UiT
THE ARCTIC UNIVERSITY OF NORWAY

Faculty of Health Sciences, Department of Clinical Medicine

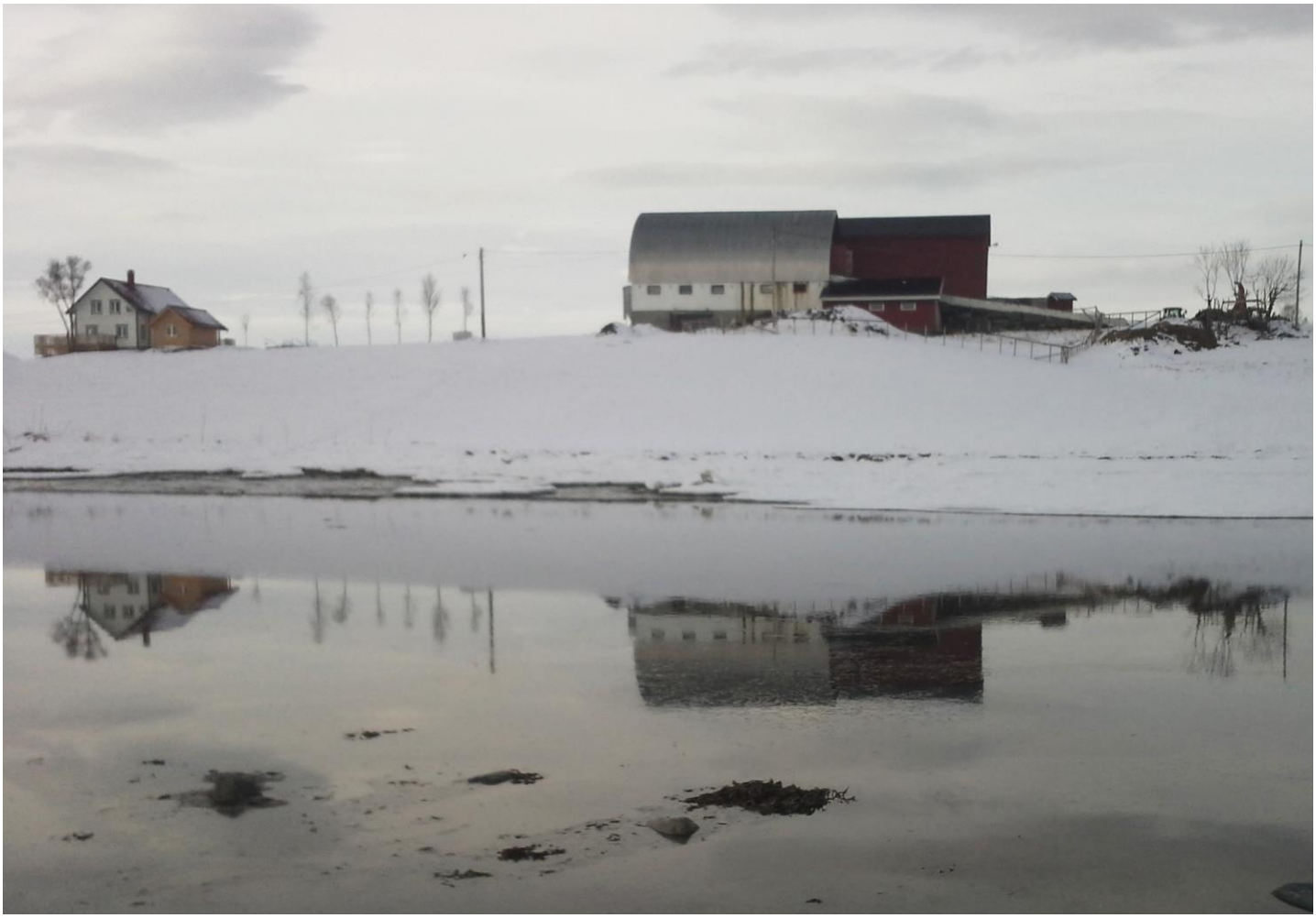
In Home we trust

An ethnographic study of mental health and the use of traditional medicine in a North Norwegian community

—

Mona Anita Kiil

A dissertation for the degree of Philosophiae Doctor – January 2019



UNIVERSITY OF TROMSØ

UiT
THE ARCTIC UNIVERSITY OF NORWAY

Faculty of Health Sciences, Department of Clinical Medicine

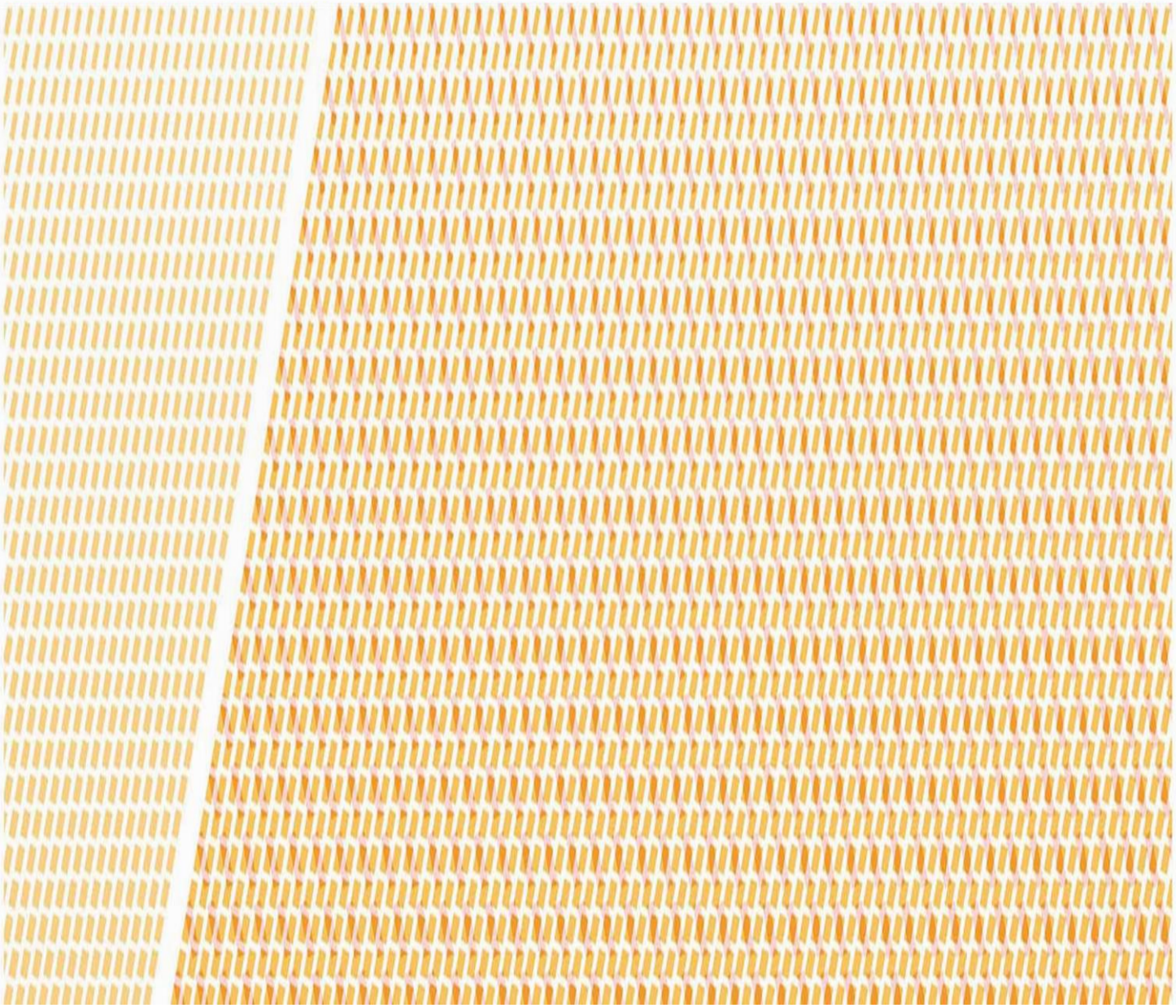
In Home we trust

An ethnographic study of mental health and the use of traditional medicine in a North Norwegian community

—

Mona Anita Kiil

A dissertation for the degree of Philosophiae Doctor – January 2019



The thing is

to love life, to love it even
when you have no stomach for it
and everything you've held dear
crumbles like burnt paper in your hands,
your throat filled with the silt of it.
When grief sits with you, its tropical
heat thickening the air, heavy as water
more fit for gills than lungs;
when grief weights you like your own
flesh only more of it, an obesity of grief,
you think,
How can a body withstand this?
Then you hold life like a face
between your palms, a plain face,
no charming smile, no violet eyes,
and you say, yes, I will take you
I will love you, again.

Ellen Bass, from *The Courage to Heal*, 2008

Acknowledgements

I did not realise that I had bags already packed for me at the time of embarking on this journey. My own past stories were neatly wrapped, some tossed around, to make me more curious or perhaps confused. My cosmopolitan self has been challenged along the way. I have come to realise that there is a belonging to the North which I can never escape. This journey has also been coloured by an illness narrative of my own, and a life less than ordinary. Between the stories found in this thesis, there is an invitation to wonder and search for more than what science of today can explain. In the midst of crisis and everyday struggles there is always beauty and magic.

Most importantly, I acknowledge those women and men who have participated in my research. All of them gave of their time selflessly, and I am most grateful and humble for the stories told by all these extraordinary "everyday people" whom I was fortunate to meet. I would like to thank the outpatient clinic for mental health in Northern Troms, in particular May Lisbeth Mikkelsen, for co-ordinating the participants, and the former Head of Clinic, Ida Musum Bakkejord, for hospitality and valuable insights to the field.

Thanks also to the Research Council of Norway for supporting the project. Thanks to all the members of the Psychiatry Research Group at the Department of Clinical Medicine, and my supervisor Professor Tore Sørlie for trusting me to "do my thing". Thanks to my co-supervisor PhD Barbara Helen Miller.

I am most grateful to the National Research Centre in Complementary and Alternative Medicine where I was located halfway through this journey, in particular Trine, Anita, Agnete and Åsa: Thanks for vivid discussions and sparkling sessions at home and abroad! Thanks to the members of the Pedagogical Anthropology Research Group for stimulating discussions. Warm thanks to Tatiana, Marcela and Rita for disciplinary input and extracurricular activities. To everyone in the corridor and the office at Åsgård: I have learned to never underestimate the value of being surrounded by therapists.

Thanks to the Centre for Arctic and Global Health where I have worked since 2016, and my fellow musketeers Inger and Turid. To Gaute: Thanks for commenting on articles, and for fieldwork therapy. Solveig: Thanks for being a technical angel first time around. Thank you Agnete for the front-page photo! Heartfelt and special thanks to Tone and Trine for teaming up with me in the final stage.

To all my dear friends whom I value deeply, you know who you are. Warm thanks to my father Tollef, and my mother Synnøve, who never ceases to be optimistic on my behalf.

To my children, Simon, Gabriel & Miriam: I love you endlessly. Make your lives spectacular.

Tromsø, January 2019, Mona Anita Kiil

Contents

Acknowledgements 7
List of articles 12
List of appendices 13
Summary 14
Summary in Norwegian 16
Introduction 17
Northern Troms 17
A post-colonial community 18
The Sami 20
Forced assimilation and World War II 20
The coastal Sami awakening 21
Use of traditional medicine: Encounters of pragmatism, spirituality and pietism 22
From shamanism to reading 23
Traditional medicine versus complementary and alternative medicine 24
Traditional medicine in databases 25
Traditional knowledge and local values: Qualitative studies from present to 2000 26
Everyday practices and spirituality: Qualitative studies from the period 1999-1980 28
TM and CAM: Quantitative studies from present to 2000 28
From folk medicine to CAM: Quantitative studies- from the period 1999-1970 30
The outpatient clinic for mental health care in Northern Troms 31
Why this study? 31
Aims and primary objectives 32
Outline of the thesis 32
Material and methods 33
Material 33
Participants and recruitment 34

Interviews 35
"The miraculous kitchen" as a setting for doing sensory ethnography 36
Positions in the field 37
Doing anthropology "at home" 37
Reciprocity in the field 38
Analysis 40
Ethics 41
Recommendations and registrations 41
Procedures and consent 41
Ethical considerations 41
The therapeutic and friendly researcher 42
The compassionate researcher 43
Findings 44
Article 1: In between coffee and God: Mental health and emotional landscapes in Northern Norway 44
Article 2: What is at stake in the clinical encounter? Mental health care and belonging in a local community in Northern Norway 45
Article 3: Angels and charlatans: Contrasts and tensions between different medical systems in a North Norwegian community 46
Discussion 47
Home 47
Home as narrative identity 49
Trust as embodied 53
Trust as hope 53
Trust as a scarce resource 54
Trust as uncertainty and risk 56
Trust and worldview 57

Trust and hybridity 59
Methodological considerations and reflections 60
Field and home 62
The ethical dilemma of anthropology 63
Moving towards a sensory ethnography 64
Implications for clinical practice and further research 66
Closing remarks 67
References 69
Article I: 77
In between coffee and God: Mental health and emotional landscapes in Northern Norway 77
Article II 93
What is at stake in the clinical encounter? Mental health care and belonging in a local community in Northern Norway 93
Article III: 121
Angels and Charlatans: Contrasts and tensions between different medical systems in a North Norwegian community 121
Appendix 1 145
Ethical recommendation Regional Ethics Committee, REK nord 145
Appendix 2 148
Confirmation Norwegian Social Science Data Services 148
Appendix 3 150
Letter of invitation with declaration of consent 150
Appendix 4 155
Declaration describing the independent research contribution of the candidate 155

List of articles

1. **In between coffee and God.**

Mental health and emotional landscapes in Northern Norway, in Nergård, J-I & P.Vitebsky, *Culture as a Patient. Unusual encounters for usual people*. Oslo: Universitetsforlaget. In print.

