just speak Sami, it's no problem to speak Sami if you want to, but often when they've started a conversation in one language, we tend to continue in that language.

Whatever language the patients choose, they usually switch between Sami and Norwegian during therapy. Sami-speaking patients may choose to speak Norwegian in therapy but switch to Sami when communicating what the participants consider sensitive topics such as "[...] emotions, that's very often in their mother tongue, the language of the heart [...]."

Language switch may also appear suddenly in the middle of a conversation without an explanation. According to one of the participants, this is how everyday conversation goes on:

¹²Two municipalities in the inland in the county of Finnmark with a majority of Sami, often called the "core Sami area."

In our world, people are bilingual in many ways. . . some topics we speak about in Sami, and some topics we speak about in Norwegian [. . .], alternating.

All the Sami-speaking participants said that when a patient switches between languages, they switch as well. The participants have not explored when and why language switch occurs during therapy. One participant stated: "I don't know, I haven't thought about it, I just follow, when the patient switches, I switch as well." According to these participants, the meaning of language in therapy is not discussed among health professionals at their workplaces. They do not have training in language assessment.

Our findings indicate that the Sami-speaking participants in this study always identify the patient's language proficiency and offer to speak Sami in therapy. In their experience, Sami-speaking patients benefit from using Sami language in therapy because they communicate more easily in Sami. However, Sami-speaking patients may choose to speak Norwegian or switch between languages during therapy.

Offering referral to Sami-speaking services

Non-Sami-speaking participants reported having two choices when they identified patients as Sami-speakers: referring them to a Sami-speaking therapist or using an interpreter.

Offering referral to Sami-speaking therapist. Eight non-Sami-speaking participants reported that they had offered referral to a Sami-speaking therapist, but that the patients hardly ever accepted the offer. In their opinion, Sami-speaking patients may have several reasons to reject such an offer. Some said the offer is given too late, and that Sami patients are polite and may feel uncomfortable about rejecting a therapist's offer to his face. Some assume that patients may be afraid to lose or delay the treatment if they want to speak Sami in therapy. A few reported that a Sami-speaking patient may refuse referral to Sami-speaking clinician when offered by a non-Sami-speaking participant, but accept to speak Sami when offered by a Sami-speaking clinician. However, the contrary may also happen: Instead of transferring to a Sami-speaking therapist, a Sami-speaking patient may prefer to see a non-local therapist, even if it means speaking Norwegian. One participant reported:

I've offered follow-up care with a Sami therapist, but people don't want to be referred there [. . .] The reason is that Sami community is so small and family ties and kinship are really important, they didn't want others to know they had problems and got psychiatric help.

Consequently, most of the non-Sami-speaking participants continued the therapy in Norwegian with Sami-speaking patients.

A few of these non-Sami-speaking participants reported that even if Sami-speaking patients choose to speak Norwegian themselves, language problems and language switch may occur during therapy. Occasionally, when Sami-speaking patients may struggle to express themselves in Norwegian, some participants may encourage patients to "say in Sami" because they believe it helps to think aloud in their mother tongue, even though they themselves would not necessarily understand what the patients are saying. Two participants reported that they have re-examined patients' language choice because of language problems. One of them stated:

I had a patient who didn't want an interpreter, but I thought this was quite wrong, this was a patient in a crisis who had a lot of difficulty making himself understood [. . .] then I thought, well, it's quite natural that what you speak then is your mother tongue, it's what lies deepest in a person. [. . .] But the patient can say no, I'm going to speak Norwegian, and he can deny or refuse to tell, or God only knows what reason people have, that's a different matter [. . .] But I felt it was far too difficult, I couldn't reach him and I didn't understand, and the patient couldn't explain what he meant either, he couldn't find the Norwegian words that were good enough to give an explanation of how things were inside him.

This participant was dissatisfied with progress in the therapy, evaluated the patient's language choice as insufficient for therapy, and insisted on transferring the patient to a Sami-speaking clinician, which the patient finally accepted.

These participants emphasized the importance of maintaining a continuous language awareness and evaluating whether patients' language choice works for therapy or not. One participant emphasized that therapists must have a "double attention" and be aware of possible communication failures because of language difficulties during therapy.

Several non-Sami-speaking participants emphasized that they would prefer Sami-speaking patients to receive therapy in Sami. They considered the lack of therapists, especially psychologists and psychiatrists, who speak different Sami languages as limiting the offer of language-appropriate services:

Sami patients should receive services in their own language but they don't, not in this institution anyway. The offer of services in Sami is predominantly available in the Northern Sami area, and it's poor even here.

The findings indicate that when therapists offer language choice, patients' responses may depend on when the offer is given, by whom and whether they can choose a therapist with whom they can have a strictly professional relationship, which may be difficult in small communities.

A few of these participants evaluate language in therapy, and may re-examine patients' language choices and insist that patients accept referral to Sami-speaking care. However, these non-Sami-speaking participants found limited opportunities to offer language-appropriate services.

Offering a Sami interpreter. Six non-Sami-speaking participants had offered an interpreter in therapy with Sami-speaking patients, but their patients always rejected the offer. The reasons are assumed to be that Sami patients wish to avoid an interpreter with whom they have a non-professional relationship, that they may find it difficult to use an interpreter or that they may find it "kind of humiliating to be asked if they need an interpreter, because that sort of implies they don't even know Norwegian properly."

None of the 15 non-Sami-speaking participants had used a Sami interpreter in their present positions in the northern Sami area. Two participants had earlier used a Sami interpreter but stated that "it's difficult to use interpreter." Another participant reported that, in her clinic, the use of Sami interpretation was not an issue.

Potential differences in the application of Sami language by clinicians versus interpreters were not mentioned; however, two non-Sami-speaking participants said they preferred referral to Sami-speaking therapist instead of offering interpretation services.

The findings indicate very limited use of Sami interpreters. Only one participant reported that she evaluated and re-examined patients' rejection of interpretation. The example may indicate that even though a patient has rejected an offer of an interpreter, a language need may appear.

No offer of language choice

Seven *non-Sami-speaking participants* (four did not identify preferred therapy language) claimed that they have never found it necessary to offer a choice of therapy language because they never have met a monolingual Sami-speaking patient, and judge Sami-speaking patients to be fluent in Norwegian. These participants have not experienced problems understanding Sami-speaking patients during therapy. One of them stated:

I very rarely have problems [with understanding] [...] even one patient, I took over a patient, an elderly person, first [me and my colleague] started together and then I got this patient alone and there haven't been any problems. He accepted it, in the beginning he felt he ought to ask my colleague what I said, but when my colleague wasn't there, he understood everything perfectly. I speak very clearly [...] and if I speak slowly, [...] it helps.

This participant, who does not routinely identify patients' language preference, stated that when he can understand the patient, it is unnecessary to offer a language choice for therapy.

These participants reported that Sami patients have not addressed language problems. However, one participant did not discover a language problem until being told that a patient had asked to see another clinician because of language problems. Another participant recalled one incident where a language problem was not identified until a discharge letter from another institution revealed it:

[...] Actually, there was a patient who never said that in our talks, but then I got a discharge letter from another institution, I read that [the patient] thought that [the therapist] talked in such a strange way and was difficult to understand. And that surprised me! We had had lots of long conversations, and it had never been an issue when we talked, things went fine. [...] but in fact the patient may not have understood everything I said, but that wasn't the impression I had, as the conversation went very smoothly [...].

These findings indicate that some participants are satisfied with the communication if they understand what the patient says, and that they have not identified patient-assessed language problems during therapy. However, patients' language problems have been discovered when patients have complained to others or in retrospect. Consequently, potential language needs may remain unidentified and language-appropriate services have not been provided.

Discussion

This study aimed to explore how clinicians provide language-appropriate mental health care for Sami patients by investigating whether and how, clinicians identify and respond to Sami patients' language proficiencies and preferred therapy language.

The participants in this study reported that even if institutional systems for language identification are available, they are not obligatory and not always used. This leads to insufficient registration of patients' language data and inadequate organization of language-appropriate services prior to admission for patients in need of specialized mental health care. Consequently, clinicians can decide for themselves whether to identify patients' language data or not when they meet patients. In most cases, the participants identified Sami language data ad hoc by using various individual approaches. Sami-speaking patients were in most cases offered some kind of Sami-speaking services. However, Sami-speaking patients may choose to speak Norwegian or switch between languages during therapy. Both Sami- and non-Sami-speaking participants experienced language switch during therapy but had not clear ideas of when and why this occurred. Seven participants did not find it necessary to offer Sami-speaking services and trusted the patients to address language problems. Our findings indicate that provision of language-appropriate care to

Sami patients depends on whether individual clinicians explore and assess their patients' language proficiencies and preferences during therapy, hold continuous language awareness and evaluate whether the chosen language works for therapy or not.

Assessment of patients' language proficiency and language needs is a complex matter. Lack of objective criteria and clear definitions of fluency in mother tongue as well as in the second language complicates the assessment even more. When clinicians assess patients' language data based on what they perceive as "Sami characteristics", or local places' "ethnic rumours" (40), this may indicate ethnic affiliation but entail a risk of maintaining stereotypes about a group of people. Using stereotypical characteristics is an "accidental and unreliable method, based on old-fashioned and static ideas of who are likely to be minority speakers" (6). Furthermore, using personal, local knowledge from social networks, based on knowing "who's who" (6), may well indicate patients' language proficiency, but does not ensure identification of the preferred therapy language nor the need for language-appropriate care. When clinicians trust stereotypical assumptions, or that they will get "a hunch" about patients' language proficiency or that patients will request language-appropriate care, language preferences may remain unidentified and patients may not receive a language choice for therapy.

Most Sami-speakers are bilingual (29–32) but bilingualism is neither unambiguously nor easily defined (41). People may describe themselves as bilingual, but "the term does not describe the individual's level of fluency [...]" (42). Bilinguals may appear as fluent in the majority language and "it is often assumed that individuals who speak [Norwegian] on an everyday conversation, do not require health interpretation" (7). However, being "fluent in a language varies from individual to individual and a person's fluency in both languages can fluctuate during life, as a result of changes in their circumstances" (42). As for the Sami, the level of fluency in Sami language necessary to be accepted as Sami-speaking has not been defined (21,28). In addition, findings in a previous study (12), as well as in the present study, indicate that Sami-speaking patients switch between languages depending on with whom they talk, and when talking about emotional issues. Bilingualism and the use of language switch in different situations may conceal language needs (42). Therefore, assessment of language needs is emphasized as particularly important when bilingual patients speak some majority language, because language needs may not be obvious (43).

Questions about language proficiency often dichotomize language ability as either - or. Either the patient need an interpreter, or he speaks, or claim to speak, the majority language sufficiently well for therapy. In our study, some participants assessed Sami-speaking patients' Norwegian proficiency rather than their need for Sami-

speaking care. This might conceal the need for Sami-speaking services.

Clinicians may lack skills to assess language proficiency (43), and they often overestimate patients' ability to understand and communicate (7). Some of our participants found that their patients, whom they assessed to speak good Norwegian in therapy, had complained about language problems to other people. This concurs with Sørli and Nergård's study (23), where the therapists were more satisfied with the communication than were the Sami patients. The Sami patients were skilled in Norwegian, but "their ability to express complex emotions [in Norwegian] may have been more limited than the therapists realized" (23). Patient's Norwegian proficiency may also be more limited than what the patient himself realized.

Patient's assessment of language needs is in line with the principles of patient-centred care (7). However, when health services leave the responsibility to patients, it may reinforce patients' feeling of shame or being a burden (4,11). Limitations of patient assessment are that patients may overestimate their language skills or may continue to use the majority language instead of admitting limited fluency in the second language (42). It is assumed that language congruence, where clinician and patient share a common language, enhances the quality of interaction (7). Still, as our findings indicate, Sami-speaking patients may assess their Norwegian proficiency as satisfying for therapy and prefer to speak Norwegian with Sami-speaking therapists. However, even though patients have assessed their language skills and chosen the therapy language themselves, clinicians should evaluate the significance of language and maintain continuous awareness to identify language needs and address language problems.

Actually, clinicians are the ones who hold a language need because they depend on high-quality communication to enable them to provide a high-quality mental health care. This agrees with the "active offer" principle, which moves "the responsibility [...] from the user to ask for services to the services to provide them" (44). An "active offer" in a Sami context would mean provision of health care in all Sami languages without patients having to ask for it. Mandatory use of standardized routines in the identification of patients' mother tongue and preferred therapy language might serve as a step to improve language-appropriate services for Sami patients.

The lack of mandatory, routine language identification, leaving the assessment to clinicians, emphasizes the significance of awareness towards the power imbalance that exists within health care provider and patient relationship (45). Services depending solely on the individual clinician's knowledge, attitudes and choice of actions are vulnerable and do not necessarily ensure recognition of language needs and an offer of language-appropriate

services (6,8,43). Lack of standardized routines and objective criteria to identify language needs jeopardizes the right to receive equitable health services (43). Lack of language-appropriate services is a violation of the Norwegian Patient Rights Act (13). In a Sami context, when health institutions do not offer language-appropriate services to patients with a right and need to speak Sami, it also violates the Sámi Act. The findings indicate a disparity between Sami patients' statutory rights and actual health care available in Sami.

Methodological considerations and limitations

The sample, which was limited to therapists working in the northern Sami area because institutions in other areas refused to participate in the study, represents a potential source of selection bias. Therapists working with, for example, Lule or southern Sami populations might have other experiences due to demographic, linguistic, individual and contextual differences, as well as differences in health services. The study findings are therefore not generalizable or valid for mental health services for the entire Sami population. The study does not comprise information about mental status or possible interconnections between language use and mental health status.

The study was conducted in Norwegian because the interviewer (the first author) did not speak Sami sufficiently well to conduct interviews in Sami. As the results show, five participants were fluent in Sami. A Sami-speaking interviewer might have increased recruitment of Sami-speaking participants and could have explored and discussed the issues in more detail with them. A broader sample and interviews in both Sami and Norwegian might have revealed a broader range of meaning units associated with the importance of the Sami language in mental health care.

We have no interaction data, and we have not interviewed our participants' patients. Therefore, we do not know how many of them would have preferred to speak Sami; nor do we know whether the participating therapists reflect their patients' experiences as the patients would have expressed them. We consider our findings to be transferable to health care involving bilingual patients and/or therapists because language is highly significant in communication and mutual understanding.

Conclusion

Our study indicates that Sami patients' language proficiency, both in mother tongue and other languages, and preferred therapy language are not systematically identified prior to treatment. Our study demonstrates that clinicians have to deal with identification of language competence and preferred therapy language, as well as organize Sami-language services ad hoc when patients arrive. This complicates the provision of therapy in the patient's preferred language. Our findings correspond with those of Nystad et al. (22) and Sørli and Nergård (23) and indicate

that Norwegian health care needs to improve organizational systems and enhance clinicians' awareness of Sami patients' language needs.

We suggest that clinicians maintain continuous language awareness, evaluate language choice and assess language needs during therapy. This may enhance identification of language needs even if a patient has decided against speaking his or her mother tongue in therapy. We use the phrase "continuous language awareness" to emphasize that language is not identified "once and for all" on admittance, but is an ongoing process, including attention to language switch and the significance of language in itself in therapy. We also suggest that language-appropriate services rest on the principle of "active offer", which emphasizes that health services hold the responsibility.

The findings show that language-appropriate services are a complex matter; their aim is not only to identify language data and offer language choice, but also to accept Sami-speaking patients' right to reject the offer of Sami as therapy language, while at the same time maintaining language awareness and assessment of language needs.

Clinical recommendations

To improve language-appropriate care for Sami-speaking patients, health services need to systematize the identification of language data and organization of language-appropriate services in line with the patient's preference. Mandatory identification and documentation of language needs among minority-language patients, preferably before the initial consultation, is recommended to ensure access to high-quality, equitable health care. Provision of language-appropriate services depends on the recruitment and presence of minority-speaking clinicians and organization of interpreter services. Sami patients may avoid admitting limited Norwegian proficiency and choose to speak the majority language for a number of reasons. Health services must ensure that organizational factors, for example, lack of minority-language therapists and inadequate routines, do not prevent patients from agreeing or demanding to speak their mother tongue. Clinicians should also be aware of the significance of patients' first language even if they choose or agree to speak the majority language in therapy. As one participant said: you never know who speak Sami.

Further research

Assessment of language proficiency and language needs is a complex matter and requires competence in language use and assessment. Further research may benefit from a multidisciplinary approach. This study had a small number of Sami-speaking participants and should be followed up with a broader demographic sample to reveal experiences with the Sami language in mental health care, also in other Sami areas in Norway and in other countries. Sami-speaking and bilingual researchers should conduct further research to explore Sami-speaking and

bilingual therapists' experiences in their first language, which may provide more detailed descriptions and discussions. The significance of Sami languages in relation to mental health care for Sami outside the core Sami areas, such as Lule or South Sami populations, will probably add important understanding to the topic.

This study concurs with findings in a previous study showing how Sami-speaking patients switch between Sami and Norwegian in therapy (12). This raises questions about the significance of language switch in therapy. When and why does it occur? Does language switch influence the therapy process, and even the outcome? We suggest further research to explore the significance of language and language switch in therapy.

Furthermore, the use of Sami music or poetry in therapy may demonstrate acceptance of Sami identity and allow the patients to admit, or remember, Sami language competence. Sami patients may have forgotten, or chosen to hide, their Sami language proficiency, but when processing childhood memories, the Sami language may be important to them. This calls for further investigation of the significance of mother tongue for minority speakers, when processing traumatic events in the majority language.

Language awareness and language-appropriate care enhance health services and outcome for minority-language patients (2,4,6). For the Sami population, knowledge about the significance of therapy language for health status is limited. One example in our study is that Sami-speaking participants found that patients speaking Sami allowed for more nuanced descriptions and more profound understanding, which probably improved therapeutic communication. We suggest further research to establish more knowledge about this important issue.

Disclaimer

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Dagsvold, I., Møllersen, S., Blix, B.H.

Clinicians' assumptions about Sami culture and their experiences with providing mental health services to indigenous Sami patients in Norway.

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Introduction

Culture matters in healthcare services because people's experiences and expressions of mental health problems, as well as health-related beliefs, help-seeking behaviors and ideas about treatment, are influenced by culture (Helman, 2007; Kirmayer, 2012; Kleinman & Benson, 2006). Cultural differences are often used as an explanation of why minority populations and indigenous people are less satisfied with health services than majority populations (Alizadeh & Chavan, 2016; King, Smith, & Gracey, 2009). In Norway, studies indicate that the indigenous Sami population experiences more communication problems and are less satisfied with mental health services than the majority population (Dyregrov, Berntsen, & Silviken, 2014; Møllersen, 2007; Sørli & Nergård, 2005). The Sami people in Norway have a statutory right¹ to receive equitable health services, and "Sami cultural competence" among health professionals is described as a means to achieve the aim (Ministry of Health and Care Services, 2009; Ministry of Health and Social Affairs, 1995; Ministry of Labour and Social Affairs, 2008). The concept of cultural competence is often referred to as a means to adjust for cultural differences and enable provision of "culturally adapted" health services to patients with "diverse values, beliefs and behaviors [and] meet patients' [...] cultural [...] needs" (Betancourt, cited in Kirmayer, 2012, p. 151). However, limited research is available regarding the impact of culture and the provision of culturally adapted mental health services to Sami patients. The aim of this study is to explore clinicians' assumptions about Sami culture and their experiences with providing "culturally adapted" mental health services to Sami patients and to enhance the understanding of possible ways to incorporate culture into mental health services.