In Norwegian: 2019: I mellom kaffe og Gud, i Nergård, J-I& P. Vitebsky, *Kulturen som pasient. Uvanlige møter for vanlige folk.* Oslo: Universitetsforlaget.

2. **What is at stake in the clinical encounter?**

   Mental health care and belonging in a local community in Northern Norway
   Submitted to Journal of Circumpolar health June 16th 2018.

3. **Angels and Charlatans**

   Contrasts and tensions between different medical systems in a North Norwegian community.
   Submitted to BMC Complementary and Alternative Medicine June 22nd 2018.

List of appendices

1. Ethical recommendation Regional Ethics Committee, REK Nord.
2. Confirmation Norwegian Social Science Data Services.
3. Letter of invitation with declaration of consent.
4. Declaration describing the independent research contribution of the candidate.

Summary

The overall aim of this study is to explore how mental health care is mediated in a specific North Norwegian context, and to provide greater insight into mental health care and participants` use of traditional medicine.

The ethnographic field research that formed the basis for this thesis focused on how the ambiguous historical context has created a certain framework for understanding dynamics of belonging, and specifically, how users of an outpatient clinic in Northern Troms experienced the oscillation between significantly different medical and cultural systems.

Unofficial health care exists in many North Norwegian communities, consisting of traditional and religious healers (*readers*), whom people actively use or would consider using when faced with illness or crisis. The municipality of Nordreisa in Northern Troms is commonly described as "the meeting place of three peoples": Sami, Kvens and Norwegians. Despite this, the notion of culture appears connected to ambivalence as well as ambiguities, particularly concerning the Sami identity which can appear invisible or hidden; however, the cultural diversity is nevertheless expressed and manifested through the use of *reading*, as well as identified through Laestadianism.

A total of 61 people participated in this study. Twelve participants were users of the outpatient mental health care clinic in Northern Troms; further participants were eight therapists and other staff at the clinic, five traditional healers and four complementary and alternative medicine providers. Thirty-two people from the local community were also included in this study. The twelve patients were aged 22-74 years and had all been diagnosed with depression and anxiety disorders; they also all used traditional medicine, in particular *reading*, to complement clinical treatment. Some also used complementary and alternative medicine modalities such as acupuncture and homeopathy.

The findings revealed different dynamics of belonging, which are discussed using "home" and "trust" as analytical lenses. As users of traditional medicine, the participants in this study experienced a significant sense of vulnerability in their encounters with conventional mental health care. They expressed a lack of trust in conventional mental health services in regard to how their traditional and religious practices were being understood. Among other factors, they feared being misdiagnosed with more severe mental health disorders if they communicated their personal treatment philosophies. Regardless of negative experiences with

conventional mental health care in the past, the users preferred a connection to both *readers* and conventional mental health care.

The participants` stories give an understanding of *nerves* as an embodied idiom of distress in the region. *Nerves* appear closely connected to people`s experiences from the process of forced assimilation and the expulsion from their homes during World War II. The continuous concealment which surrounds these events seemingly creates a type of local trauma but also insights for the people in Northern Troms; through *nerves*, mental distress is managed and identities are negotiated.

As they are users of conventional clinical treatment, *reading* and complementary and alternative modalities, these patients are experienced navigators between the different medical systems available in the community. The various modalities intertwine, and they simultaneously correspond to similar and different spheres and worldviews among people in the region. Disruption of traditional medical practices contains the element of an increasing combination with complementary and alternative modalities. However, the distinction between *reading* and complementary and alternative medicine is still valid for most people as it includes navigation of the skills and intentions of providers based on values and knowledge related to local insights and the common use of *reading*.

Summary in Norwegian

«Det trygge hjemmet». ***En etnografisk studie av psykisk helse og bruk av tradisjonell medisin i et nordnorsk lokalsamfunn*****.**

Dette antropologiske doktorgradsprosjektet studerer hvordan hjemmeboende psykisk syke i Nord-Troms håndterer erfaringer i pendlingen mellom ulike medisinske og kulturelle hjelpesystemer: konvensjonell behandling ved den distriktpsykiatriske poliklinikken, bruk av tradisjonelle helbredere (*lesere*) og også alternativ behandling. Studien bidrar med kunnskap om spørsmål vi så langt vet lite om i en norsk sammenheng. Den baserer seg empirisk på et etnografisk feltarbeid med til sammen 61 deltakere, hvor både pasienter, terapeuter og andre ansatte ved klinikken, tradisjonelle helbredere/*lesere*, alternative behandlere og folk i regionen deltok. Antropologiske analyser som fokuserer på ulike tilhørighetsdynamikker bidrar til å sette disse erfaringene inn i et større bilde av hvordan psykisk helse og identitet forhandles innenfor en nordnorsk kontekst.

Gjennom deltakernes fortellinger avdekkes en kulturelt kompleks region hvor tilhørighet (er) til det norske, samiske og kvenske sammen med Læstadianisme artikuleres som tvetydig og delvis skjult. Fortellingene åpner opp for en utforskning av erfaringer knyttet til identitet og helse i lys av kulturelle, sosiale og historiske kontekster. Den enkelte deltakers livsfortelling er således rammet inn av den store fortellingen om Nord-Troms, hvor hendelser som fornorskingsprosessen og tvangsevakueringen under Annen Verdenskrig inngår og oppleves som *lokale traumer* -også uttrykt som *nerver*, som ikke har fått status som nasjonale traumer i skyggen av motstandsbevegelsen, frigjøringen og gjenreisningen av nasjonen Norge.
Et hovedfunn er at pasientene opplever manglende tillit til det konvensjonelle psykiske helsetilbudet med henblikk på hvordan deres tradisjonelle og religiøse praksiser blir forstått, og blant annet frykter feildiagnostisering. Uavhengig av dette ønsker pasientene konvensjonell behandling og derigjennom en god klinisk allianse i tillegg til deres bruk av tradisjonell medisin. Studien viser også et økt fokus på bruk av komplementær og alternativ behandling i regionen, selv om disse evalueres innenfor en annen verdisfære i forhold til tradisjonell helbredelse. De dypt forankrede tradisjonelle helbredelsespraksisene ser ut å fungere som et kompass for hvordan folk i regionen både navigerer mellom behandlingstilbud med utgangspunkt i lokale verdier, tillit og kompetanse hos terapeutene, og evaluerer og til dels sertifiserer disse med bakgrunn i lokal kunnskap.

Introduction

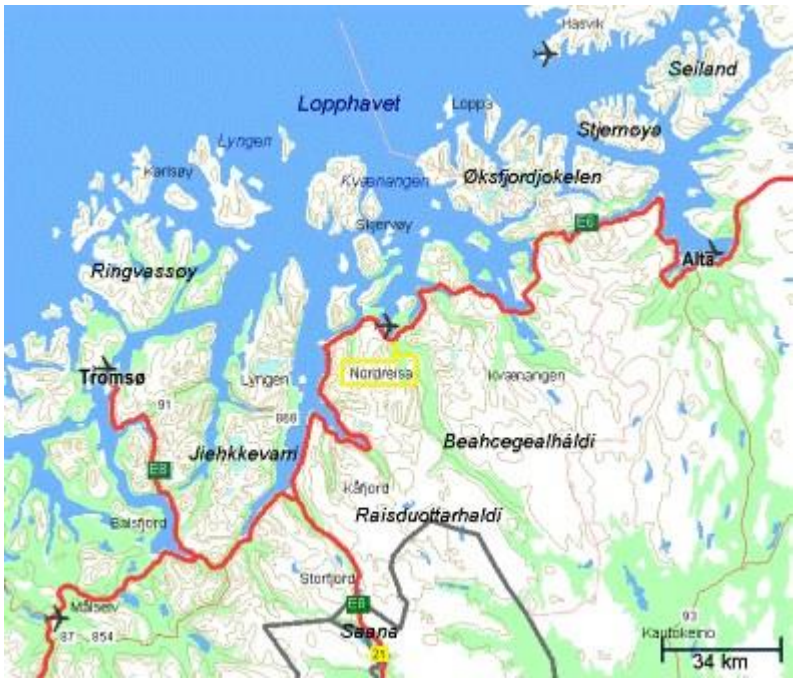
> The thing about trust, it´s not easy. It can be difficult to trust people at all, not to mention doctors. I know they're here to help me, but still…. There are lots of things that are difficult in this community, it has been like that for many years. No wonder people are struggling…still I believe the only way to heal is through the community, if you know what I mean…and there are lots of good things here too, aren't there? Perhaps it`s in our blood to suffer, just our destiny… like the ones before us, this battle with *nerves*, I don`t know…what I do know though is that the only things I can completely trust are what feels like home to me, how I understand the world, that is a big part of me, both in the body and in my soul. …Trust is not for anyone, it must be earned.
>
> …We owe a great deal to the *readers* (traditional healers) in the community, I think the work they do is more than many people understand.

This passage from Johan`s story, one of the participants in this study, gives a direction to the core themes that will be addressed in this thesis. To grasp the context of the participants in this study, and the ramifications for understanding what constitutes sociocultural belonging and how people relate to the different medical systems, I will start by providing some key information.

Northern Troms

The region of Northern Troms in the North of Norway is composed of the municipalities of Nordreisa, Skjervøy, Kåfjord and Kvænangen. The ethnographic fieldwork this study is based on was conducted in the municipality of Nordreisa, which makes this the main locus of attention and which is "the community", whenever the term is applied in this thesis. Marked in yellow on the map below is Nordreisa (in Norwegian: Nordreisa kommune (in Northern Sami: Ráissa suohkan, in Kven: Raisin komuuni). To the north, Nordreisa borders on Skjervøy, to the east it borders on Kvænangen and Kautokeino (in Northern Sami: Guovdageaidnu), and to the west it is bordered by Kåfjord (in Northern Sami: Gáivuona suohkan, in Kven: Kaivuonon komuuni). Nordreisa has 4945 inhabitants and 1822 of these live in the administrative centre of Storslett (Statistics Norway (SBB) 2018). The famous Reisa river terminates in the fjord at Storslett. Farming and forestry are important sources of

livelihood, along with tourism, health care services and trade. The Reisa national park, with powerful rivers and a high mountain landscape, borders on Finland in the southern part of the municipality. Fishing and hunting are both vital recreational activities in Nordreisa. Fishing tourism, in particular angling, has increased in recent years (Svensson G 2015).



A post-colonial community

While giving lectures in social and medical anthropology to nursing students at UiT The Arctic University of Norway, I used examples from my own research in the field of mental health in Northern Troms and the common use of traditional medicine (TM) in the local communities. One day, I was talking about the medical practices in relation to the cultural diversity, including the Sami indigenous heritage in Nordreisa specifically, when one of the students[1] raised her hand, stood up angrily and almost shouted at me:

We're not Sami in Nordreisa!

During the course of this ethnographic study, this outspoken protest was one of many manifestations of Northern Troms as an ambiguous context in terms of ethnicity.

[1] The student has given oral consent for the use of her statement for the purpose of this thesis.

Northern Troms has historically been a crossroads of three cultures: Sami, Kven and Norwegian (Bjørklund I 1978). This longstanding contact between the Sami, Kven and Norwegian communities has resulted in most people having ancestors from all three groups, and ethnicity and cultural identity are consequently considered complex and ambiguous matters within the region (Bjørklund I 2000, Hansen LI and Olsen B 2004). This multi-ethnicity is also found in names used for people (Imerslund B 2008) and places (Imerslund B, Lindgren A-R et al. 1993) in Northern Troms, and indicates a complex cultural and linguistic history. For instance, as Svensson (Svensson G 2016) notes, a lake can have three different names, ending in javri (Sami), järvi (Finnish and Kven) and vann (Norwegian). This is a practice which can create confusion for people unfamiliar with the cultural heritage of Northern Troms (Svensson G 2016).

The Sami heritage has been under-communicated or hidden in this region for a long time (Bjørklund I 1985). In Nordreisa, there seems to be less political controversy attached to the Kven culture, while issues concerning Sami identity continue to be more challenging and stigmatising but simultaneously more common to pursue (Brostrøm BT 2014). The overall and official impression of the region is that matters of ethnicity have not led to conflict in recent decades (Svensson G 2016). However, when the neighbouring municipality of Kåfjord started putting up road signs with both the Norwegian and the Sami name for places, people in the municipality started shooting at the Sami names and a public debate was triggered (Bjørklund I 2000, Hansen L 2008). This debate is still ongoing throughout Northern Norway, as more municipalities choose to use Sami signs, and some places also signs in Kven (Andersen V 2019). Also public initiatives aiming to establish an understanding of "who we are or what we are", among them an "image-building" project, have created some controversy in the area (Omdømmeprosjektet) (Brostrøm BT 2014).

Due to the nature of the ambiguities in this context, and how people in the region deal with matters of ethnicity and cultural identity, Northern Troms is, in my experience, better understood as a "Northern Norwegian cocktail" of people and traditions rather than an indigenous Sami context.

The Sami

The indigenous population of the Sami in Norway have a history which is estimated to go back at least 5000 years (Bradbent ND 2010). The region of Northern Troms is part of what is referred to as *Sápmi*. Sápmi is a cross-border traditional Sami region covering parts of Norway, Sweden, Finland and Russia, and the common ground for Sápmi rests on culture and language (Bjørklund I 2000).