The concept of culture is complex, and the definitions are many (Browne & Varcoe, 2009; Kroeber & Kluckhohn, 1952; Sobo, 2009). Several definitions of culture are variations on Tylor's definition from 1871: "Culture, or civilization [...] is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (cited in Sobo, 2009, p. 107). This definition is often understood and used in an essentialized way that represents culture as a static set of beliefs and practices of groups of people. Culture theorizing has changed over time, and culture has come to be viewed as dynamic, complex, related to world-view, "meaning-

making” and closely related to social interaction, historical and political factors and power structures (Vandenberg, 2010, p. 240). Culture is also described as patterns of thought, communication and behavior (Schackt, 2009). However, although common culturally based patterns may be of (strong) influence, they do not *determine* individuals’ mindsets and modes of living, nor are they totally out of reach of conscious reflection. Thus, considerable within-group cultural differences and individual variations exist. Within nursing and health care, the tendency is to view culture in an essentialized way, assuming that patients of a certain ethnic group “possess a particular set of [cultural] attributes or traits, about which clinicians can be trained to develop cultural competence” (Vandenberg 2010, p. 241, Blix 2014).

Many models and programs describing cultural competence have been developed, but the impact of culture and cultural adaptation in clinicians’ cultural competence in health services for indigenous patients is increasingly being questioned and debated (Good & Hannah, 2015; Kirmayer, 2012; Kleinman & Benson, 2006; Sobo, 2009). The cultural competence concept has been criticized for being based on an essentialized view of culture, presupposing that individuals of a certain (particularly cultural or ethnic) group think, feel or act in certain ways due to their culture, failing to consider the individuals’ life histories or social contexts. Such an essentialized view of culture involves a risk of ignoring complexity and other significant factors, such as gender, education, class, economy and geographical location (Kirmayer, 2012; Kleinman & Benson, 2006, p. 1673). Cultural competence is also criticized for “othering”, i.e., focusing solely on the culture of the culturally different “others” and ignoring the significance of the cultures of health services and clinicians. Moreover, evidence of the benefits and efficiency of culturally competent care is lacking (Alizadeh & Chavan, 2016; Browne & Varcoe, 2009; Kirmayer, 2012, Kleinman & Benson, 2006). Additionally, descriptions of how to operationalize cultural competence in clinical practice without reducing holistic care to “technical skills for which clinicians can be trained to develop expertise in how to treat a patient of a given ethnic background” (Kleinman & Benson, 2006, p. 1673) are limited.

Our aim is not to assess different models of cultural competence but rather to reflect on one of the critical arguments against the concept, i.e., the process of incorporating culture into health care practice, which is sparsely described in the literature. We will explore and discuss the impact of culture theorizing and the clinicians’ experiences with the integration of cultural aspects into mental health care.

Method and material

Design

We used a qualitative design with individual interviews to explore issues of which we have limited knowledge, narrated by clinicians with relevant experience (Malterud, 2011).

Recruitment procedure

The study included clinicians providing therapy to Sami patients in outpatient mental health clinics. We requested permission from seven mental health clinics serving patients in the Sami Language Administrative Districtⁱⁱ in Northern Norway to recruit participants among their clinicians; three clinics consented, all located in the northern Sami area. Informational meetings were organized, and written information about the study, including the interview topics and an invitation to participate, was distributed to 60 clinicians during 2012-2013. The only inclusion criterion was experience providing mental healthcare to Sami patients. Clinicians interested in participating submitted the consent form to the first author, who contacted them and made appointments for interviews.

Sample

Twenty clinicians in mental health outpatient clinics in the Sami Language Administrative District agreed to participate, and all were included in the study (Table 1).

Table 1 here

Data collection

The interviews, conducted by the first author, took place at the participants' chosen locations (their workplaces) and lasted from 50 to 140 minutes. A semi-structured thematic interview guide included items concerning assumptions about Sami culture, the significance of Sami culture and cultural competence/understanding in mental healthcare, the integration of Sami cultural aspects into mental healthcare, and the provision of "culturally adapted" mental health services to Sami patients. The impact of the use of Sami vs. Norwegian language in therapy is discussed in other publications from this studyⁱⁱⁱ.

The questions were open-ended and the order flexible. The participants were encouraged to talk freely and draw on their experiences. All interviews were conducted in Norwegian because the interviewer did not speak Sami fluently. The interviews were audiotaped and transcribed verbatim.

Analysis

The transcribed texts were analyzed thematically using an inductive approach, inspired by systematic text reduction (Malterud, 2011; Malterud, 2001, 2012), as follows:

1) All transcripts were read several times to obtain a general impression of the whole, and preliminary themes were identified. 2) The texts were then systematically examined and meaning units relevant to the research question were identified. The meaning units for each participant were condensed and coded. 3) The codes were systematized and categorized, and related codes were sorted into themes and subthemes. 4) Finally, we formulated short texts, summarizing our interpretations of each theme. These texts formed the basis of the presentation of the results. The first author read all the interview texts and selected half of the interviews for the third author to read. Furthermore, the first author formulated code groups and themes, which were introduced to the coauthors along with selected quotations. The code groups and themes were modified and further developed cooperatively by the authors. The analysis was a process of reading and rereading, formulation and revision of themes and subthemes, and selection of quotations representative of the participants' stories.

Ethical considerations

The research protocol was approved by the Regional Committees for Medical and Health Research Ethics (REC)¹ and was conducted in accordance with the Helsinki Declaration of 1975, revised in 2008. To safeguard the participants' anonymity, name, age, occupation and other personal² details are not included in the presentation of the findings.

¹ The REC number may be supplied on request

² All clinicians are referred to as "she", and all patients as "he".

Results

From the analysis, we identified two themes (Table 2). Theme I is about the clinicians' assumptions and descriptions of Sami culture in general, whereas theme II is about the clinicians' descriptions of the impact of Sami culture in clinical encounters with Sami patients in therapy.

(Table 2 here)

I. Sami culture is different

When referring to Sami culture, the participants discussed 1) certain cultural traits of the Sami way of living, 2) Sami attitudes toward and communication about mental illness and 3) that the Sami communicate with deceased people.

The Sami way of living is different. Several of the participants referred to Sami culture by characterizing the lifestyle and behavior of the Sami people, such as stating that the Sami live close to nature in geographically remote areas, they live by traditional occupations (reindeer herding and fisheries), they have a Sami family structure (the extended family), and they keep problems within the family. Most participants included certain Sami historical and political elements, particularly the assimilation process, in their descriptions of Sami culture.

Moreover, the participants typically referred to external cultural markers such as Sami arts, handicrafts (*duodji*), music (*joik*) and traditional clothing (*gákti*) when referring to Sami culture.

Sami attitudes toward and communication about mental illness. Several participants stated that the Sami have “*old-fashioned attitudes toward mental problems and receiving treatment*” and more specifically, that the Sami consider mental illness to be weakness and a shame. Consequently, in their opinion, the Sami “*do not talk about emotions and mental illness*” [...], they “*hide their problems [and do not ask for help] because one is not supposed to show weakness*”. Some claimed that the Sami solve their problems within the family; however, most of the participants stated that the Sami prefer to manage on their own (“*ieš birget*”) and avoid seeking help from both family members and mental health services. Moreover, several participants stated that the Sami communicate in a “different” way, e.g., in an indirect or slow manner, with metaphors or body language, or with silence.

The Sami communicate with deceased people. Several participants referred to the assertion that the Sami communicate with deceased people, particularly deceased relatives. Some stated that this behavior is a common Sami cultural phenomenon and hence is considered “normal” in a Sami cultural context. One participant stated “*Talking to a deceased grandmother is a Sami tradition, it is a coping strategy and the person feels protected*”. Another Sami participant referred to this type of communication as an “*inner conversation*” with a trusted person, which may increase self-reflection and self-understanding.

Our findings show that most participants tended to refer to Sami culture by discussing distinct cultural traits characteristic of the Sami people. Integrated in the participants’ descriptions of Sami culture were also references to history and politics. Sami culture and the Sami people were defined by virtue of “difference”. However, the basis of comparison remained transparent and was an unspoken norm.

II. The impact of Sami culture in therapy

Although most participants described what they assumed to be Sami culture, only a few described how, in their experience, clinical encounters with Sami patients were influenced by Sami culture. We identified three aspects illustrating the clinicians’ reflections on the impact of Sami culture on clinical work: (1) assumptions about the Sami way to communicate; (2) clinical assessment of Sami patients’ experiences as cultural phenomena or clinical symptoms; and (3) a lack of integration of Sami cultural issues into professional discussions.

The Sami way to communicate is diverse. Although several participants referred to the “Sami way”, that is, assumed Sami cultural norms of “not seeking help” and “not talking about emotions and illness”, their experiences from therapy with Sami patients indicated otherwise. In their experience, Sami individuals do indeed seek mental health services, and they do talk while in therapy. However, Sami cultural norms may influence what Sami patients talk about in different contexts and how mental health issues are worded or expressed. Some participants stated that the Sami norm of “not talking” might restrain communication about mental health problems and treatment in public in Sami communities and in some families. Some participants noted that Sami patients themselves occasionally initiated the consultations by stating that “*the Sami do not talk about emotions and mental health issues*” but nonetheless continued to talk about such issues in therapy. One participant elaborated the statement:

“Sami patients are as communicative as Norwegian patients once they’ve come in here. The ones who come here have acknowledged that they have a problem they need help with. So my main impression is that there’s not such a big difference, we have good talks.”

This participant framed Sami patients’ willingness to speak while in therapy as adapting to the context and accepting the “*rules of the game*” of therapy, where communication about sensitive matters is a significant aspect:

“I think something happens when they get into our offices, it’s our chairs and tables, you know. And we sit right opposite each other, kind of business-like. They change, they take on the role of a patient, and of course they too have an idea about what the session is for.”

Another aspect assumed to be influenced by Sami norms was the wording or expression of mental health issues. One participant stated that the topic of conversation influenced the communication: [Sami patients] “*speak in metaphors or indirectly, when they find it difficult to talk about sensitive matters*”. Another participant noted that Sami patients frame mental health problems differently from the “*psychological way*”:

“Sami patients [...] may say that something’s getting worn out, more like a practical problem than a psychological problem [...]. It seems to me there are really two different cultural ways to talk about how you feel.”

One participant reported that the Sami way to communicate influences clinical interviews and medical histories:

“There aren’t many Sami who are very spontaneous, they don’t tell you things spontaneously, so you have to drag their medical history out of them ... things go a lot more slowly than I’m used to. They generally talk more slowly, ... and sometimes they’ll keep eye contact with you for a long time before saying anything [...].”

This participant maintained that the “*slow communication*” was a “*Sami way*” of communicating, without reflecting on other aspects such as language problems, lack of habit to talk about certain issues, individual personality or the relational aspect of the communication. Consequently, the possibility of the patient’s “*slow*” communication being a response to, for example, the therapists’ conduct rather than a cultural trait was not discussed.

Clinical assessment of Sami patients' experiences: cultural phenomenon or clinical symptom?

Several participants stated that they had heard it said that the Sami “talk to deceased people”. However, only a few participants reported that they had met Sami patients in therapy who claimed to communicate with the dead. The participants emphasized the necessity of exploring such experiences to make an adequate clinical assessment of whether this behavior is a symptom of illness, affecting the patients’ “functioning”, or alternatively, a familiar phenomenon in the patients’ cultural context.

Some participants suggested to “*entering into the patient's stories*” and including the deceased in clinical communication, for example, by asking the patient: “*‘What would Grandmother say about this?’*”. One participant described communication with the dead as an integral theme of her initial interviews in therapy:

“To me it's natural to ask about such things [talking to dead people] when you take a patient's history, at least if you want to find out about the family. Then you have to include things like that and if it's a deceased grandmother who's important, however dead she is, well then that's important information.”

Another participant compared talking with the deceased with obsessive thoughts that potentially could hinder recovery and suggested that the therapy should aim to remove such nonfunctional strategies:

“The feeling that ‘Grandma's looking after me’, well, I'd call that a security strategy that becomes an obstacle to daring to do things on your own and will prevent you from getting well. In compulsive thinking, it's often about like if I do something magical, things will be ok. So if you think Grandmother's there and that's why things turned out ok, you won't get rid of your anxiety. Because if your grandmother suddenly isn't there one day, you're just as afraid. So whether this security strategy is inside your head or you're taking Valium, it's the same phenomenon.”

Other participants assessed communication with deceased people as a symptom of mental illness if it tormented the patient or affected his/her functioning negatively.

Some of the participants addressed the impact of clinicians’ perceptions of illness and their power to define “normality”, based on their assessments of patients’ experiences. One stated:

“It's very much about the view of the work we do in mental health care. Who is the person we meet, are we meeting normality ... we have different explanatory models, we have a disease model where everything is pathology, and then talking to your dead father is pathological, it's a delusion.”

So health care and psychiatry, ... it gets so one-sided in terms of disease and diagnosis and you get caught up in that limited life that is your diagnosis. It seems like it's a bit about roles, about power, I mean the power of definition in relation to normality."

Another participant pointed out the risks associated with automatically jumping to cultural explanations and emphasized the necessity of carefully exploring the patients' experiences:

"As therapists, we must be aware of what something is, you shouldn't think straightaway, 'Oh yes, well, this is Sami culture, so it's okay,' or say, 'No, we mustn't talk about that.' We need to explore it, talk about it and ask how the patient experiences it, what does it mean to the patient, is it a problem, does it affect your functioning, we have to make an assessment and look at the whole situation ... and decide if the patient is actually becoming psychotic. You can't rule out anything. We have a responsibility to assess and treat our patients, so you can't just say something's a cultural phenomenon without examining it, so it's a balancing act. It's not one or the other, it's a bit of everything."

Sami culture is not integrated into professional discussions in the clinic. According to the participants, *"we don't have [team] discussions about individual patients where we include cultural aspects, [asking] what's important to consider, what is this, what can we do, what about doing things differently ..."* Some participants described attempts at integrating cultural issues in team discussions as unsuccessful: *"We [tried but] got off track, it just ended up as a professional [mental health] issue, but I think this culture is also a professional issue"*. Information about patients' culture was described as a necessity to ask informed questions in therapy and to explore individual patients' experiences and way of life, as described by one participant:

"We have to get hold of what the patients experience, ask patients to tell us about their everyday lives, because people's own stories are more important than general ideas about culture. [However,] you have to know a lot about the culture to listen closely to the conversations to find leads that are important to follow ..."

Another participant expressed concerns that an exaggerated focus on Sami culture in team discussions and patient assessments could divert attention from the individual patients' needs and preferences. The participant stated that:

"When the focus is on culture, you don't get the chance to gain access to the person, the individual patient. That would be a strange approach to our work that I'm not comfortable with."

The findings show that only a few participants referred to clinical experiences where they considered that Sami culture influenced on their clinical assessments and communication with Sami patients. Those who did refer to such experiences reported that Sami patients do not always act in accordance with assumptions about Sami culture. Their experiences emphasized

that general descriptions of Sami culture do not necessarily correspond with the lifestyle and behavior of individual Sami patients. Moreover, the participants reported a lack of team discussions about the impact of Sami culture into practice. The findings indicate a lack of professional training in the transformation and incorporation of Sami culture into mental health care.

Discussion

This study aimed to explore clinicians' ideas about Sami culture in general and how they transform culture into "culturally adapted" mental health services to Sami patients, in order to achieve an enhanced understanding of the complexity of incorporating Sami culture into mental health care practice. We will discuss our findings in light of culture theory and reflect on possible consequences for clinical practice.

An understanding of the concept of culture will influence approaches to incorporating culture into health care (Guarnaccia & Rodriguez, 1996). In our study, we found that the clinicians referred to Sami culture predominantly with reference to particular "cultural traits" typically considered "different" and implicitly compared with an unspoken norm of "ordinary". Several of the Sami cultural traits described in our study concur with the representations of the Sami population and culture in Norwegian media and in public discourse. Here, the Sami are often presented as "the exotic others"; a "natural people", who live close to nature as nomadic reindeer herders or as sea Sami fishermen in rural Sami areas. Such descriptions of Sami culture reflect an essentialized view of culture as static and narrow in scope. Through these descriptions, the Sami are perceived to hold certain "authentic" qualities, different from and in contradiction to modern, "civilized" peoples and societies (Gaski, 2008; Kvidal-Røvik & Olsen, 2016; Mathisen, 2001). Essentialized descriptions do not reflect the fact that contemporary Sami societies are as complex and diverse as other societies. The Sami population and their needs and preferences are heterogeneous. Indeed, less than 10% of the Sami are engaged in reindeer husbandry, many Sami live outside the so-called Sami core areas, and many Sami do not speak the Sami language or possess visible cultural markers (Gaski, 2008; Soerlie & Broderstad, 2011; Sørli, Hansen, & Friborg, 2018). Moreover, several descriptions of Sami culture in our study concur with those in health-related literature, which has typically stated that the Sami have particular "Sami attitudes" toward mental

problems; they consider mental illness to be a shameful matter and thus do not talk about mental problems or emotions, they prefer to manage on their own (*ieš birget*), and they can communicate with the deceased (Bongo, 2012; Ministry of Health and Care Services, 2015; Ministry of Health and Social Affairs, 1995; Nymo, 2011; Sexton & Sørli, 2009).

One problem with an essentialized approach to culture in health care is that health professionals are taught to look for specific cultural traits representing “difference” when trying to identify patients who might need “culturally adapted” care (Browne, 2005). Consequently, clinicians may refrain from reflecting on patients’ cultural backgrounds and fail to identify cultural aspects of clinical relevance unless they fit the stereotypical characteristics of Sami culture. In a previous study, clinicians identified patients’ Sami language competence if they observed what they considered typical Sami characteristics, such as a speaking Norwegian with a Sami accent, “looked like a Sami” or had a typical Sami name or place of residence, failing to identify Sami-speaking patients from the coast (Dagsvold, Møllersen, & Stordahl, 2016).

Another problem with cultural essentialism is that it implies culturalism, for example, anticipation that Sami patients will act in accordance with “their culture” in therapy—in our case, not talking about emotions and mental illness. Essentialized descriptions and a static view on culture ignore individual innovation and the dynamic perspective of culture. Using a dynamic approach to culture promotes individual choices and shows that cultural norms and values are not static. For example, in contrast to their assumptions about Sami culture, some clinicians in our study reported no clinical differences and stated that Sami patients do in fact talk about their problems, although the patients occasionally mentioned the assertion that “the Sami do not talk about...” before they started to talk about it themselves. This example illustrates that cultural ideas and practices may have different meanings for individuals in different situations and must be understood in the context in which they appear (Sobo 2009). In our case, the norms of “*ieš birget*” and “not talking about” emphasize that the transference of cultural norms from one context to another must be done with caution. “*Ieš birget*” and not talking about personal problems might be productive within the context of primary industries such as reindeer herding and among fishermen, who work under harsh conditions and are forced to fend for themselves out on the tundra or at sea. However, such cultural norms may not necessarily be adequate in the context of mental health care. An essentialized idea of an ethnic group sharing cultural meanings may lead to dangerous stereotyping (Kleinman &