In Norway, the Sami were mainly converted to Christianity during the early eighteenth century (Mathiesen P 1990). In this period, Norwegian settlements increased in the traditional Sami areas, and today the Sami are a minority group within Norway, Sweden, Finland and Russia, they number approximately 70 000 and are engaged in a variety of traditional and modern occupations (Statistisk sentralbyrå (SSB). English: Statistics Norway (SSB) 2012). Historically, most Sami communities have practiced a semi-nomadic lifestyle, moving together between the mountain areas and the coastal areas according to the season. There is a tendency to associate Sami culture with reindeer pastoralism, but this industry only employs about 10% of the Sami population today and does not apply to coastal areas like Northern Troms. In Northern Troms fishing, combined with farming, mostly small-scale, is predominant but many inhabitants are employed in health services and trade (Statistics Norway (SBB) 2018). There is no significant difference in health between the majority Norwegian population and the Sami, unlike the situation in most other Western countries between the indigenous and non-indigenous populations (Blix BH and Hamran T 2015). This can be explained by the similar socio-economic living conditions between the Sami and the majority population in Norway, which does not lead to the same challenges as witnessed in for instance Canada and the USA (Cotton ME, Nadeau L et al. 2014, Kvernmo S 2014, Blix BH and Hamran T 2015).

Forced assimilation and World War II

The process of forced assimilation of the Sami and Kven populations by the Norwegian Government started around 1850, and impacted different geographical areas to varying degrees, resulting in people with Sami ancestry living in coastal regions like Nordreisa forming a diaspora, while many now consider themselves as Norwegians (Johansen E 2012).

To prevent the Soviet advance in World War II, Hitler applied the "scorched earth policy" in Finnmark and Northern Troms in the autumn of 1944, so that by force, 75 000 inhabitants were evacuated from their homes, and mainly moved to the still occupied south of Norway (Bjørklund I 2000). After the burning, there were few material memories of the past, including material manifestations of the Sami and Kven legacy (Johansen E 2012). The assimilation process escalated after the war, with the social fabric of local life vastly affected. The introduction of a new welfare system, with a higher level of bureaucracy, resulted in an urgent need to master the Norwegian language and cultural diversity was repressed, having no place in the national rebuilding of Norway (Bjørklund I 2000). The events surrounding the burning and evacuation of Finnmark and Northern Troms have not been properly recognised or given status as a national trauma, but as Bjørklund (Bjørklund I 2000) notes, they remain in the shadow of the Norwegian resistance movement and the liberation of Norway after World War II.

The coastal Sami awakening

The coastal Sami awakening started in the municipality of Kåfjord (Hovland A 1996). This was a process that not only revitalised the old coastal Sami culture, but implemented characteristics from the entire Sami cultural sphere. According to Hovland (Hovland A 1996), the process of Sami revitalisation implied a gathering of cultural symbols from the Northern Sami nomadic culture in order to awaken the coastal Sami culture. This hybrid culture has accordingly been composed of a mix between a forcibly assimilated coastal Sami culture and a revitalised Sami nomadic culture, where elements such as kofte[2], joik[3] and language include symbols that were used by the old coastal Sami culture prior to its domination by the Norwegian majority culture (Mathisen SR 2000). Parts of the culture have been reconstructed using symbols from the reindeer-herding culture, and became expressed in modern ways through the process of revitalisation. For elderly people of coastal Sami background, this process was likely to have been experienced as strange and somewhat alienating. Consequently, the younger people chose to acknowledge a belonging to this new hybrid culture and also contributed to the promotion of Sami language by implementing measures in the inner parts of the municipality of Kåfjord (Johansen E 2012). Sami identity

[2] Piece of traditional clothing worn by Sami people. In Northern Sami, gákti.
[3] Traditional Sami singing, also referred to as luohti, vuolle, leu`dd and juoiggus.
[5] Known as the "Alta-case".

thus returned as an intentional policy, and even though the process started within Sami fractions[5], the reconstruction was eventually supported by Norwegian authorities, leading to the creation of the Sami Parliament and the official recognition of the Sami as an indigenous people (Bjørklund I 2000). The indigenous *Riddu*[4] festival has also played a vital part in the coastal Sami revitalisation, by introducing young coastal Sami to a global indigenous scene which has promoted their own culture through placing it in a larger context. The Kven *Baaski*[5] festival in Nordreisa and the Sami *Verdde*[6] festival in Kvænangen are also relevant in this context but have not been as influential and politically significant as the Riddu.

Use of traditional medicine: Encounters of pragmatism, spirituality and pietism

The Norwegian health care system of today is designed to cover Norwegian citizens` health care needs based on scientific biomedical knowledge as the basis for treatment (Salamonsen A and Ahlzen R 2017). However, TM is still sought after in regions like Northern Troms, mainly complementary to the conventional health care, and used for very diverse conditions.

There is a long and uninterrupted tradition in Northern Norwegian communities of relieving and treating both physical and mental illness (Norges offentlige utredninger. English: Official Norwegian Paper 1998). TM practices are widespread, and have a solid position throughout Northern Norway, specifically in areas with a historical large Sami population (Mathisen SR 1989). As a result, TM played a significant part in managing health and illness long before Western medicine was made available in these communities (Myrvoll M 2010). Historically, TM in the northern regions of Norway includes various treatments, theories, and beliefs about health and healing based on the Sami cultural heritage. Although Sami folk medicine in its original form no longer exists, fragments of it are still vital and part of everyday life in areas traditionally populated by Sami people such as Northern Troms. To my knowledge, what some may refer to as Sami folk medicine today is more appropriately understood as TM, and includes a variety of healing methods, massage, (blood) cupping, bloodletting, the stopping of blood and moxa burning, and assets from plants, animals and metals can also be used (Mathisen SR 2000). Other parts of TM have been recognised as useful everyday

[4] *Riddu* means "small storm at the coast", an expression often used to describe the coastal Sami revitalisation in Northern Troms.
[5] A *baaski* is a small boat which was used to transport equipment across the Reisa River.
[6] *Verdde* is an old Sami tradition referring to the reciprocal relationship between coastal Sami and semi-nomadic Sami involving exchange of services.

knowledge and are thus available for anyone to practice, like removing warts and to a certain degree also the stopping of blood.

The traditional healing practice of interest in this thesis is the most commonly used technique in Nordreisa, usually referred to as *reading*, but also as *curing* or *blowing*. *Reading* is particularly related to the spiritual aspect of TM, and implies certain spiritual abilities, often perceived as *gifts of grace* (Myrvoll M 2015). Different traditional healers are known to possess different types and levels of skills, and *readers* are considered particularly suited for mental distress and psychological crises. *Reading* is a type of prayer used for a local and specific problem, a form of spiritual guidance and compassion during times of illness, where the *reader* uses words from the Bible with the intention to activate healing. The belief is that it is not the actual words that heal, but the power of God that follows from the words (Miller BH 2007). However, *readers* may also use a combination of remedies that include plant and animal products. *Reading* is passed on from generation to generation in extended families, which means that most people in the region have a healer within their close or more distant family.

This ethnographic fieldwork showed that *reading* was often performed through telephone calls, either made by the one seeking help or by family members or others in the community. The one calling would typically address the nature of the matter and explain if it was an acute or chronic condition. Sometimes the phone call was short, the *reader* received all the necessary information and was asked to pray for or *read* on the person in question. At other times the phone call seemed more like a therapy session in itself, as the "patient" would go into detail about his/her concerns, receive advice from the *reader* and discuss them. However, these calls also ended with the *reader* performing *reading*, usually after the call but sometimes before the call ended. When visiting a *reader*, I witnessed natural elements being used as complementary tools: water, stones, soil, a knife and paper.

From shamanism to reading

Reading, as practiced in Northern Troms today, is neither a pure Sami tradition nor a typical Northern Norwegian tradition, nor is it common among indigenous peoples. These practices most likely arrived in Northern Norway with Christianity in the Middle Ages and can thus be seen as Christian methods of healing, mostly common in areas where Lutheran Christianity is

not dominant (Mathisen SR 1989); some of these methods are also used in Judaism and Islam.

However, in terms of the social role of the traditional healer there is a line from shamanism to *reading*, and there may also be influences from the old Sami religion. Before Christianity, the noaidi had a central role in the Sami communities (Nergård JI 2005) The noaidi was a Sami healer who possessed medical knowledge and healing abilities for the common use for people in the community. The noaidi also had status as a religious and spiritual leader (Nergård JI 2005).

The noaidi operated in many ways as the traditional healer does today, and the noaidi also filled many of the same roles as the shaman did in the old religion. Shamans had the ability to reach altered states of consciousness and communicate with "the other world", and by doing so bring healing and harmony between humans and God (Kristiansen R 2005). The practices, however, differ in their expression. The use of the drum is one such example (Rydving H 2004). Whereas the shaman and also the noaidi used the drum extensively, many *readers* today will see drums as connected to the devil. Most *readers* in Northern Troms today have a Laestadian background and consider themselves as Christians (Nergård JI 2000). The pietistic religious movement of Laestadianism, based on the preachings of the Swedish-Sami minister Lars Levi Laestadius, has had a significant impact on people and culture in Northern Troms since the 1840s. Laestadius' approach and attitudes found a sympathetic response in people of the region as he managed to integrate Sami perceptions of reality and religion with key messages from the Bible (Northern People 2010). Some conceptions from the old Sami culture still seem to influence the worldview of people in the region, particularly in regard to perceptions of mental illness, crisis and bad luck. The idea that illness or crisis are caused by powers external to human beings (Sexton R and Stabbursvik EAB 2010), including someone possessing the ability to cast a spell on you[7], ganne, is still often mentioned in conversation.

Traditional medicine versus complementary and alternative medicine

TM is understood (World Health Organization 2013) as the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures,

[7] Ganne, in Northern Sami. An expression commonly used also used by "Norwegians" in this region.

whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.
Traditional healing, *like reading*, is defined as complementary and alternative medicine[8] in some studies (Kristoffersen AE, Fønnebø V et al. 2008), and as something different from CAM in others (World Health Organization 2013). Kiil and Salamonsen (Kiil MA and Salamonsen A 2013) understand CAM as commercial health care practices, such as acupuncture, massage, homeopathy, and "modern" spiritual healing offered to the public outside the Norwegian conventional health care system. The authors describe traditional healing in this area of Norway as a culturally based healing practice that differs significantly from commercial CAM modalities introduced over the last twenty years. Nonetheless, according to Kristoffersen (Kristoffersen AE, Stub T et al. 2017), many healers in Northern Norway practising modern healing techniques will have their cultural roots in regions like Northern Troms, and thus also be aware of *reading*. Consequently, elements of *reading* or the awareness of an inherited "healing gift" may well be embraced in their modern healing practices, making the borders between traditional and modern healing practices less distinctAn overview of traditional medicine in Norway

The World Health Organization distinguishes between Complementary and Alternative Medicine (CAM) and traditional medicine (TM). However, traditional medicine is considered as CAM (World Health Organization (WHO) 2014). CAM is defined as a treatment modality that is used alongside conventional treatments, but not considered standard medical treatment .

Traditional medicine in databases

I searched the following databases for relevant literature: High North Research Documents, Web of Science, PubMed, Scopus and JSTOR. Additional studies were identified performing manual searches. Reference lists of publications were also checked for literature.
Methods: Depending on the database, various combinations of *keywords* and *MESH terms* were applied and combined with AND and OR. The following MESH terms were used: Complementary therapies; alternative medicine; alternative therapy. These keywords were used: Faith healing; traditional healing, spiritual healing; indigenous healing, Sápmi; Sami, Saami.

[8] Hereafter, CAM.

Traditional knowledge and local values: Qualitative studies from present to 2000

Langås –Larsen et al. investigated the social processes, the understanding and experience of traditional healing and conventional health care in three groups: The users, the traditional healers and health personnel. They found that health care personnel have great knowledge and respect for *reading* (Larsen AL, Hamran T et al. 2014). Moreover, they facilitated the use of traditional healing and respected their patient's faith (Langås-Larsen A, Salamonsen A et al. 2017).The traditional healers in this study understood traditional healing as the initiation of the patient's self-healing power. Traditional healers profile included trustworthiness, calmness and strong mentality (Langås-Larsen A, Salamonsen A et al. 2017). At last, health personnel working in communities with mixed ethnicity should have thorough knowledge of the mixed culture, including the importance of traditional network to the patient (Langås-Larsen A, Salamonsen A et al. 2018).

Andersen et al. investigated which coping strategies psychiatric patients in Finnmark applied in their maintenance of health (Andersen KB, Persen S et al. 2015). The participants experienced that when other people prayed for them and talking to a healer were beneficial health promotion measures. Many participants had access to networks and other health promotion resources in the Laestadian community. They experienced that health personnel lacked knowledge of how to handle disease and people´s everyday practical faith. The researchers reported that health personnel should increase their knowledge of traditional coping strategies and encourage the patients to use these strategies when facing illness and disease.

Kiil performed an ethnographic fieldwork among 61 participants, where 12 were patients at a psychiatric clinic in Northern Troms. She found that *reading* was common when seeking help for mental distress, independent of ethnic and religious affiliation. The participants in the study were reluctant to inform the health personnel about their use of reading, due to fear of being misdiagnosed (Kiil MA 2015)

Hætta (Hætta AK 2010, Hætta AK 2015), interviewed 15 persons in Nordland about the transfer and management of traditional healing knowledge. Three of the participants were traditional healers. The participants reported that the healing knowledge was only available to the *readers*, and that the knowledge belonged to the local community. Moreover, the *readers* had different areas of expertise. Younger *readers* were more reluctant to use their healing abilities, because it was difficult to combine such a practice with other work.