Benson, 2006) and mental health issues being mistaken for cultural differences (Vandenberg, 2010, p. 243). Clinicians' essentialized cultural assumptions may lead to a lack of health care provision, such as when clinicians attribute the reluctance of Sami service users to seek and accept help to their culture (Blix & Hamran, 2017). Assumptions that Sami patients act in accordance with Sami culture ignore other possible explanations as to why patients seemingly prefer to "*ieš birget*" and appear less talkative. This behavior may be explained by a reluctance to share personal matters with clinicians in small communities with close and multiplex relations (Dagsvold, Møllersen, & Stordahl, 2015; Dyregrov et al., 2014), lack of language choice (Dagsvold, Møllersen, & Stordahl, 2016), unfamiliarity with talking about certain issues (Dagsvold et al., 2015), sociohistorical processes and the impact of the majority culture on health care relations (Blix & Hamran 2017), lack of trust or simply individual preferences. Additionally, cultural (or personal) differences in communication style and norms between the patient and the clinician may lead to misunderstandings or that the clinician does not recognize what the patient is trying to say. The clinicians in our study stated that the Sami "do not talk about" or referred to the Sami way to communicate as indirect, "slow", metaphorical, nonverbal, or silent. In a previous study, Sami patients receiving mental health care stated that they had to change their way of communicating, that is, be more talkative and "use fancy words" to "get some actual help from psychology". The patients' request to clinicians was that they should learn "how Sami express things" (Dagsvold, Møllersen, & Stordahl, 2015). One clinician in the present study referred to "the way a Sami expresses things" as talking about sensitive topics in another cultural way [compared to the health services], that is, in a "practical" manner. The concept of "double attention" was used to describe the need to be aware of possible linguistic communication problems with Sami patients during therapy in another study (Dagsvold, Møllersen, & Stordahl, 2016). The concept "double attention" may also be useful for describing the attitude necessary to recognize that a patient is talking about mental problems or emotions as a practical problem or in another non-psychological way. Put another way, double attention includes a focus on the culture of the clinician (or health services) as well as the patient. According to Vandenberg (2010, p. 243), "continued emphasis on 'difference' [in "the other"] can distract from the complexities of relationship building". Assertions about the "Sami way", for example, the clinician in our study who stated that she had to "drag the words out of the Sami" because the Sami speak in a "Sami way", disregard the relational aspect of communication and interaction and ignore the impact of the clinicians' own (cultural) way of communicating. Moreover, a clinician may have internalized the same norms as the patient and be unaccustomed to or

uncomfortable with talking about what they consider culturally sensitive issues, therefore failing to talk about sensitive issues of personal preferences (Dyregrov et al., 2014).

Health professionals are recommended to critically assess the implications of how the use of culture theory may influence mental health care (Guarnaccia & Rodriguez, 1996; Kleinman & Benson, 2006; Vandenberg, 2010, p. 243). Most clinicians in our study had not reflected on the impact of culture theorizing or the discrepancies between their theoretical assumptions about Sami culture in general and their clinical experiences in the context of the therapy room. The few clinicians who referred to clinical assessments of patients' "cultural experiences" referred to the assumed Sami cultural phenomenon of talking to the deceased. The clinicians emphasized the importance of exploring and clinically assessing the patient's experiences. Clinical assessments of the possible delusional nature of experiences of talking with the deceased imply a decision as to whether it is a "normal cultural expression" or abnormal and thus a psychiatric symptom (Guarnaccia & Rodriguez, 1996). The clinicians in our study referred to the assessment process as balancing between different explanatory models. Kleinman and Benson (2006) suggest that health professionals should critically reflect on the impact of the explanatory model they use when making clinical assessments of patients' mental health. The authors urge clinicians to perform critical self-reflection and examine their own position of "being between social worlds", that is, the world of the clinician, the world of biomedicine and the world of the patient. To achieve this, clinicians should be trained to perform cultural self-reflection and to consider the effects, not only of the culture of the patient but also of the culture of biomedicine that may delimit the assessment of patients' experiences, recasting it into biomedical categories, without acquiring an understanding of the meaning of illness as experienced by the patient (Kleinman and Benson 2006, p. 1675). The clinicians in our study did not report having explored the experience of talking with the dead for its own sake, such as determining whom they are talking with, about what, and in what language. Here, assessing whether the Sami literally "talk" when they refer to talking with the dead might also be useful; it could, for example, mean having a sense of closeness or good memories of a deceased grandmother, thinking "What would she have done?", or having a conversation in one's head.

The responsibility to take into account the culture of patients is not exclusive to health professionals but is also important at the level of health organizations and institutions (Kirmayer 2012). The clinicians in our study stated that they are in a position of power to

decide whether a patient's expressions and experiences are pathological or not. However, they reported a lack of team discussions about how to "exercise the power" to assess culture and integrate it into clinical practice. Institutional structures may not result in actual "cultural adaptation" of care by staff, but a lack of suitable structures and settings does not enhance professional development of the operationalization of culture. The lack of professional discussions left the responsibility for assessing the impact of culture and determining how to incorporate culture in practice to the individual clinician. The clinicians in our study expressed a strong desire to take into account the patients' cultural background. However, they had no guidelines or professional training in how to explore, assess and operationalize cultural factors into clinician mental health care.

Methodological considerations and limitations

A different and/or broader demographic sample and other methodological approaches might have resulted in different findings. The sample, which was limited to therapists working in the northern Sami area because institutions in other areas refused to participate in the study, represents a potential source of selection bias. Clinicians working in, for example, Lule or southern Sami areas, might have other experiences due to demographic, linguistic, individual and contextual differences. The study findings are therefore not applicable to mental health services for the entire Sami population.

Our data are too limited and too heterogeneous to investigate the impact of clinicians' characteristics. Moreover, we have no information about their clinical approaches. However, our findings might indicate that the clinicians who had the longest local residency and clinical experience presented the most comprehensive stories and the richest descriptions about the impact of culture in therapy. This topic should be further investigated.

The study was conducted in Norwegian because the interviewer (the first author) did not speak Sami sufficiently well to conduct interviews in Sami. A Sami-speaking and bilingual interviewer might have increased the recruitment of Sami-speaking participants and could have explored and discussed language switch and other issues in more detail with them. For Sami-speaking participants, the use of Norwegian may have limited the ability to speak freely. A broader sample and interviews in both Sami and Norwegian might have accessed other stories about clinician experiences and identified a broader range of meaning units associated with the impact of Sami culture on mental health care.

Conclusion

This study aimed to explore clinicians' ideas about Sami culture and how they transform culture into "culturally adapted" mental health services to Sami patients, in order to achieve an enhanced understanding of the incorporation of Sami culture into mental health care practice. We discussed our findings in light of culture theory and reflected on possible consequences for clinical practice.

The findings indicate that the incorporation of culture into mental health care is a complex process involving culture theorizing, assessing the impact of culture and explanatory models of the patient, the clinician and the culture of mental health, and accounting for contextual differences as well as individual needs and preferences. Moreover, the findings indicate that most clinicians' knowledge of Sami culture was narrow and that their descriptions of Sami culture were dominated by particular "cultural traits" typically considered "different" and implicitly compared with an unspoken norm of "usual" or "normal". The findings indicate limited degree of self-reflection and consideration of the possible impacts of the clinicians' own culture in clinical encounters.

A few descriptions of the integration of cultural perspectives into clinical encounters in general and of clinical assessments of the "normality" of Sami patients' cultural experiences in particular were provided. For the most part, such descriptions referred to the phenomenon of "communication with the deceased". Our findings indicate that the clinicians balanced between assessing such experiences as cultural phenomena and viewing them as symptoms of mental illness. The impact of aspects of power inherent in such clinical assessments were mentioned. Clinical assessments involving cultural phenomenon were rarely a part of professional discussions in the units, and several participants missed team discussions that included the significance of culture. Consequently, the incorporation of culture into clinical practice became the individual clinician's responsibility and therefore possibly arbitrary. A discrepancy existed between the participants' descriptions of Sami culture ("they do not talk about mental problems") and their experiences from clinical encounters with Sami patients (who do indeed talk about it). The discrepancy between assumptions about culture on a group level and individual preferences reminds us that "people have a wide range of opinions about how they put consensual culture into action: some are right in tune with consensual culture; others deviate from the cultural norm" (Matsumoto, 2006, p. 43).

Knowledge about Sami culture and history is vital within mental healthcare but must be used with caution in clinical encounters with patients to avoid stereotyping and disregard of the individual patients' needs and preferences.

Clinical recommendations

Health organizations, institutions and health professionals should contribute to critical culture theorizing and aim for a professional understanding of how to incorporate culture into mental health care. Health institutions should develop structures and settings for professional discussions on how to assess cultural phenomena. Cultural considerations should not be limited to the culture of "the others" but include critical cultural self-reflection by clinicians and reflection on health care services as a whole.

Further research

The findings in this study should be followed up with studies including Sami patients and their experiences with receiving mental health care and exploring, for example, whether they feel that clinicians understand them when expressing "cultural experiences". Further research should include observational and field work, examining clinicians' assessments in more detail in clinical encounters with Sami patients, including team discussions on how to understand patients' "cultural expressions and experiences". In the present study, the participants expressed a need for professional discussions and development to provide better mental health services to Sami patients. One tool that might be useful for improving mental health care to Sami patients is the Cultural Formulation Interview (CFI) DSM-5, originally published by the American Psychiatric Association (APA). A few of the participants had heard about the CFI, but none of them had used it in their clinics. Our data did not contain sufficient information about this topic to include it in this study. Moreover, the CFI was not translated to Sami at the time of the interviews for this study. However, the Sámi Norwegian National Advisory Unit on Mental Health and Substance Use (SANKS) is currently developing a Sami version of the CFI and plans to publish this version in spring 2019. The translation of the CFI-DSM-5 to Sami languages and the use of such interview guides might contribute to a better adaptation of the treatment offered to Sami patients by the Norwegian health care system. We recommend that the use of a Sami version of the CFI is monitored in research.

Moreover, research on clinical assessment of culture should include considerations about the culture of the clinician as well as that of the mental health services. Additionally, the impact of clinician characteristics, such as clinical experiences, professional background and time of residency in the area, as well as clinical approaches, should be further investigated.

Disclaimer

The views expressed in the submitted article are our own and not an official position of the institution or funder.