Nymo investigated health and healing among the elderly in South Troms. She found that the participants combined conventional medicine with traditional healing. They understood

reading as a coping strategy. Therefore, it was important to look after other family members and neighbors, because they were a possible safety net in cases of illness and disease (Nymo R 2011, Nymo R 2015).

Myrvoll (Myrvoll M 2010) found, in a study from a Lule Sami area in Nordland, that the use of traditional healing was a kind of user control. When the doctor was far away, it was important that one member of the family was able to stop bleeding (Myrvoll M 2010, Myrvoll M 2015).

Henriksen (Henriksen AM 2010) interviewed users of the conventional health care services and traditional medicine and Troms and Finnmark. She found that traditional healing was understood as practical help in the daily life and a loving and caring public health measure. Moreover, it was an expression of the Christian practice and faith in Northern Norway.

Sexton and Stabbursvik (Kiil MA, Sexton R et al. 2010) conducted an interview study among eight traditional healers during 2003-2007. The participants were of mixed ethnic background and lived in Sami areas. The healers came from healer families, where the knowledge had been passed on for several generations. They applied methods such as laying on of hands and healing by prayer. Many of the younger healers used a modern approach, where they combined traditional methods with elements of modern healing (chakra healing).

Miller (Miller BH 2007) investigated how the knowledge of healing was passed on from generation to generation. The knowledge was passed on by the means of four basic concepts. First, when the healer was to find a successor, they often got spiritual assistance. Secondly, the healer continues to instruct the successor. Third, the ability to heal was either passed on from a former healer during a period of practice. Alternatively, the successor received a message in a dream, and last the healing ability was a special interaction between the healer and an almighty God. However, healers have always supplied their own knowledge and understanding in their clinical practice.

Nergård (Nergård JI 2005, Nergård JI and Eriksen J 2006) interviewed a female healer from a sea Sami community, and a male healer from a reindeer herding community in Finnmark. The female healer put her abilities in a Christian Laestadian context, whereas the male healer explained his practice in accordance with ancient Sami tradition.

Aspaas and Henriksen (Aspaas J and Henriksen AM 2002) published an information booklet about the North-Norwegian healing traditions in 2002. The booklet was published by the University of North Norway (UNN), with the aim to provide health personnel with thorough

information about traditional healing. *Reading* was understood as an important resource that may mobilise the patient´s inner resources in cases of illness and stress.
Mehus (Mehus G 2002), investigated the significance of traditional healing for health personnel, scholars and users. She interviewed six persons and found that the *healers* took major social responsibility. They take care of people´s basic needs in cases of illness. The health care personnel (nurses) had facilitated the contact with healers upon the user's request.

Everyday practices and spirituality: Qualitative studies from the period 1999-1980
Olsen and Eide (Olsen T and AK 1999) examined how the inhabitants in Tysfjord (a municipality in Nordland) handled illness and health. The material included 10 Sami people, and 10 health care service representatives from the municipality. They reported that both Norwegians and the Sami consulted traditional healers. Traditional healing was used complementary to the public health care service. However, the users seldom told the health personnel about their use of traditional healing. Accordingly the modality mobilise the social and religious resources among the inhabitants (Olsen T and AK 1999).
Mathisen (Mathisen SR 1986) analysed literary documents and interviewed healers and users in North Trøndelag, Troms, and Finnmark. In this material, healing was generally understood as a miracle exercised. According to Mathisen, conventional and traditional medicine were based on different values and principles. Conventional medicine is based on reasonable, scientific principles, whereas traditional medicine is a part of a cultural system, including irrationality and superstition. Mathisen referred to many great healers in Norway. However, the Sami and Kven healers possess extra strong healing powers (Mathisen SR 1986).

TM and CAM: Quantitative studies from present to 2000
In the SAMINOR I survey, Kristoffersen et al. (Kristoffersen AE, Sirois FM et al. 2017) analysed data from 16,544 respondents. They found that 13.8% had used traditional medicine at one time. The use was associated with Laestadianism (34.3%), living in Inner Finnmark (31.1%) and Sami ethnicity (25.7%).
The National Research Center in Complementary and Alternative Medicine (NAFKAM), investigated the use of CAM among the Norwegian population in 2012 (Alraek T, Borud E et al. 2011). In a telephone survey, including 1,002 people, fourth-five percent had used CAM

during the last 12 months. Of these, 36.6% had consulted a CAM provider and almost 4 % reported to have consulted a healer[9] for their health complaints.

NAFKAM repeated the study in 2016, and reported that the number of participants who had consulted a healer[10] for their health complaints had decreased to 1.1% (Salamonsen 2016).The researchers found that 24% had consulted a CAM provider during the past twelve months. Healing was among the nine most commonly used CAM modalities. Fifty-eight percent reported that their health complaints were ameliorated after the healing sessions. Even though the term *CAM provider* was not defined in this study, the most commonly used CAM providers in Norway are massage therapists, acupuncturists, reflexologists, spiritual healers, and homeopaths. Steinsbekk (Steinsbekk, Adams et al. 2010), reported that most people who used CAM did so on the recommendation by friends and acquaintances.

Bakken and colleagues (Bakken K, Melhus M et al. 2006) investigated the use of medication for insomnia and the use of healers among people in areas with Sami and Norwegian settlements in the SAMINOR 1 survey. They found that, at one time or another, 16.7% had consulted a healer. There was a more frequent use among people with Sami affiliation. Thirty-two percent of the participants with Sami affiliation consulted healers in contrast to 21.8% of those with a weaker affiliation or non-Sami (11.8%).

In the HUNT study (1997-2008), Steinsbekk (Steinsbekk A, Rise MB et al. 2011) reported that 9.4% of the adult population had consulted a CAM provider over the past 12 months. The *laying on of hands* modality was included among the CAM modalities in this study. In 2008, the number of participants who had consulted a CAM provider had increased to 12.6%.

Sexton and Sørlie (Sexton R and Sørlie T 2009) investigated the patients´ attitudes towards integration of traditional healing in their health care. Eighty-one percent of the Sami participants were positive to an integration compared to 37% of the Norwegian participants. Forty-eight percent of the Sami participants used traditional healing, in contrast to 31% of the Norwegians. These research documented that psychiatric patients applied healing for their health complaints, but under-communicated this use to the health personnel (Sørlie T and Nergård JI 2005, Sexton R and Sørlie T 2008).

In 2008, Sexton and Sørlie (Sexton R and Sørlie T 2008) investigated the use of traditional healing among psychiatric patients (n= 186) in North Troms and Finnmark. In accordance with Sørlie and Nergård, they found that the Sami patients applied traditional healing more

[9] The term healer was not defined. This could indicate use of both a traditional healer and a CAM healer.
[10] The term healer was not defined. This could indicate use of both a traditional healer and a CAM healer.

frequently and had greater faith in religion and spirituality in contrast to the Norwegian patients.

Hanssen et al (Hanssen B, Grimsgaard S et al. 2005) investigated the use of CAM in Scandinavia in 2005. They found that one third of the Norwegian participants had applied some CAM modalities during the past twelve months. The CAM modalities included in this study were acupuncture, chiropractic, homeopathy, massage, spiritual healing and reflexology (Hanssen B, Grimsgaard S et al. 2005).

During 2000-2002, Sørlie and Nergård (Sørlie T and Nergård JI 2005) conducted a study among 68 psychiatric patients at the emergency ward at the University Hospital of North Norway (UNN), and asked them about use of traditional healing. They found that 64% of the Sami patients applied traditional healing, whereas 38% of the Norwegian patients used such healers.

From folk medicine to CAM: Quantitative studies- from the period 1999-1970

The health survey from 1995 (Statistics Norway 1995) found that 16,000 people had consulted a healer during the last 12 months. More females than males sought help from a CAM provider. The concept of traditional healer was not included in the study. However, healers were defined as natural healers, naturopaths, and other providers.

Gjemdal (Gjemdal T 1979) conducted a study in 1978 and reported that 16 out of 100 patients who were hospitalised in the internal medicine ward at the hospital of Fredrikstad, had consulted paramedical personnel. One of the patients had consulted a provider with electric hands. Gjerdal argued that seriously ill people may often be irrational and seek help from alternative providers and continue to use traditional medicine.

In 1975 Efskind & Johansen (Efskind L and Johansen AT 1976) conducted a survey among people in Alta, Finnmark. One-hundred and fifty participants were asked about their relationship to folk medicine such as the laying on of hands, prayer and blood stemming. Fifty-five present reported that they believed in spiritual healing such as laying on of hands and the healing by prayers.

In 1977 Bruusgaard and Efskind (Bruusgaard D and Efskind L 1977) conducted a follow-up study. In a national survey, they examined the attitudes to and the use of folk medicine such as herbs, homeopathy, religious and spiritual healing. Forty-three present stated that they believed in spiritual healing and people who possessed special gifts. In addition, 33% believed in religious healing. The study revealed a higher number of participants who

believed in people with special gifts and religious healing in Northern Norway (63%) in contrast to the rest of the country (41%). Consequently, the researchers argued that folk medicine is not a typical phenomenon of Northern Norway.

The outpatient clinic for mental health care in Northern Troms

The participants in the study were patients at a conventional outpatient clinic for mental health in Northern Troms, "Senter for psykisk helse Nord Troms" (hereafter referred to as the clinic). The clinic, which is part of the General Division for Psychiatry at the University Hospital of North Norway in Tromsø, was officially opened in September 2006. Prior to this, starting from 1986, patients received treatment at an outpatient mental health care clinic located in the basement of Sonjatun, a community centre for general health in Storslett. Today, the clinic provides treatment for between 400 to 500 patients annually, and the majority of these patients are from Nordreisa. The clinic`s stated aim (University Hospital of North Norway 2017) is to enable people living with mental illness to live a life of participation in the community, experiencing independence and being able to master their everyday lives. The clinic offers a variety of treatments, and treatment of substance abuse and art therapy are integrated in the clinical treatment.

My interest in this field started as a project coordinator and researcher in the research project "Sensicam: Cultural, Self-Help and CAM Sensitive Psychiatric Treatment Approach - An Interventional Study", which was partly conducted at the outpatient clinic for mental health in Northern Troms. As an extension of this project, I developed the research project "Cultural Perspectives on Mental Health in Northern Troms" which this thesis is based on. This PhD study was supported by the Research Council of Norway under Grant No 190510.

Why this study?

Northern Troms has been subject to little research in general, and in mental health and the use of traditional medicine in particular. Research on related issues has mostly been from the Sami core areas of mid-Finnmark, and has been dominated by epidemiology and quantitative studies. The medical pluralism including the reservoir of local knowledge and compassion this region represents has, in my opinion, often been ignored to the benefit of a problem-orientated focus related to themes such as depopulation, the prevalence of unemployment, suicide rates and substance abuse compared to urban areas of Norway, as well as some episodes of ethnic tension. With this study I aim to address different meanings of wellbeing

which are rooted in cultural needs and highlight the strengths of these local communities` resources for the prevention of mental health problems and the maintenance of good mental health. Traditional medical practices seem to have striking resilience and have proven that they can survive despite cultural and historical disruptions, and the establishment of conventional health care in the region. Gathering knowledge of the practices and more importantly, the people using them, is therefore necessary in efforts to enhance mental health care. Moreover, there have been limited contributions of anthropology to narratives of health and healing from this region. The study thus seeks to explore mental health through social and medical anthropological approaches.

Aims and primary objectives

The overall aim of this study is to explore how mental health care is mediated in this specific North Norwegian context, and to provide more insight into aspects of mental health and patients` use of traditional medicine, in order to improve mental health care in the region.

The primary objectives of this study are:

- To explore mental health care patients´ experiences with traditional healing, conventional mental health care and CAM modalities.
- To examine whether the cultural context influences the choice of mental health care, and if so, how.
- To gather knowledge relevant to develop patient-centred and culturally sensitive/culturally safe mental health care in Northern Norway.
- To explore and discuss methodological issues related to an under-explored and complex cultural health practice and context.

Outline of the thesis

In addition to the introductory chapter, this thesis is organised into four chapters. In Chapter 2, the material and the methods are presented. Chapter 3 presents the three articles that form the core of the dissertation. Chapter 4 contains the discussion and closing remarks. Due to the nature of this study, I have chosen to emphasise the methodological reflections that have emerged in the course of this research project. I also suggest some possible implications for practice and further research.

Material and methods

Material

This thesis is based on ethnographic fieldwork conducted over a period of 18 months in Northern Troms. The fieldwork was mainly performed in the municipality of Nordreisa but partly also in the neighbouring municipalities of Kåfjord, Kvænangen and Skjervøy. The study included a total of 61 participants, including 12 (7 women and 5 men) who used the clinic. The remaining participants were conventional mental health therapists and administrative staff at the clinic, *readers* and CAM providers in the region, in addition to people in the local communities whom I spoke and interacted with in various settings.

The material consists of in-depth qualitative interviews and participant observation. In total, 36 semi-structured interviews were conducted. Each of these interviews lasted between approximately 90 and 180 minutes. Each of the 12 patients was interviewed using a thematic interview guide for our first meeting.

In addition to the semi-structured interviews, an unknown number of ethnographic interviews with the patients and other participants were performed continuously over the fieldwork period. Ethnographic interviews are typically flexible, making it convenient to conduct spontaneous interviews whenever the opportunity arises (Holliday A 2007). When interviewing the conventional mental health therapists, *readers* and CAM providers, I applied an open-ended and theme-based approach. These interviews were performed either at the clinic, over the telephone, at a CAM clinic, or in the participants' homes.