Conflict of interest and funding

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Tables

Table 1 Sample

Participant characteristics	N
Clinicians (age 25-65 years)	20
Gender	
Female	11
Male	9
Profession	
Healthcare professionals (nurses, social workers, physiotherapists)	10
Psychologists, psychiatrists	10
Trained in cultural studies	3
Ethnic self-identification	
Sami	11
Non-Sami	9
Clinicians who provide therapy in Sami language	5
	Years
Residency in the Sami area	1- approx. 60
Clinical experiences from mental healthcare	2 - approx. 40

Table 2 Results

Theme I	<p>Sami culture is different</p> <ul style="list-style-type: none"> ○ The Sami way of living is different ○ Sami attitudes toward and communication about mental illness. ○ The Sami communicate with deceased people
Theme II	<p>The impact of Sami culture in therapy</p> <ul style="list-style-type: none"> ○ The Sami way of communicating is diverse ○ Clinical assessment of Sami patients' experiences: cultural phenomenon or clinical symptom? ○ Sami culture is not integrated into professional discussions in the clinic

Notes

ⁱ Several national laws, notably the Hospital Trust Act, Health and Care services Act, Sámi Act and the Patients' Rights Act, confirm Sami patients' right to receive equitable health services. The Patients' Rights Act specifies the right of all patients, including Sami, to receive health services, particularly information, adapted to individual needs, including cultural and linguistic background.

ⁱⁱ The Sami Language Administrative District covers the municipalities in which Sami patients, according to the Sami Act, have an extended right to use the Sami language in encounters with public services.

ⁱⁱⁱ Dagsvold, I. Møllersen, S. and Stordahl, V. (2015). "What can we talk about, in which language, in what way and with whom?" Sami patients' experiences of language choice and cultural norms in mental health treatment. In: *International Journal of Circumpolar Health*; Volum 74. ISSN 1239-9736.s doi: 10.3402/ijch.v74.26952.

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Appendix

1. Approval Regional Committee for Medical and Health Research Ethics
2. Approval of project changes Regional Committee for Medical and Health Research Ethics
3. Information to participants about the delay of the study
4. Informational letters to managers
5. Informational letters and consent forms to therapists
6. Informational letters and consent forms to patients
7. Thematic interview guide to therapists
8. Thematic interview guide to patients

Appendix 1

Approval Regional Committee for Medical and Health Research Ethics

Fra: Regional komite for medisinsk og helsefaglig forskningsetikk REK nord

Til:

Vigdis Stordahl

vigdis.stordahl@helse-finnmark.no

Dokumentreferanse: 2010/2238-9

Dokumentdato: 07.01.2011

KULTURKOMPETANSE I SAMISK PSYKISK HELSEVERN - GODKJENNING

Vi viser til prosjektleders tilbakemelding av 22.12.2010 vedlagt revider forespørsel merket 20.12.2010.

Etter fullmakt har komiteens leder fattet slikt

vedtak:

Med hjemmel i helseforskningsloven § 10 og forskningsetikkloven § 4 godkjennes prosjektet.

Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen, og de bestemmelser som følger av helseforskningsloven med forskrifter.

Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK. Vi gjør oppmerksom på at hvis endringene er vesentlige, må prosjektleder sende ny søknad, eller REK kan pålegge at det sendes ny søknad.

Det forutsettes at forskningsdata oppbevares forskriftsmessig.

Godkjennelsen gjelder til 28.02.2014

Prosjektleder skal sende sluttmelding i henhold til helseforskningsloven § 12.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jf. forvaltningsloven § 28 flg. Eventuell klage sendes til REK Nord. Klagefristen er tre uker fra mottak av dette brevet.

Vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Beate Solbakken
førstekonsulent

**REGIONAL KOMITÉ FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK,
NORD-NORGE**

REK NORD

Besøksadresse: TANN-bygget, Universitetet i Tromsø, N-9037 Tromsø
telefon sentralbord 77 64 40 00 telefon ekspedisjon 77620758

Appendix 2

Approval of project changes Regional Committee for Medical and Health Research Ethics

Region: REK nord	Saksbehandler: Monika Rydland Gaare	Telefon: 77620756	Vår dato: 28.06.2012	Vår referanse: 2010/2238/REK nord
			Deres dato: 14.06.2012	Deres referanse:

Vår referanse må oppgis ved alle henvendelser

Vigdis Stordahl

2010/2238 Kulturkompetanse i samisk psykisk helsevern

Forskningsansvarlig institusjon: Samisk nasjonalt kompetansesenter - psykisk helsevern ved Ruth Persen
Prosjektleder: Vigdis Stordahl

Vi viser til tilbakemelding av 14.06.2012 hvor prosjektleder, i henhold til komiteens vedtak av 05.06.2012 på prosjektendringssøknad av 20.04.2012, gir en nærmere drøftelse av hvordan forskergruppen skal klare å få kartlagt det kulturelle aspektet uten å benytte seg av det samiske språket.

Vedtak

Med hjemmel i helseforskningsloven § 10 og forskningsetikkloven § 4 godkjennes prosjektendringen.

Endringen godkjennes under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden, endringssøknaden, oppdatert protokoll og de bestemmelser som følger av helseforskningsloven med forskrifter.

For øvrig gjelder de vilkår som er satt i forbindelse med tidligere godkjenning av prosjektet.

Sluttmelding og søknad om prosjektendring

Prosjektleder skal sende sluttmelding på eget skjema senest et halvt år etter prosjektslutt, jf. helseforskningslovens § 12. Dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden må prosjektleder sende søknad om prosjektendring til REK, jf. helseforskningslovens § 11.

Klageadgang

Du kan klage på komiteens vedtak, jf. helseforskningslovens § 10 tredje ledd og forvaltningslovens § 28 flg. Klagen sendes til REK nord. Klagefristen er tre uker fra du mottar dette e-brevet. Dersom vedtaket opprettholdes av REK nord, sender REK nord klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Monika Rydland Gaare
seniorkonsulent

Kopi til: ruth.persen@helse-finnmark.no

Appendix 3

Information to participants about the delay of the study



Til
Deltakere i studien "Kulturkompetanse i
psykisk helsevern til samiske pasienter"

Deres ref:

Vår ref:

Dato:
08.09.2015

Informasjon om forlengelse av studien du har deltatt i

I 2012 samtykket du i å delta i studien "Kulturkompetanse i psykisk helsevern til samiske pasienter". I informasjonsskrivet ble du informert om at lydbåndopptak og navnelister ville bli tilintetgjort ved prosjektets avslutning anslagsvis februar 2014. Prosjektet er av flere årsaker blitt forsinket og vi har fått tillatelse av Regionalt forskningsetisk komité (REK Nord) til å forlenge prosjektet under forutsetning av at vi informerer deltakerne om dette. Prosjektet er nå godkjent forlenget til 1. juli 2017.

Lydbåndopptaket som ble gjort av intervjuet med deg er slettet. Listen med deltakernavn oppbevares i kryptert form på passordsikret område på stipendiatens PC ved UiT – Norges arktiske universitet. Utskrifter fra intervjuene er anonymisert og det er derfor ikke mulig å identifisere deg. Utskriftene brukes fortsatt i studien og vil følgelig ikke bli slettet før ved prosjektavslutning.

Det er publisert en artikkel fra intervjuene med pasienter:

<http://www.circumpolarhealthjournal.net/index.php/ijch/article/view/26952> Denne artikkelen fikk også noe mediaoppslag: <http://forskning.no/blogg/sesam/hva-kan-man-snakke-om-med-hvem-og-pa-hvilket-sprak>. Intervjuene med terapeuter er analysert og det blir skrevet to artikler fra dette materialet. Det er altså publiseringen av artiklene som er forsinket i henhold til opprinnelig plan.

Med vennlig hilsen

Vigdis Stordahl
Vigdis Stordahl

Prosjektleder

Vigdis.stordahl@finnmarkssykehuset.no

Inger Dagsvold
Inger Dagsvold
Stipendiat
inger.i.dagsvold@uit.no

Informational letters to managers

Til ledere av helseinstitusjoner

Forespørsel om tillatelse til å informere om studien på institusjonen.

Kulturkompetanse i psykisk helsevern til samiske pasienter.

Betydningen av kulturelle aspekter ved hjelpetilbudet sett fra terapeuters og samiske pasienters synsvinkel

Mitt navn er Inger Dagsvold og jeg er doktorgradsstudent ved Senter for samisk helseforskning, Universitet i Tromsø. Jeg holder på med et doktorgradsprosjekt som omhandler hvilken betydning kulturkompetanse generelt, og kompetanse om samisk kultur spesielt, har for tilbudet samiske pasienter får innen psykisk helsevern.

Ansvarlig prosjektleder/hovedveileder er Dr. philos Vigdis Stordahl, SANKS. Biveiledere er Dr.psychol. Snefrid Møllersen, SANKS og Dr.med Ann Ragnhild Broderstad, Senter for samisk helseforskning, Universitetet i Tromsø.

Informasjon om studien

Bakgrunnen for studien er at den samiske befolkningen har rett til helsetjenester som er språklig og kulturelt tilpasset, men vi vet ikke så mye om hva dette egentlig innebærer.

Det er ikke tidligere beskrevet hva det innebærer å «kulturelt tilpasse» helsetilbudet til samer, utover pasientens rett til å snakke samisk eller få bruke tolk. Vi vet lite om hvordan terapeutenes kulturkompetanse innvirker på deres helsefagutøvelse til samiske pasienter.

Studien vil derfor utforske hvilke erfaringer terapeuter har med kulturell tilpasning av behandlingen, og om kulturelle forhold har betydning for terapeuters tilnærming til og forståelse av pasientene. Har terapeuter kjennskap til samisk kultur, vet de at de har samiske pasienter, har de erfaringer med å gi behandling til samiske pasienter og har de erfart at samiske pasienter har/ikke har andre behov enn andre pasientgrupper?