I was also present when some of the participants were in contact with *readers* over the telephone and on some occasions in the home of a *reader.* I engaged in relevant conversations with people in the local communities and also locals living outside of the region. I consider the head of the clinic to have been a key participant throughout the study; with her particular insights into the field both from "the native`s point of view" and also as someone with extensive experience of mental health care in the region, she provided important perspectives relevant to the study as a whole. She had the role of a cultural interpreter in terms of the tacit knowledge (Polanyi M 1966) incorporated in the places and people of Northern Troms.

I found the explorative, qualitative approach used in this study well suited to develop knowledge that could generate empirically and theoretically based hypotheses for further research (Gobo G 2008).

Participants and recruitment

The focus on the use of traditional medicine was reflected in the inclusion criteria used in the study. There were no inclusion criteria with regard to age, gender or ethnicity. In terms of ethnicity, by contrast, it was important, in order to follow up the core themes of the study, not to construct narrow Sami or Kven categories but to approach the field broadly in order to grasp the diversity in the various cultural aspects. None of the 12 patients clearly reported Sami or Kven ethnicity but nine of them told of the feeling of being part of a culturally diverse context and considered themselves as part of a mix, but mostly as Norwegians (Kiil MA 2015). Furthermore, the participants were sampled on the basis of their interest in participating in the study and not by any specific diagnostic criteria. Regardless of this, all participants had been diagnosed with anxiety and/or depression disorders. Participants with severe mental illness were not included in the study, but two of the participants had a history of more severe mental illness than their current situation suggested. A linguistic interpreter was not used during the fieldwork; this was not necessary as all participants spoke Norwegian as their mother tongue[11].

The participants were recruited in collaboration with a coordinator from the administrative staff at the clinic. The coordinator presented the study to them, and afterwards I arranged a time and place for my first meeting with them.

From the early days of the study, I had an open dialogue with the head of the clinic as to what types of questions could be asked, in terms of appropriateness related to cultural codes and local experiences. The clinic preferred the recruitment of participants to be as informal and personal as possible, and clearly stated the need to demonstrate cultural sensitivity when recruiting participants. Several of the participants had previously taken part in a quantitative study (Kiil MA, Sexton R et al. 2010) on self-help strategies, including the use of traditional medicine (Sexton R and Sørlie T 2008) and expressed challenges with the questionnaire used in that study. In their feedback they stated a preference for an interview situation, and thus

[11] The term mother tongue was something of a paradox, as two of the participants in the course of the fieldwork discovered that their "mother tongue" was supposed to be Sami, despite having been raised by Norwegian-speaking parents; this is an example of how forced assimilation has influenced this area.

confirmed the information from the clinic about a dialogical approach being more appropriate in this context. The participants in this study requested that, when possible, our meetings should take place in their homes or elsewhere outside of the clinic. Due to a number of practical factors, I met all of the 12 patients at the clinic for the first time, and afterwards we met in their homes. In addition to the clinic and the participants` homes, we met and interacted on several other settings such as the local café and bistro, a small shopping centre at Storslett, during visits to their extended families and friends, and when they were consulting *readers* and CAM providers.

Interviews

In the semi-structured interviews, the participants were invited to tell how they as patients in this particular cultural context understood and managed their mental illness, and how they related to the clinic and to the *readers* they were using. How they related to CAM modalities was also a topic.

The thematic interview guide consisted of a broad and open introductory question, followed by several bullet points that suggested themes for the interviews. The interviews would begin with me inviting the participant to speak about her/his illness and life in the manner she/he found best. My main intention was to avoid an alienating and academic approach, and I wanted to let the participants speak as freely as possible and therefore attempted not to interrupt their stories unnecessarily (Holstein JA and Gubrium JF 2004). How they chose to tell their stories, however, varied in several ways, some would e.g. jump from major life events to more trivial stories unchronologically, while others only focused on the life events which were directly linked to their illness. Interestingly, while at the clinic most participants would illuminate their illness story and tell it in a linear and chronological manner, but focus more strongly on their life story when at home; here, the narrative would be more circular and unchronological, as explained above. As the interviews with conventional mental health therapists, *readers* and CAM providers were usually performed ad hoc, there was no specific interview guide to use, but instead an open-ended thematic approach which aimed to reflect the patient`s experiences.

Prior to starting the tape-recorder, I noted basic data such as gender, age, marital status, place of birth, self-perceived ethnic identity, whether they were Laestadian or came from a Laestadian family background, and their given diagnosis. A tape-recorder was used whenever the participant felt comfortable with it and the setting allowed it. In total, 958 pages were

recorded and transcribed verbatim by me. Regardless of the use of a tape-recorder, I made (reflexive) notes, resulting in four books of hand-written notes containing 200 pages each. These reflexive notes were taken throughout the fieldwork, and always after interviews, also in connection with ethnographic interviews, different observations and interactions. I also noted my reflections regarding various contextual matters, like ongoing debates in the local and the regional newspaper.

"The miraculous kitchen" as a setting for doing sensory ethnography

Sutton (Sutton D 2001), Pink (Pink S 2009) and Harris (Harris A and Guillemin M 2011) all promote a sensory ethnography where objects such as food, photographs, music, and clothing in the participants' homes can evoke memories, experiences and stories on different levels. Doing sensory ethnography was a key element of the study as a whole, as objects and also people served as background material in the many and varied settings we interacted in, particularly in regard to "the kitchen", and sometimes made a significant difference to our interaction and to how stories were told by the participants. The sensory aspect was thus a common thread throughout the fieldwork, and also made me more aware of reflecting upon questions like: Who was I, and how did my presence affect the participants? How did the different types of rooms we were in create possibilities and space for the participants` stories to be told? Were other things happening during the interviews which could interfere with and make a difference to their stories? Were family members, pets or others surrounding the interviews, and how could they influence the setting? How did my presence as a researcher influence the setting?

Most of the interactions, and also the interviews, took place in the participant`s kitchen, where we sat and sometimes stood, while making and drinking coffee was a vital part of our conversations and interactions. As Pink (Pink S 2009) notes, even if little analytical attention has been paid to the universal human practice of sitting, it is a sensory embodied practice for both the interviewer and interviewee just like eating and walking are.
Not only did the kitchen reveal itself as a stage for many of the stories, it appeared to be a comfortable arena for "doing the telling", a safe haven for both people and stories. I pictured the kitchen as a receiver, both in the sense of receiving stories but also receiving the one telling. With reference to the overall theme of home, there was a type of homeliness present in these situations. The making and drinking of coffee was also an important aspect of the kitchen stories. In general, it would be fair to say that people in this region have a widespread

coffee culture in terms of consumption. Coffee seemed to make stories happen, and without coffee, the narrative may not have been possible. These kitchen encounters were in many ways a manifestation of everyday life and traditions in Northern Norway, they often reminded me of my own childhood and made me emotional at times, a fact I did not hide from the participants. I believe that these "kitchen encounters" represented a window to everyday practices that might be disappearing with the older generation. Several of the participants referred to childhood memories of sitting under the kitchen table while listening to the grown-ups telling stories. They would characterise these stories as both Sami and Norwegian stories: stories of everyday life, but also myths and wondrous tales (Nergård JI 2005). Some were stories of noaidis like Johan Kaaven[12], shamans from the past, and *readers* of today. When people were letting me in on some of these stories, the tales would sometimes challenge my (scientific) reasoning, my sense of reality, but regardless of how I understood the stories, I understood their importance, their mission and how these stories, in particular the re-telling of them, have shaped Northern Troms, also as a narrative landscape.

Positions in the field

Doing anthropology "at home"

The administrative centre Storslett in Nordreisa, as mentioned, is a relatively small place and my presence at both the clinic and in the local community did not go unnoticed. Although I did not sense a particular need to be approved by the community, I learned through the various encounters at the clinic and in other settings that there existed a core community value in Nordreisa, namely "to vouch for someone". In short, this implied that others needed to assure the participants that I was a trustworthy and reliable person, and I had to be approved before entering certain arenas. These "others" were in this case primarily the coordinator and head of the clinic, but also local people I got to know along the way, such as people who knew someone I knew from Nordreisa. The participants would typically start our conversation by asking questions which could place my background, particularly whether I had relatives in the area. They would be curious about my surname, which is quite rare in Norway but known in some areas of Northern Troms, even though I do not have any relatives from the region, and my name was therefore something of a door-opener in the field. By talking about my name, I would also tell about my family history and reveal personal

[12] Johan Kaaven (1835-1918), famous traditional healer, also known as the man who stopped the Coastal Steamer.

information that enabled the participants to establish a relationship of trust with me (Järvinen M 2005). Originally coming from the central and inner part of Troms made me somewhat local and familiar, despite significant differences between the two regions. One the one hand, it was fieldwork at home, on the other hand (and metaphorically speaking), it was far from home. Even though the geographical distance was close, the cultural and religious landscape differed vastly. Even so, one could say I had both an insider and outsider position in the field, and in my experience this was an advantage as many seemed to understand me as someone who could understand them. I appeared to be a "harmless" researcher because I did not have family in the region. I was not aware of conflicts between families and neighbours, and presumed not have a hidden agenda or an interest in passing on sensitive information. Even though anthropology traditionally has focused on foreign cultures, there has been increasing acceptance of what Frøystad and Madden (Frøystad HK 2003, Madden R 2013) refers to as "interior anthropology". However, the idea of doing anthropology "at home" has been subject to debate. Howell (Howell SL 2001) claims that fieldwork performed in one`s own culture runs the risk of compromising methodological ideals in anthropology. As the anthropological tool is specially designed for studying "the other" or "strangers", it can lose some of its potential when studying one`s own culture and one may experience "home-blindness". My previous fieldwork experience was from West Africa, and I did consciously attempt to employ similar strategies in order to explore this field as equally "foreign".

Reciprocity in the field

> I see a woman carrying a suitcase. A stranger. She is walking upwards the hill, towards our house. Her hair is all silvery grey, she is short and tubby. I have never seen that woman before. She enters the house and hangs up her coat, the suitcase rests heavy on the floor. She hugs me. Hard. Long. Then I remember. It is my mother. She is home.

As with most ethnographic fieldwork, the study had a reciprocal element. To make the participants comfortable to speak freely about sensitive matters, I found it necessary to make a personal contribution in my encounters with them, more so than merely listening (Hendry J 1993). By acknowledging an open-mindedness to themes we discussed, and through sharing parts of my own life story, the boundary between research and more common social interaction became less visible. I came to realise that there were events in my story which

linked me to the project thematically, like my grandmother whose story is presented above. My grandmother suffered from severe depression, and from the information I have, I believe she was bipolar. She was eventually admitted to a psychiatric hospital outside Bodø where she stayed for two years and received electroconvulsive therapy. The story as stated, which is my mother`s childhood memory, tells of her homecoming after two years of hospitalisation. I use this as an example, as sharing this type of information with the participants, along with similar stories which I was not necessarily aware of when commencing the project, was an example of how I marked my position in the field (Johanson A 1981, Smith LT 1999).

This connectedness between the participants and myself implied a great responsibility to protect the participants and their stories. Moreover, I chose a reciprocal attitude in the encounters with the participants, which included a constant bearing in mind "what was in it for them" to participate, which was one of the reasons of why I chose to share my own stories. My ideal was to achieve a conscious reflection of how I could contribute to their participation by making a difference to them in their everyday life of managing mental distress.

Further, telling the participants about my discovery of the existence of the use of traditional medicine within my own family history and personal experiences related to spirituality were aspects of how I placed myself in the landscape (Johanson A 1981, Smith LT 1999). To allow oneself to be introspective and demonstrate empathy is in my opinion one of the most distinct strengths of using qualitative methods. The participants would occasionally mention things that would trigger my curiosity to explore my own unknown past, and by sharing this with them, it also opened up for new perspectives or layers in their own stories.
I also used other sources of inspiration and knowledge to grasp the field, such as newspapers, documentaries and fiction on the topics of interest, in order to provide a broader context for the results. However, while such tools are useful additions, intensive participation in the different settings in the community, including drinking coffee, sharing meals, going fishing or visiting different types of healers, was the real heart of the anthropological encounter in this study, or as put by Okely and Callaway (Okely J and Callaway H 1992), it is the everyday activities that make a difference in comprehending people`s lives and attitudes.

Analysis

As a researcher in general, and an anthropologist in particular, it is necessary to pay significant attention to the role one has in the production of data and how representations of lived experience are manifested in the textual material. The process of analysis when dealing with large and multi-layered material of this kind is an ongoing process throughout the fieldwork, and it is therefore crucial to show one's workings (Holliday A 2007) in all stages of the project. The analytical process is thus present right from the first thoughts leading to the becoming of the project until the final evaluation report (Kvale S 1996). When planning the study, I set out with a broad theme of interests: the experiences of patients in this context positioned between traditional medicine and conventional mental health care, also keeping the use of CAM modalities in mind. The interviews were recorded, transcribed, and anonymised. The interview transcripts were analysed using thematic content analysis, as a systematic classification process of coding and identifying different themes or patterns (Hsieh HF and Shannon SE 2005). I coded directly from the text data and used the phrases and words of the participants. (Pope C and Mays N 1995). In addition, this method classifies and develops categories, enabling coding to take place (Hsieh HF and Shannon SE 2005). In this study, some codes were predefined and others were defined during the analysis (Kvale S, Brinkmann S et al. 2009) They were grouped according to the questions in the interview guide. The interviews, as well as the reflexive field notes, were intensively read as a whole to gain a general understanding of different aspects of the material with relevance to the primary objectives of the study. With respect to the analysis of the interviews, my approach was of an inductive character, and I based the analysis on patterns in the participants` descriptions of, and reflections on, their experiences. The findings have thus been analysed as the project progressed, and suitable theoretical perspectives have been added.