Det er også begrenset kunnskap om hvilke «kulturelt baserte» behov samiske pasienter eventuelt har. Jeg er interessert i samiske pasienters opplevelse av sin situasjon som psykisk syk, og av det hjelpetilbudet de får fra psykisk helsevern. Jeg ønsker derfor å få mer kunnskap om hvilken betydning kulturkompetanse og kulturbakgrunn kan ha for hjelpetilbudet til samiske pasienter innen psykisk helsevern. Studien skal altså undersøke hva "kulturelt tilpasset" psykisk helseverntjeneste kan innebære, sett fra terapeuters og samiske pasienters ståsted.

Det vil benyttes kvalitativ metode med intervju av ca. 1- 1,5 times varighet av terapeuter og samiske pasienter. Terapeuter og pasienter intervjues hver for seg, og studien vil ikke ha opplysninger om hvilken terapeut pasienten får behandling hos. En kvalitativ utforskning vil bidra til å få en dypere forståelse av hvilken betydning kulturelle aspekter og kulturell tilpasning av helsetilbudet har for terapeuters helsefaglige arbeid og for samiske pasienters opplevelse av, og om de føler seg forstått og hjulpet av det tilbudet de får innen psykisk helsevern. Resultatet vil kunne anvendes i kunnskapsproduksjon, undervisning og kompetansebygging for helsepersonell. Alle terapeuter, uansett faglig og kulturell bakgrunn, ved voksenpsykiatriske poliklinikker og evt. akutteam ved utvalgte DPS'er som har sitt opptaksområde i ulike samiske områder, får tilbud om å

delta i denne studien. Samtykkekompetente pasienter over 18 år som d.d. mottar poliklinisk behandling inviteres til å delta, og de som oppfatter seg som samisk kan inkluderes i studien. Studien er basert på informert frivillig samtykke og ubegrenset rett til å trekke seg.

Prosjektet er godkjent i Regional Etisk Komité, REK. Studien er godkjent av Regional Etisk komite/REK), og finansiert gjennom forskningsmidler fra Helse Finnmark.

Jeg ber om tillatelse til å komme til [aktuell institusjon] og informere om prosjektet, samt levere ut informasjonsbrev med forespørsel om deltakelse til terapeutene og diskutere muligheten for å levere ut forespørsler til pasienter.

Ber om tilbakemelding om jeg kan få komme og informere mer om prosjektet så snart som mulig på telefon 97 46 13 30 eller e-post inj101@uit.no

Med vennlig hilsen

Inger Dagsvold

Appendix 5

Informational letters and consent forms to therapists



Forespørsel om deltakelse i forskningsprosjektet.

Kulturkompetanse i psykisk helsevern til samiske pasienter.

Betydningen av kulturelle aspekter sett fra terapeuters og samiske pasienters synsvinkel

Mitt navn er Inger Dagsvold og jeg er doktorgradsstudent ved Senter for samisk helseforskning, Universitetet i Tromsø. Jeg holder på med et doktorgradsprosjekt som handler om hvilken betydning kulturkompetanse generelt, og kompetanse om samisk kultur spesielt, har for tilbudet samiske pasienter får innen psykisk helsevern. Ansvarlig prosjektleder/hovedveileder er Dr. philos Vigdis Stordahl, SANKS. Biveiledere er Dr. psychol. Snefrid Møllersen, SANKS og Dr. med Ann Ragnhild Broderstad, Senter for samisk helseforskning.

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i denne forskningsstudien som utforsker hvilke erfaringer terapeuter har med kulturell tilpasning av behandlingen, og om kulturelle forhold har betydning for terapeuters tilnærming til og forståelse av pasientene. Studien vil også utforske samiske pasienters opplevelse av sin situasjon som psykisk syk og av det hjelpetilbudet de får fra psykisk helsevern.

Bakgrunnen for studien er at den samiske befolkningen har rett til helsetjenester som er språklig og kulturelt tilpasset, men vi vet ikke så mye om hva dette egentlig innebærer. Vi ønsker derfor å få mer kunnskap om hvilken betydning kulturkompetanse og kulturbakgrunn har for hjelpetilbudet innen psykisk helsevern. Studien skal altså undersøke hva ”kulturelt tilpasset” psykisk helseverntjeneste kan innebære, sett fra terapeuters og samiske pasienters ståsted.

Kriterier for deltakelse

Alle terapeuter, både samiske og ikke-samiske, ved din arbeidsplass får tilbud om å delta i denne studien. Jeg skal ikke sammenligne gruppene, men ønsker å få høre erfaringer fra terapeuter med ulik faglig og kulturell bakgrunn.

Hva innebærer studien?

Deltakelse i studien innebærer du blir intervjuet av meg. Intervjuet vil være som en samtale som varer ca. 1-1,5 time, og det vil bli tatt opp på lydbånd. Deretter blir det skrevet ut som tekst. Utskriften av intervjuet vil bli anonymisert ved at navn og personlige opplysninger fjernes. Anonymiserte sitater fra intervjueteksten vil bli brukt i artikler.

Det kan bli aktuelt med oppfølgingsintervju, dette står du fritt til å takke nei til.

Intervjuet vil måtte foregå på norsk da studien skal foregå i ulike samiske områder med ulike språk/dialekter, og det har vist seg vanskelig å skaffe kvalifiserte tolker med helsefaglig kunnskap i alle områdene.

Hovedtema for intervjuet vil være: erfaringer fra møter med samiske pasienter med fokus på betydningen av språk og kulturelle aspekter i pasientbehandlingen, og om terapeuter mener at kulturkompetanse er, eller bør være en del av deres fagkompetanse og fagmiljø.

Mulige fordeler og ulemper

Resultatene av denne studien vil ikke ha noen direkte betydning for deltakerne i prosjektet, men vil frembringe kunnskap om kulturelle aspekter i helsefaglig arbeid. Det kan få betydning for terapeuters kulturelle fagkompetanse og for hvilket tilbud samiske pasienter innen psykisk helsevern får i framtida.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysninger som navn og fødselsnummer eller andre direkte gjenkjennerende opplysninger vil fjernes fra det skriftlige materialet. En kode knytter deg til dine opplysninger gjennom en navneliste. Det er kun autorisert personell som har adgang til navnelisten og som kan finne tilbake til deg. Alle opplysninger om deg vil oppbevares innelåst ved Institutt for samfunnsmedisin, Universitetet i Tromsø. Lydopptak og skriftlig materiale oppbevares på passordbeskyttet pc og vil kun være tilgjengelig for meg, som har taushetsplikt. Navneliste og lydopptak tilintetgjøres ved prosjektets avslutning, anslagsvis februar 2014. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få noen konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Dersom du ikke ønsker å delta trenger du ikke å gjøre noe.

Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte meg, Inger Dagsvold på telefon 46 81 09 93, e-post: inger.j.dagsvold@uit.no

Økonomi

Studien er finansiert gjennom forskningsmidler fra Helse Finnmark. Dersom gjennomføring av intervju medfører utgifter for deg så vil du få kompensasjon for det.

Rett til innsyn og sletting av opplysninger om deg

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Informasjon om utfallet av studien

De som deltar i studien har rett til å få informasjon om resultatet av studien.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien "Kulturkompetanse i psykisk helsevern for samiske pasienter". Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Du beholder selv denne delen av brevet.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien ”Kulturkompetanse i psykisk helsevern til samiske pasienter”. Jeg er villig til å delta i studien

Navn, store bokstaver

(Signert av prosjektdeltaker, dato)

Kontaktinformasjon:

Jeg kan kontaktes på

Telefon:.....

E-post:.....

Denne samtykke erklæringen legges vedlagte svarkonvolutt og sendes til:

Inger Dagsvold
Senter for samiske studier
Universitetet i Tromsø
9037 Tromsø

Appendix 6

Informational letters and consent forms to patients

Forespørsel om deltakelse i forskningsprosjektet

Kulturkompetanse i psykisk helsevern til samiske pasienter.

Betydningen av kulturelle aspekter sett fra terapeuters og samiske pasienters synsvinkel

Mitt navn er Inger Dagsvold og jeg er doktorgradsstudent ved Senter for samisk helseforskning, Universitetet i Tromsø. Jeg holder på med et doktorgradsprosjekt som handler om hvilken betydning kulturkompetanse generelt, og kompetanse om samisk kultur spesielt, har for tilbudet samiske pasienter får innen psykisk helsevern. Ansvarlig prosjektleder/hovedveileder er Dr. philos Vigdis Stordahl, SANKS. Biveiledere er Dr.psychol. Snefrid Møllersen, SANKS og Dr.med Ann Ragnhild Broderstad, Senter for samisk helseforskning.

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i denne forskningsstudien som utforsker samiske pasienters opplevelse av sin situasjon som psykisk syk og av det hjelpetilbudet de får fra psykisk helsevern. Studien vil også utforske hvilke erfaringer terapeuter har med kulturell tilpasning av behandlingen, og om kulturelle forhold har betydning for terapeuters tilnærming til og forståelse av pasientene.

Bakgrunnen for studien er at den samiske befolkningen har rett til helsetjenester som er språklig og kulturelt tilpasset, men vi vet ikke så mye om hva dette egentlig innebærer. Vi ønsker derfor å få mer kunnskap om hvilken betydning kulturkompetanse og kulturbakgrunn har for hjelpetilbudet innen psykisk helsevern.

Studien skal altså undersøke hva "kulturelt tilpasset" psykisk helseverntjeneste kan innebære, sett fra terapeuters og samiske pasienters ståsted.

Kriterier for deltakelse

Pasienter som får behandling ved poliklinikken får tilbud om å delta i denne undersøkelsen. Ettersom dette gjelder tilbudet til samiske pasienter, så kan du velge å delta dersom du oppfatter deg som same.

Hva innebærer studien?