Groups with overlapping information were merged into five main themes; these were renamed according to key information in the text (Malterud K 2011). The quotations were printed in Norwegian before being translated into English. Themes which emerged from the overall analysis in the discussion in thesis were: Home; Home as narrative identity; Trust as embodied; Trust as a scarce resource: Trust as hope; Trust as uncertainty and risk; Trust and worldview; Trust and hybridity.

Ethics

Recommendations and registrations

All participants in the study have been given pseudonyms. Relevant events, places and other personally identifiable factors mentioned have been altered to ensure the participants' anonymity. The descriptions and quotes used in the thesis have also been read and approved by all participants mentioned. The study received approval and was recommended by the Regional Ethics Committee for Northern Norway (REK Nord) (Appendix 1) and registered with the Personal Protection Commission for Research and the Norwegian Social Science Data Services (NSD) in 2011 (Appendix 2, which confirms deletion of transcribed data in 2014). The study was conducted according to the rules of the Helsinki Declaration (The World Medical Association (WMA) 2013).

Procedures and consent

The participants received letters of invitation including ethical information and information about the aim of the study and the research procedures (Appendix 3). The patients then provided their written consent to participate (Appendix 3).

The clinic did not know exactly which patients participated in the study. I was given a list of names of patients who were willing to participate, and then contacted them directly. Some of the patients may have told their therapist at the clinic about their participation in the study, in particular those that I met at the clinic, as the interviews would typically take place prior to their consultation.

Voluntary participation as well as their option of withdrawal at any time was emphasised both before and during the study. No participants withdrew from the study. Regarding the participation of the conventional therapists, the CAM provider and the traditional healers that were interviewed, information about the study was given orally by me, and the participants also gave oral consent.

Ethical considerations

Regardless of the methods applied in such a study, there is always a potential risk of being understood as positioned exclusively in the role of a researcher, and in this context also as a representative for what is considered to be "Norwegian". To cross this implicit boundary, it was crucial to develop a relationship of trust between the participants and me, and through this approach obtain the necessary and relevant data (Järvinen M 2005).

Research encounters that move into the sphere of mental health are by nature sensitive, and the participants can be perceived as being in a particularly vulnerable position (McIllfatrick S, Sullivan K et al. 2006). As a researcher, one needs to be prepared for the different emotional reactions that the interviews can evoke and reflect upon how such reactions should be met. I also needed to reflect upon myself as a socially positioned person, and that I, with my own cultural background and set of values, participate and directly or indirectly influence how the participants respond, and can potentially impact their lives. However, it was important that their diagnosis did not become an obstacle to important discoveries. Consequently, the interviews were conducted with sensitivity to the needs and abilities of each of the participants (Rose K 1994). I understand reflexivity as "bouncing back" rather than merely reflecting, and there has been an overall aim to highlight my position *in* the field, as well as my preconceptions *of* the field in the text, to enable the reader to relate to the different (levels of) stories presented. The relational aspect of the research process did not go from one point to another; it was rather, as Ellis (Ellis C 2007) puts it, being in "a constant dialogue and interaction". Towards the end of the fieldwork, I contacted all the participants with an invitation to elaborate on how they had experienced taking part in this research project. All participants expressed that it had been rewarding for them to participate. Most participants also mentioned this during the fieldwork. The participants believed that their participation had made a difference to their own healing process. They also expressed gratitude because their contribution to the study could highlight relevant issues regarding mental health in the region, and thus improve mental health care both locally and globally.

The therapeutic and friendly researcher

As the fieldwork progressed, the relationship to some of the participants took on a form of what can be considered as a type of friendship, more than a typical researcher-participant relationship. This was undoubtedly an advantage for me as it made the setting more informal, but one could naturally question whether this situation was appropriate in ethical terms. Could it be that some participants have been misled by their somewhat personal relation to me (Hendry J 1993), or is this just proof that the status of a fieldworker is somewhat interwoven with other statuses? In any case, I found the relationships with the participants to be characterised by intimacy more than friendship, and a sharing of moments rather than nurturing a friendship. On some occasions I found that the conversations between the participants and myself were of a more therapeutic nature; two of the participants reached a point where they asked if I would be their therapist instead of their regular therapist at the

clinic. I believe that revealing untold stories could connect the participants to me on a therapeutic level, yet I also believe I was clear and straightforward about my role in the study.

The compassionate researcher

At times, when listening to stories of trauma and suffering, I would feel empty and at a loss for words to express my emotions or at least my sympathy with the participant. It was sometimes challenging for me to listen to some of the painful memories told, and merely act as a passive spectator. Several times I experienced immense sadness and felt like crying, sometimes I even did have tears in my eyes. On two occasions, I had to fetch tissue paper for the participant and myself, as we were both in tears. Under these circumstances I often found silence to be the most proper way to show my sympathy with the participants, or as Jackson (Jackson M 2004) expresses it:

"For there are certain events and experiences of which we choose not to speak. Not because they hold us in thrall, freezing the tongue. Nor because we fear they might reveal our flaws or frailty. Still less because we feel our words can never do them justice. Silence is sometimes the only way we can honour the ineffability and privacy of certain experiences".

By allowing myself to empathise and include my emotions, I sought to implement a search for a reflexive and self-critical approach to my own work, and in this way aimed for an anthropology that was not "shamans of objectivity" (Ruby J 1980).

Findings

Article 1: In between coffee and God: Mental health and emotional landscapes in Northern Norway

The main purpose of this article is an attempt to grasp conceptualisations of culture and emotion in Northern Troms, as understandings of mental health in this region.

Jacob`s story introduces us to the concept of *nerves*. In the study, *nerves* were connected to psychological or psychiatric problems, privacy, and stigma, and had the capacity to communicate a continuum from normal emotional problems to severe mental illness. For Jacob, as for the other elderly participants in the study, *nerves* are closely connected to their experiences from the assimilation process and the expulsion from their homes during World War II. The continuous concealment surrounding these events plays a key role and creates a type of local trauma but also insights for the people in Northern Troms; through *nerves*, identities are being negotiated.

The participants` stories give an understanding of *nerves* as an embodied idiom of distress and demonstrate the importance of including patients' collective experiences of local trauma with individual needs in mental health care. Jacob, as well as the other participants, would tell of clinical representations which did not include the popular understanding and experience of *nerves*; on the contrary, the participants experienced risk and uncertainty related to diagnosis and consequently medicalisation. When embodied poor mental health is to be dealt with in conventional mental health care, treatment and clinicians must account for life stories and contextualised experiences such as those described by Jacob.

Jacob`s story shows that nerves can be an open and harmless category, and therefore accessible and usable for people, and that nerves is a concept which manifests an *in-between* condition between health and illness.

It is crucial to understand and raise awareness of the package of experiences presented and hidden in the clinical encounter. In between the life world of Jacob, his experiences with traditional healers, spirituality and everyday life, lies the story of how people in Northern Troms negotiate their lives and identities in between past and present, and how their stories reveal local trauma.

Note: In this article (book chapter), methodological aspects have been integrated in the empirical presentation, as the editors of "Culture as a Patient. Unusual Encounters for Usual People" stated this as a preference.

Article 2*:* What is at stake in the clinical encounter? *Mental health care and belonging in a local community in Northern Norway*

Based on the stories and statements from patients visiting a conventional mental health clinic in a mixed ethnic area in Northern Norway, we identified a strategy of being careful about what information to share with the therapists at the clinic. In this article, we investigate what is at stake in the patients` encounters at the clinic, and what makes this carefulness a reasonable strategy for them. We will discuss this by comparing the participants' stories of experiences within conventional medicine with their experiences from their use of traditional medicine, as these alternatives were frequently compared by the participants.

Ethnographic fieldwork were performed among the 61 participants. Special emphasis was placed on data from 12 patients visiting a mental health clinic in Nordreisa, Northern Norway, which included repeated in-depth semi-structured interviews. The data were transcribed verbatim and the analysis of the material was conducted according to thematic content analysis. Some codes were predefined and others were defined during the analysis.

Visiting the conventional mental health care clinic, the participants experienced that their local worldview and ways of handling social relations, death and illness in everyday life could be misunderstood by the therapists. They emphasized the difference between being diagnosed and being understood. The participants understood their health problems as part of life itself, and seeking help from *readers* and traditional medicine was a way of "managing on one's own".

The participants in this study experienced a need to protect themselves by being selective in sharing health information with conventional health care therapists, as this information could be misunderstood and used against them, leading to the wrong diagnosis and treatment. *Readers*, on the other hand, stood for respect and understanding in terms of individual health complaints, the local culture and the community. Thus, it is important for conventional mental health therapists to increase their knowledge and understanding of patients' lives, cosmology/ontology and how their illness is experienced individually in their particular life context.

Article 3: Angels and charlatans: Contrasts and tensions between different medical systems in a North Norwegian community

The region of Northern Troms, Norway, is characterised by a multi-ethnicity of Norwegians, Sami and Kvens. This ethnic and cultural mix has historically been challenged, particularly with the forced assimilation policies of the Norwegian government. Hence, the background of this region is complex and creates a particular therapeutic landscape. In addition to conventional medicine, traditional medicine and complementary and alternative medicine are commonly used among the population in this area.

The aim of the study was to explore how patients related to different medical systems in this region, particularly related to the evaluation and navigation between traditional medicine (in particular *reading*) and complementary and alternative medicine.

This 18-month ethnographic study was based on fieldwork among 61 participants. However, the main source of information for this study was collected from a sub-sample of 12 patients from an outpatient mental health clinic in Northern Troms. The information was retrieved from 36 semi-structured interviews with these participants. The conversations and ethnographic interviews with the other 49 participants also had considerable impact on the data analysis.

The study findings demonstrate that the participants were quite capable of dual use of distinct medical subsystems, either simultaneously or sequentially. *Reading* made a significant contribution to their management of everyday life and mental distress because it was easily accessible within the community and represented a form of empathic care that had long been familiar in the area and used across social relationships. Principles of availability, familiarity, compassion and empathic care in traditional medicine can be experienced as incompatible with values attached to complementary and alternative practices, particularly regarding the degree of familiarity, empathic care and the use of payment within this medical system.

The participants in this study actively adapted their holistic health care to meet medical, cultural and spiritual needs. The widespread use of traditional medicine created a local system for evaluating the use of modalities in complementary and alternative medicine. It is, however, important to note that most encounters took place in between these spheres and that

the use of traditional medicine also seemed to make participants more open towards the use of complementary and alternative medicine.

Discussion

In this final chapter, I will draw parallels and bring together themes from the thesis and articles. The theoretical and methodological framework for this study attempts to unite aspects of mental health with social and medical anthropology. With an ambiguous historical and cultural context as a backdrop, perceptions of **home** and **trust** and how they shape the human experience, also in the clinical encounter, are central. In the following, I provide an account of anthropological approaches and ontological and epistemological positions relevant to understand the participants` use of TM, conventional mental health treatment, and also CAM modalities, as medical but also cultural systems. Finally, I present some methodological reflections based on experiences and challenges of doing fieldwork in the contemporary world and "at home".

Home

Home is an overall theoretical and methodological theme for the study. It ranges from the more basic and obvious connections in the participants` houses, such as their kitchen table and homely objects, to the more abstract perspectives of home as dynamics of belonging, such as trust and worldview, which I will discuss later. In the three articles (for example in Jacob's making coffee in Article 1), home is implicit but also played out, portrayed and discussed as ambiguous, with reference to the specific therapeutic and emotional landscape of Northern Troms (Miller BH 2015).

I find "home" a useful analytical concept because it refers to those fluid spaces "*where one best knows oneself*" (Rapport N and Dawson A 1998), and thereby constitutes a platform to explore and understand belonging and identity. The search for belonging involves movement, in body and mind, *within* and *between* spaces and traditions[13] that are identified as home. As such, I see home as a space of social relationships and of identification. In both these conceptual terrains, home is not stripped of its social context. Rather, it evokes images and

[13] I understand the term tradition not as a description of a static state of being that has been lost, but rather in the sense of Asad T (2003). Formations of the Secular: Christianity, Islam and Modernity. Stanford, CA Stanford University Press. .He argues for: "*a body of knowledge and a tradition of interpretation and debate about that knowledge, which references its own past, which is both continuing and therefore continuous, without being static".*

imaginings of Northern Troms as a homeland, drawing ethnic collectivities within spaces of common religious and cultural backgrounds.

The stories of home presented in this thesis express place and traditions as the locus of belongingness and stability - particularly in an era of movement - and thus encapsulate TM as a type of local care which makes a significant difference to people in this context. An example is Elsa in Article 2 who is comforted and "stabilised" by her *reader* after a sad event concerning her daughter. Moreover, the individual stories are framed by both personal experiences as well as social and political discourses (Keddell E 2009), where part of the construction of home is also post-colonial, showing how this affects mental health and wellbeing. This collective "state of mind" requires sensitivity to the needs of individuals whose cultural identities are fluid or ambiguous as a consequence of colonisation and forced assimilation (Bjørklund I 2000). Paying attention to stories, both from a mere narrative point of view but also in the clinical encounter, is thus crucial in contexts like Northern Troms. What emerges from these stories is not only a sense of belonging for the narrator to her/his own story and to the story of Northern Troms, but also a reminder to clinicians of how stories can be expressions of the embodiment of inequity often found in indigenous and transcultural contexts (Adelson N 2005).
An important empirical pattern related to "home" in this context is the connection to traumatic historical events (Johansen E 2012). These events may have created a *local trauma*, as expressed in Article 1 by Jacob, who revealed layers of stories connected to the master narrative (Mattingly C and Garro CG 2000) of Northern Troms. This is the regional history of forced assimilation of the Sami and Kven population by the Norwegian authorities, World War 2 with the extensive burning of houses and landscape followed by a forced evacuation to the south of Norway. Traumatic and painful accounts, as Antze and Lambek (Antze P and Lambek M 1996) note, are not necessarily mere "medical words for physical wounds". Peoples` accounts can also be understood as different ways of remembering traumatic experiences that are shaped by personal and cultural forces (Douglas M 2013). "Narratives of trauma may be understood then as cultural constructions of personal and historical memory" (Kirmayer LJ 1996).

Through the personal accounts of belonging in this thesis, home can be conceived as the untold story of lives being lived. Home simultaneously includes resistance, a surrender to home, a

powerlessness of home, peoples` cultural repertoires, and how home is manifested in the body**.** Perhaps a sense of homelessness derives, paradoxically, from a reaction against movement, a refusal of the fluid boundaries which are the essence of Northern Troms, and yet, it could be as Mahfouz (Byrne A 2015) puts it:

Home is not where you are born. Home is where all your attempts to escape cease.

Home as narrative identity

The phenomenological question which anchors this study is what lived experience consists of in the context of Northern Troms, and how this influences mental health and the use of *reading*. In his pursuit to conceptualise health, Gadamer (Gadamer HG 1993) believes that good health is equivalent to being at home in the world. As human beings we are constantly relating to our life world; we have a belonging to our specific world, we know the context and we seek to master it, and we can apply the necessary tools available within our world. Similarly to how TM can represent tools corresponding with Gadamer`s position, stories as a natural part of everyday life also constitute such tools to express and negotiate experience, as in the example of Jacob, whose story had previously not been told. This can suggest narrative identity as much as cultural identity, or perhaps these are two sides of the same coin. Stories create a setting where one can explore opinions which people, individually or collectively, can ascribe as lived experience. Narratives, like ethnographic fieldwork itself, are not transparent transactions of truth; they reflect a dynamic interplay between life, experience and story (Madden R 2013). Placed in a broader socio-political and cultural context, stories can provide insights from contexts like Northern Troms that have ruptures or wounds from the history of forced assimilation (Johansen E 2012). In this way, local communities represent a collective story which is interwoven in the participants` individual stories and can give direction to how one attempts to re-establish identity and belonging during one's life course (Rapport N and Dawson A 1998)**.**

The articles have shown different aspects of how most people in Northern Troms are rooted in the use of TM, and thus have implemented complementary strategies for dealing with illness and crisis. Moreover, stories have the capacity to identify valuable experiences and contribute to the management and interpretation of mental distress (Beatty A 2014). An example is Brita (in the third article) who applies different treatment modalities in order to cope with life. The idea that stories can be an interpretative process of meaning related to

identity is not controversial. Within narrative research and theory, this connection to identity issues is essential (Andrews M, Squire C et al. 2013).

All kinds of stories can be understood as representations of self where the narrator portrays and promotes an identity (Clandinin JD and Connelly FM 2004). This close connection between narrative and identity has paved the way for the concept of narrative identity. The concept originates from Ricoeur (Rowe R and Calnan M 2006), who argues for an identity which can create a narrative context of heterogeneous elements and events in our lives. It is the narrative identity which seeks to find or create a context where the representation of self is at stake. When this does not succeed, the stories end up with ambivalence and despair. According to Rimmon- Kenan (Rimmon-Kenan S 2002)**,** context is constructed both by the stories we tell ourselves and others about ourselves, and by the master narratives that consciously or unconsciously serve as models in our lives. This underlines how both inner and outer stories along the cultural scripts affect us (Andrews M, Squire C et al. 2013). The different stories presented in the three articles can be understood as an attempt to find a context despite the heterogeneous elements which these stories also contain. Through the participants` stories, a picture of a narrative identity emerges (Ricoeur P 1991) A narrative identity which seeks to find meaning and direction, as shown in all of the participants` stories; like Jacob in Article 1 who for the first time tells about crucial events which has shaped his life. In the stories, the participants` illness plays a minor role and they come forward as much more than a mentally distressed person (Mattingly C and Garro CG 2000). What the stories seek is a continuity which tries to grasp major parts of life: from childhood and adolescence until the present. Through the stories we gain insights into what has been and still is essential in order to achieve a good quality of life, also while being ill (Frank AW 2013). The stories interplay between continuity and discontinuity and can be seen as a "double movement" (Frank AW 2013). On the one hand, the participants confirm themselves through their stories: "We are still here with our mental illness, but also with our story, our memories, our social relations and with our own voices". On the other hand, the stories imply a narrative relationship between the participants and the audience through what is told (Ellis C 2007). For instance, their stated fear of misdiagnosis may just as much be an expression of risking self- representation, and not being at home in their own stories (such as Birgit in Article 2 who was afraid of being perceived as psychotic).

Telling involves a creation of meaning throughout life, and what is important here is how this way of telling differs from the institutionalised cognitive and more structured, dialogical approach (Seikkula J 2011). To constantly keep in mind what can be talked about and what needs to be kept secret creates a very stressful and un-therapeutic setting (Mol A 2008). Adapting to the therapist's life world instead of enabling the therapist to adapt to the patient`s life world will without doubt provide poorer treatment (Mol A 2008). It is of vital importance to keep in mind the participants` stated wish for conventional mental health care as well as their use of traditional healing, and that this can be just as much a question of alliance with "culture" as alliance with the therapist (Mattingly C 2010). Regardless, a therapeutic alliance should be based on cultural premises and encourage self-help for the patients in question (Toombs SK 1987, Sørlie T and Nergård JI 2005). As a mental health patient, one must be able to tell freely, and re-explore as a telling person: in this way, the story can help to build a new and "healthier" life, a life more *at home* than the "ill" condition, and perhaps more importantly, a way to deal with the "in-between".

Narratives help us make sense of the world; they shape our historical and contemporary understanding of cultures and societies (Goffman E 1974, Clandinin JD and Connelly FM 2004). It is still that sense in which many people are at home in untold stories (Overing J 1998), here the stories we chose not to highlight. This is by no means the same as being homeless, like being without a moving account of one`s passage across boundaries and through life, but it is a recognition that, as an individual, mobile and private person, the idea of home can for many remain invisible (Rapport N and Dawson A 1998).
An underlying factor was also the need to demonstrate the importance of having a voice, being able to tell one's story, and somehow "do an act of memory" (Feuchtwang S 2010). This also became connected to the history of the process of forced assimilation, and stressed the importance of bearing witness, having a voice despite an insecure status in society due to illness or identity issues; in short, having access to words despite what some participants experienced as a type of alienation or homelessness (Bhabha HK 1994). Another factor is that forms of communication among Sami people are often characterised by silence when discussing health or illness (Bongo BA 2012), and even if the participants saw themselves more as mixed than as Sami, the context indicates relevance to this matter. As Brainard (Brainard J 2001) states, by their words, people remind the world about the most obvious: their own humanity. Perhaps the essence of it all is summed up by Marquez (Marquez GG

1970): *What matters in life is not what happens to you but what you remember and how you remember it".*

Taking such a perspective into account, personal experiences are not necessarily identical with historical personal events, as they actually happened. They are rather constructed experiences coloured by the social and cultural context one is part of (Richardson L 2003). This is also a position that applies to me as a researcher: the understandings and interpretations I have from my experiences today may differ greatly from other peoples` experiences, because we do not live within identical and corresponding social and cultural borders (Fabian J 2010). Consequently, belonging can be found in a type of post-colonial resistance as much as in merely understanding the participants' experiences as shaped by the local trauma and a sense of powerlessness (Overing J 1998). The continuity of traditional healing, and the secrecy and protection of practices surrounding *reading* can perhaps be seen both as an interwoven type of resistance and also as empowerment in relation to established models of interpreting mental health.

All three articles show that the use of TM should be understood as complementary to conventional mental health care, and also that it creates belonging through a sense of "being at home" for the participants in this study (Langås-Larsen A, Salamonsen A et al. 2018). Interestingly, even if most participants told of negative experiences of conventional mental health care, they still aimed for a successful relationship and an alliance with a conventional therapist. This paradox is perhaps the essence of the participants` lived experiences. Lived experience can be perceived as nostalgia, as it often refers to past events and what *has* shaped human life. I therefore find it important to implement Van Manen`s (Van Manen M 2014) perspective: *lived experience is life as we live it*. This perspective contains a more proactive attitude in regard to how people choose to deal with their lives. They are not merely passive pawns of destiny and history, but through their stories show that they are actively creating, shaping and reflecting upon issues which have an impact on their mental health and potential healing.

TM, and occasionally also CAM modalities, were representations of home for the participants in this study. Home did in fact also include a wish to belong to conventional mental health care. This showed that the various medical systems are accepted by the

participants on different levels and consequently fulfil different needs in their repertoire of health and healing (Penkala-Gawęcka and Rajtar 2016).

Trust as embodied

The concept of embodied trust has mostly been used in religious settings, understood as trusting Gods' will with one's physical body (Rowe R and Calnan M 2006), where the crossing of the Red Sea is a classic example. Kiil and Salamonsen (Rowe R and Calnan M 2006, Kiil MA and Salamonsen A 2013) argue for an understanding of "embodied trust" as the way Csordas outlines studies of embodiment: dealing with culture and experience insofar as these can be understood from the standpoint of bodily being-in-the world (Csordas T 1999). I argue that the use of *reading* in Nordreisa can be viewed as an embodied health practice, based on how the informal networks of care are operated, and moreover, how a profound trust in *readers* seems to be transferred across generations and within extended families, and ultimately evaluated by the community (Langås-Larsen A, Salamonsen A et al. 2018). The use of conventional mental health care, or, in Kleinman's term (Kleinman A 1980), the professional sector, can still be experienced as new and somewhat strange in this epistemological and historical context. For the more heterogeneous Norwegian group of patients, it is conventional mental health care which can be interpreted as an embodied health practice because Norwegians grow up learning that citizens who become ill are supposed to trust and receive health care within the conventional health care system (Bergh A and Bjørnskov C 2011). Studies show that most Norwegians do so, even though they trust the conventional health care system less than citizens in many other comparable countries (Holmboe O, Iversen HH et al. 2011). Thus, both the participants' use of *readers* and their use mental health care can be understood based on this approach to embodied trust of conventional.

Trust as hope

One can also ask if the way the participants deal with trust also includes the aspect of hope? *Hope,* Mattingly (Mattingly C 2010) argues, *most centrally involves the practice of creating, or trying to create, lives worth living even in the midst of suffering, even with no happy ending in sight.* Hope, as such, is not simply an emotional state, but a socially embedded practice which can make a difference when dealing with mental distress (Mattingly C 2010). When faced with difficulties, hope can generate use of the available tools the context offers, like for instance *reading*, as exemplified by Birgit who used reading for her severe mental health problems.

As the use of TM may represent an embodied health strategy, it has the potential to make mental illness more manageable and also to create order and continuity (Miller BH 2007). As I have argued, there may exist both a politically initiated and officially established trust as well as an embodied trust in the conventional mental health care system among Norwegian citizens. According to Kiil and Salamonsen (Kiil MA and Salamonsen A 2012), this "embodied system trust" is based on the roots and implementation of the Scandinavian welfare state in the everyday life of Norwegian citizens. This position also corresponds with Giddens' (Giddens A 1990) perspective on trust in what he refers to as systems of experts, as he claims that modernity rests upon the idea that we trust experts. With reference to the context of Northern Troms, we can see how this prerequisite for system trust clashes with the local history of forced assimilation, self-representation and other factors at stake in the clinical encounter, as I have discussed in the second article.

Trust as a scarce resource

Illness reaches deep into our lives, raising questions and interpretations that move beyond scientific explanations. Illness is related to how we live our lives, and how we look at existence and knowledge production (Antonovsky A 1987). In the articles, the participants` stories reveal an understanding of mental distress as an interwoven part of everyday life for many people in this region. As shown in for instance Jacob`s story in the first article, mental illness can appear like an "inescapable condition", both due to the historical context itself and the ongoing negotiations of identity in the community today (Johansen E 2012). Alliance and trust seem to be crucial factors in local mental health care, and are in constant play between participants and the different types of therapists they use.

As mentioned in all the articles, a general attitude in the stories of the participants is that one seeks a medical doctor to get diagnosed, and then sees the *reader* to get well. What is stated simply is in fact a complex and multifaceted matter that the analysis has identified as different aspects of trust. The relationship to, and the barriers to, trust are essential elements throughout the study. In the three articles, trust issues appear through a set of conceptions or local values consisting of advice such as being careful with the type of information one shares with conventional therapists, protecting ones` story, and concealing sentiments in the clinical encounter.

With respect to treatment providers, the participants often expressed that "trust must be earned", irrespective of the status of the treatment or the treatment provider's status as a conventional mental health therapist or CAM provider. This also seemed to include a need *to vouch for someone* in the community. As mentioned in the methods section, I also experienced being vouched for as a researcher in order to gain access to the participants' lives and settings in the community (Holliday A 2007). *Being vouched for* as an important value in the community was evident on several occasions. One example is from a day I was at the local bistro with one of the participants (patients). Agnes had told me about a CAM provider she was consulting, one that had recently established a practice in the community. A woman came by our table and said: "My neighbour told me you'd been to the new therapist, rumour has it she's good, what do you think? Is she worth trying? It`s for my insomnia, you know." The participant answered: "I think she's good, but I don`t know how good she is with insomnia, I went to see her mostly for my migraine…so I cannot vouch for her 100% but you could give her a try".