Deltagelse i studien innebærer å bli intervjuet av meg. Intervjuet vil være som en samtale som varer ca. 1– 1,5 time, og det vil bli tatt opp på lydbånd. Deretter blir det skrevet ut som tekst. Utskriften av intervjuet vil bli anonymisert ved at navn og personlige opplysninger fjernes. Anonymiserte sitater fra intervjueteksten vil bli brukt i artikler. Det kan bli aktuelt med oppfølgingsintervju, dette står du fritt til å takke nei til. Intervjuet vil foregå på norsk

Hovedtema for intervjuet vil være: din opplevelse av å ha psykiske plager, og om du mener behandlingen du får er, eller bør være, tilpasset deres språklige og kulturelle bakgrunn.

Mulige fordeler og ulemper

Resultatene av denne studien vil ikke ha noen direkte betydning for deltakerne i prosjektet, men vil kunne frembringe kunnskap om kulturelle aspekter i helsefaglig arbeid. Det kan få betydning for terapeuters kulturkompetanse og for hvilket tilbud samiske pasienter innen psykisk helsevern får i framtida.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysninger som navn og fødselsnummer eller andre direkte gjenkjennende opplysninger vil fjernes fra det skriftlige materialet. En kode knytter deg til dine opplysninger gjennom en

navneliste. Det er kun prosjektleder som har adgang til navnelisten og som kan finne tilbake til deg. Alle opplysninger om deg vil oppbevares innelåst ved Institutt for samfunnsmedisin, Universitetet i Tromsø. Lyddopptak og skriftlig materiale oppbevares på passordbeskyttet pc og vil kun være tilgjengelig for meg, som har taushetsplikt. Navneliste og lyddopptak tilintetgjøres ved prosjektets avslutning, anslagsvis februar 2014.

Terapeuter og behandlingsinstitusjoner vil ikke få informasjon om at du deltar i studien. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Dersom du ikke ønsker å delta trenger du ikke å gjøre noe. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte meg, Inger Dagsvold på telefon 46 81 09 93, e-post: inger.j.dagsvold@uit.no.

Rett til innsyn og sletting av opplysninger om deg

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Økonomi

Studien er finansiert gjennom forskningsmidler fra Helse Finnmark. Dersom gjennomføring av intervju medfører utgifter for deg så vil du få kompensasjon for det.

Informasjon om utfallet av studien

De som deltar i studien har rett til å få informasjon om resultatet av studien.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien "Kulturkompetanse i psykisk helsevern til samiske pasienter". Jeg er villig til å delta i studien.

(Signert av prosjektdeltaker, dato)

Du beholder selv denne delen av brevet.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien ”Kulturkompetanse i psykisk helsevern til samiske pasienter”. Jeg er villig til å delta i studien

Navn , store bokstaver

(Signert av prosjektdeltaker, dato)

Kontaktinformasjon:

Jeg kan kontaktes på

Telefon:.....

E-post:.....

Denne samtykke erklæringen legges i vedlagte svarkonvolutt og sendes til:

Inger Dagsvold
Senter for samiske studier
Universitetet i Tromsø
9037 Tromsø

Thematic interview guide to therapists

Intervjuguide, terapeuter.

Introduksjon

Presentasjon. Kort informasjon om studien og tema for intervjuet som beskrevet i informasjonsbrevet.

Informasjon om intervju-form: samtale, ta opp det som du føler er relevant å snakke om på den måten som er rett for deg, du velger selv hva du vil fortelle om.

Bakgrunnsspørsmål:

- Helse/sosialfaglig utdanning
- Utdanning/kurs i kulturforståelse? Hvis ja, hva
- Alder
- Ansiennitet, antall år i arbeid i psykisk helsevern, antall år i det arbeidet du har nå
- Bodd antall år i et område hvor samisk kultur er en del av det daglige/samfunnslivet
- Språk (morsmål, kan du litt samisk)

Åpningsspørsmål:

Hvis du skulle beskrive hovedinntrykket ditt med å jobbe med samiske pasienter, hva ville du si da?

Aktuelle tema:

Om kultur og kulturell tilpasning av terapi:

Samisk befolkning har rett til å få et helsetilbud som er tilpasset ift språk og kultur. Har du noen tanker om det? Betyr det noe for deg og ditt arbeid?

Aktuelle spørsmål:

- Hva mener du ligger i uttrykket samisk kultur eller «det samiske»?
- Har du noen tanker om det har det betydning for ditt arbeid å kjenne til pasientens kultur, og om pasienten er same eller ikke?
- Har du noen tanker om samiske pasienter kan ha spesielle behov ut fra kulturbakgrunnen?
- Har du noen tanker om samer kan ha en annen måter å forstå psykiske plager på enn det du kjenner fra din helsefaglige utdanning? –eksempler?
- Har du noen tanker om hvordan du som helsepersonell bruker din kunnskap om kultur i behandlingen av pasientene?
- Har du noen tanker om kulturell bakgrunn eller kulturelle fenomener påvirker din vurdering av symptomer, diagnostisering eller behandlingsforløp?
- Har du noen tanker om hva helsepersonell som jobber med samiske pasienter bør kjenne til og ta hensyn til?
- Hva mener du det innebærer å kulturelt tilpasse behandlingstilbudet
- Opplever du at du har kunnskap til å kunne «kulturelt tilpasse» tilbudet?
- Er det på din arbeidsplass noen «verktøy» som hjelper deg å kulturelt tilpasse den helsehjelpen du skal gi? (f.eks kulturmanualer/kulturformuleringsintervju).

- Hvilke muligheter har du til å ha faglige diskusjoner vedrørende «kulturell tilrettelegging» i pasientbehandlingen?

Eventuelt:

- Det sies at samer har en annerledes måte å tenke om sykdom, og helbredelse på. Er det noe du kjenner til. Hva?
- Har du noen tanker om hvordan man kan ta hensyn til slike kulturelle forklaringer på psykiske problemer? – er det riktig, og relevant å ta hensyn til det?

Språk:

- Vet du hvilke pasienter som snakker samisk?
- Brukes samisk språk i kollegiet og i institusjonen?

Ikke-samisktalende.

- Tror du at det hadde hatt betydning for arbeidet ditt hvis du hadde kunnet snakke samisk med samiske pasienter?
- Tolk?

Samisktalende:

- Bruker du samisk i det daglige på jobb?
- Hvilket språk synes du det er best for deg å ha behandling med pasienten på?
- Synes du det er forskjell å ha terapier på norsk vs. samisk?

Avslutning:

- Hvordan har det vært for deg å snakke om disse tingene?
- Er det noe annet du vil snakke om før vi avslutter?
- Minne om retten til å trekke seg. Inviter til å ta kontakt hvis behov.

Appendix 8

Thematic interview guide to patients

Intervjuguide, pasienter

Introduksjon

Presentasjon. Kort informasjon om studien og tema for intervjuet som beskrevet i informasjonsbrevet.

Informasjon om intervju-form: samtale, ta opp det som du føler er relevant å snakke om på den måten som er rett for deg, du velger selv hva du vil fortelle om, retten til å trekke seg fra deltakelse.

Først: bakgrunnsdata

Alder, bosted, yrke, sivil status, språk

Åpningsspørsmål:

Hva tenkte du da du leste om dette prosjektet, og som gjorde at du fikk lyst til å delta?

Aktuelle tema:

Om kultur og kulturell tilpasning av terapi:

Samisk befolkning har rett til å få et helsetilbud som er tilpasset ift språk og kultur. Har du noen tanker om det? Betyr det noe for deg?

Aktuelle spørsmål hvis vanskelig å snakke om:

- Hvordan har det vært for deg å begynne å gå til behandling? Hvordan føler du at du har blitt møtt?
- Synes du at samtalen mellom deg og terapeuten ”glir godt”? Får du snakket om tingene på den måten som passer for deg?
- Betyr det noe for deg om terapeuten er samisk eller ikke?
- Hva mener du ligger i uttrykket samisk kultur eller «det samiske»?
- Opplever du at behandlere forstår det som har med [det du opplever som «det samiske»] å gjøre?
- Har du noen tanker om hva helsepersonell som jobber med samiske pasienter bør kjenne til og ta hensyn til?
- Har du noen tanker om hvordan man ser på psykiske problemer i det samiske samfunnet?
- Har du noen tanker om samiske pasienter kan ha spesielle behov ut fra kulturbakgrunnen?
- Har du noen tanker om samer kan ha en annen måte å forstå psykiske plager på enn helsepersonell? – har du noen eksempler på det?
- Hva kaller du problemet for, hvis du skal fortelle noen at du går her? Har du fortalt til noen?
 - Hvis samisktalende: Heter det noe på samisk?
- Hva tenker du selv om det problemet du har? Er det en sykdom?
 - Har du noen tanker om hva som kan være grunnen til at du plages med dette?
 - Har du noen tanker om din kulturbakgrunn har betydning for dine helseproblem?
 - Hva gjør du for å bli bra/bedre?

Språk:

Hvis samiskspråklig:

- Snakker du samisk i det daglige?
- Hvilket språk synes du det er best for deg å snakke med behandleren på?
- Vet terapeuten at du snakker samisk?
- Har behandleren spurt deg hvilket språk du helst vil snakke på i behandlingssamtalene?
- Har du noen tanker om språk har betydning for det hjelpetilbudet du får?
- Tror du at du hadde kunnet uttrykke mer om hvordan du hadde det hvis du fritt hadde kunnet snakke samisk?
- Vet du om behandleren snakker samisk?
- Tror du behandleren din hadde kunnet hjelpe deg bedre hvis hun/han kunne samisk?
- **Tolk:** Har det vært brukt tolk ila behandlingssamtalene?

Avslutning:

- Hvordan har det vært for deg å snakke om disse tingene?
- Er det noe annet du vil snakke om før vi avslutter?
- Minne om retten til å trekke seg.
- Inviter til å ta kontakt hvis behov.
- Informere om at de kan kontakte klinikken og be om time hvis behov.