Regarding *readers*, this played out differently as their skills and trustworthiness were not based on a first meeting, as would happen at the clinic, but rather through a longstanding introduction by family members or others in the community who had already validated them over time. When dealing with sensitive matters outside of "home", trust appeared as a scarce resource in the region (Nymo R 2011). The social and historical context is the most obvious explanation for this, and by extension, the stated fear of misdiagnosis, which can be equally understood as fear of risking one`s self-representation in the clinical encounter (Sørlie T and Nergård JI 2005) Moreover, there are several discrepancies between how mental illness is understood within TM and conventional mental health care (Sexton R and Sørlie T 2008). While the ability to talk to spirits and communicate with and relate to nature are often valued as skills with high status in "indigenous settings" (Sexton R and Stabbursvik EAB 2010), conventional mental health care can, as seen in for instance Birgit`s story in the second article, interpret this as mental illness. This can be one of the reasons why trust in *readers* is solid in places like Nordreisa, and why contact with *readers* is so important for people experiencing mental illness in this context.

According to Whitley, Kirmayer and Groleau (Whitley R, Kirmayer LJ et al. 2006), barriers to accessing mental health care are best studied among people who have not sought help or successfully engaged with the services. In this study, a central component was that even

though all the participants currently were in conventional treatment, they had been very reluctant to seek help from conventional mental health care. They had been going in and out of treatment based on their level with alliance with therapists; most of them had been *managing on their own*, as they would commonly state, for a number of years before entering the public mental health care system. Their relationship to *readers*, on the other hand, did not interfere with this ideal; it seemed all the more to correspond with the idea of *managing on one`s own* (Holtedahl L 1986). *Managing on one´s own* also appeared to be compatible with local care, and thus a collective value more than an expression of individualism (Holtedahl L 1986). The value of *managing on one´s own* can also be found in the fact that public health services historically have been limited in this area; further, it is connected to values found in Sami culture, namely of keeping quiet about ones´ challenges in life and not sharing health matters outside of the extended family, as a type of safeguarding of secrets, maintenance of alliances, and protection of stories and culture (Bongo BA 2012). Laestadianism can also be seen as a contribution to *managing on one`s own*, through anchoring and providing faith and strength under difficult circumstances, and thus becoming a coping resource (Myrvoll M 2010).

Trust as uncertainty and risk

Accordingly I posit that the participants in this study may place less trust in the conventional mental health care system than patients with other, less stigmatising diagnoses. In this way, we may say that trust also depends on how one understands mental illness, and the concept of trust is closely linked to the concepts of "uncertainty" and "risk" (Rowe R and Calnan M 2006, Alaszewski A and Brown P 2007). I base this on an understanding such as the one described by Rowe and Calnan:

"The need for interpersonal trust relates to the vulnerability associated with being ill, the information asymmetries arising from the specialist nature of medical knowledge, and the uncertainty and element of risk regarding the competence and intentions of the provider on whom the patient is dependent. Without trust patients may well not access services at all, let alone disclose all medically relevant information. Trust is also important at an institutional level, as trust in particular hospitals, insurers and health care systems may affect patient support for and use of services and thus their economic and political viability."

Trust seems to be part of a dynamic process of negotiating uncertainty by investing in relationships to individuals, institutions and forms of knowledge and authority (Rowe R and Calnan M 2006). A timely question is thus what types of needs the different traditions fulfil. Perhaps *readers* are better equipped to face the type of vulnerability these participants represent, compared to conventional mental health care? Because the stories, told and untold, are more familiar to them, and they are able to acknowledge the spiritual dimension which is important to many here? (Myrvoll M 2010). Moreover, the patients` stated fear of being misdiagnosed with more severe mental health disorders than if they under-communicate their personal philosophies of health must also be taken into account (Sørlie T and Nergård JI 2005). Such barriers to trust can be caused by the professional interpretation of traditional understandings to pathways of health in communities with complex and co-existing medical systems like Northern Troms (Sexton R and Sørlie T 2008).

The local trauma has created wounds which are slowly being healed, where loss of "home" continues to influence everyday life in the region: the loss of families, language, and identity and belonging underpins the importance of trust in the clinical encounter (Mol A 2008). Patients must trust that the therapists understand, respect and *trust* their worldview, and are able to provide good care based on an empathic, open-minded approach.

Trust and worldview

As demonstrated in Articles 2 and 3, the contrasts and tensions between mental illness and health, and between the different medical systems in use in Northern Troms can be explained by the different cosmologies, or worldviews employed. By the concept of worldview, I refer to a definition of worldview such as that of Rapport and Overing (Rapport N and Overing J 2007), as *an overarching philosophy or outlook, or conception of the world*. One can say that worldview focuses on thoughts and feelings in contrast to behaviour, also in a sense as *prior* to behaviour (Rapport N and Overing J 2007). Worldview is relevant in this discussion for two reasons. First, I consider this an emic concept for the participants, as they would commonly talk and explain matters in ways described as: "as we see the world", "this is how we understand the world", "*reading* is just a natural thing around here", etc. Secondly, because the concept of worldview is broad and therefore well suited to point out the critical differences between how both these different medical and cultural systems, their providers and their users relate to the(ir) world(s) (Tilburt J and Geller G 2007).

In particular, it is the distinction between a holistic worldview and a biomedical (reductionistic/rationalistic/"Western") worldview that is relevant to this discussion (Kumbamu A, Geller G et al. 2018). Holism is a treatment philosophy in psychology, biology, sociology, and anthropology that employs wholeness as its basic principle, as opposed to the study of isolated parts (Thornquist E 2003). The use of *reading* as well as the *readers`* approach to healing seems to be a natural expression or extension of this worldview (Miller BH 2007). The biomedical worldview, on the other hand, strongly influenced by reductionism, is according to (Popkin RH and Stroll A 1981) *a philosophical position that a complex system is nothing but the sum of its parts, and that an account of it can be reduced to accounts of individual constituents*. This approach which understands the nature of complex things by reducing them to the interactions of their parts, or to simpler or more fundamental things, is the opposite of holism, which argues that *complex systems are inherently irreducible and more than the sum of their parts, which is why a holistic approach is needed to understand them (Popkin RH and Stroll A 1981).*

Just as biomedicine is critical of softer and less evidence-based disciplines (Tilburt J and Geller G 2007), TM and holism are under threat according to the participants. In the second article, Birgit addressed an issue of the therapists´ personal and local worldview and how this may change when faced with the professional, biomedical point of view. Birgit, among other participants, identified a risk that even with local therapists the biomedical worldview could have "drained out local knowledge", which is strongly based on holism. In this study, patients, CAM providers and *readers* also acknowledged biomedical knowledge as indispensable tools in the clinical encounter. However, as Tilburt and Geller (Tilburt J and Geller G 2007) note, "*the medical worldview fosters a vocabulary of problem solving that may inappropriately frame problems in a manner that leads to a doctor-centered approach to decision making and health care delivery that does not optimally meet patient needs. Furthermore, in the clinical training setting, a doctor-centered perspective can lead to disrespectful, degrading, or dehumanizing attitudes and behaviors*." How to apply these clinical tools, by keeping the patient in the centre of attention also in clinical education, is therefore crucial (Tilburt J and Geller G 2007).

The patients also expressed positive outcomes of being between these medical systems and worldviews, since being part of a mix included a cultural repertoire which allowed them to "have the best of both worlds" (Salamonsen 2016). However, as we have witnessed through

the stories presented in this thesis, particularly in the second and third articles, these opposing worldviews create tensions in the participants' lives, among which is a risk of being categorised both in terms of ethnicity and diagnosis, and consequently a need to appear as Norwegian at the clinic.
Holism includes a philosophy of nature which people in Northern Troms can identify with, and which is of importance to their understandings and interpretations of illness (Lupton 2003). On the other hand, conventional mental health care represents the biomedical worldview which is founded on the principles of rationalism and reductionism with an explicit focus on diagnosis and disease (Lupton 2003) .

There is a discrepancy between the generous and empathically open-minded approach found in *reading* and the biomedical system that can be experienced as cold and depersonalized (Leder D 2016), approaching knowledge through manuals and evidence-based experience. Where the *readers* see the human being, as Jackson (Jackson M 1982) notes, the body as lived life and its insistence on meaning, *a knowing body*, the conventional therapists are trained in a biomedical tradition which corresponds more with the Cartesian (Leder D 1990) dualism viewing mind and body as distinct and separable "units", a model which continues to rule modern medicine. Leder (Leder D 1992) argues that this standpoint amounts to dealing with the *body as machine*. In Leder`s most recent book (Leder D 2016), he also links this to a lack of connection between "worlds" in the clinical encounter: between one´s own body, other people (the social world), the cosmos (one`s own identity and meaning), and argues that this may create *the distressed body*. Conventional mental health must also recognise *the knowing body* in order to provide good care. In that sense, we may say that both *readers* and conventional therapists have the capacity to lessen existential disruptions by healing the *illness*, even when there is no cure for the *disease* (Leder D 2016).

Trust and hybridity

Northern Troms is often described as a multi-cultural community. However, multi-culturalism originates from the idea that there are distinct boundaries between different cultural groups (Eriksen TH 2007). In Northern Troms, the boundaries are decidedly blurry, which makes the concept of hybridity relevant as it points to individuals or cultural forms which are mixed, meaning syntheses of cultural forms or fragments from different origins (Eriksen TH 2008). The concept of hybridity (Bhabha HK 1994) is also fruitful in comparison to the concept of home and can be relevant to this specific context. Although

people in Northern Troms are formally "at home" in Norway as a nation state, they do not always experience a belonging to a typically Norwegian or Western mind-set and may thus possess a different worldview, particularly regarding spiritual matters (Nymo R 2011). They may therefore experience that they do not have a home within the (conventional) system. In this way, hybridity can also be viewed as an experiential state in this region.
Conventional mental health care can be seen as a strong representative of both a biomedical and a Western worldview, and therefore be experienced as particularly alienating and *unhomely* for many patients in this context. Bhabha (Bhabha HK 1994) notes that the plight of unhomeliness applies to groups of people who have no home within conventional systems. Following that thought, in a state of unhomeliness, it is likely that the use of TM can represent home. If these people are to be at home, also in a bodily sense, when dealing with conventional mental health treatment, it is necessary for the conventional mental health care providers to have knowledge of and show respect towards people`s use of TM, and a profound understanding of the belief system (Good BJ 1994) shaping the holistic worldview that is locally anchored and which patients in this context navigate from when dealing with mental illness.

Methodological considerations and reflections

Inspired by experiences involved in the study, I will reflect in this section upon some of the challenges of doing ethnography today, in this study specifically, and as of today in general[14]. The reflections can also point to my professional identity and the identity of the profession, but I see these in terms of an interplay with methodology. I am aware that in some other contexts, e.g. Canada, research with indigenous peoples now requires full partnership, including the contribution of participants to the development of research questions and the agenda for research projects (Wilson S 2008). In light of this, one could perhaps claim that this was old-fashioned ethnographic fieldwork; however, this was not an indigenous study per se, as the transcultural context did not make such an approach a natural focus when embarking on the project. In retrospect, I realise that applying an indigenous methodology could have been appropriate (Smith LT 1999, Adelson N 2005), yet I believe that the material came to life through our interactions and that the participants contributed

[14] These reflections are also inspired by lectures and discussions from annual conferences held by the Norwegian Association of Anthropologists from 2011 to 2013 where related topics were on the agenda, as well as a PhD course in 2012 at UiT The Arctic University of Norway, "*Materiality, Performativity and Ethnographies"*.

significantly to the setting of the agenda and influenced the research questions as much as I did.

Ethnography, both as text and through fieldwork, is by far the most important factor in the production of anthropological knowledge and epistemology. However, the conditions for doing fieldwork have changed drastically since the practice was shaped about 100 years ago (Madden R 2013). Originally, fieldwork was intended to make room for an advanced journey, to a whole culture rather than a specific theme. Simultaneously, ethnography in the sense of a more detailed piece of qualitative research is now widespread also in other disciplines (Holliday A 2007). Timely questions are therefore how we can understand ethnographic practice in an era of intensifying global connections where nature, culture, knowledge and place are not what they used to be. This gives connotations to the idea of *being there* as a fundamental issue in anthropological method, but what is *being there* or *presence* in a world where both time and place for cultural practices change right in front of our eyes? How can we understand ethnography today, what was ethnography in this study, and what challenges is the practice of ethnography facing? One could perhaps say that this study was a kind of "ethnography by arrangement", and that *being there* - as the anthropological cornerstone - was somehow challenged; instead of being in the field permanently, I moved in and out of the field. Although I never doubted performing this study as an ethnographic fieldwork, I did at times question if "ethnography" could be justified, and if a more structured narrative method, e.g. by using the McGill Illness Narrative Interview (Groleau, Young A et al. 2006) would have been more appropriate. Nevertheless, through the study itself, and staying in touch with the participants also when "out" of the field, the field was somehow incorporated in me and thus close and distant at the same time. This position made me reflect upon ethical challenges, perhaps more than I would have if I had been present in the field continuously. Performing fieldwork in all the four communities of Northern Troms could have given more thorough knowledge of the field, but was practically challenging, and Nordreisa was therefore the main fieldwork setting and was also where nine of the twelve patients in the study lived.

In the attempt to grasp the methodological essence of this study, stories, and how they constituted the field, were the key element. The participants' childhood stories, inter-generational stories, their reminiscences, and how levels of all these different stories made the context and moved the field beyond time and space, corresponded with what Marcus

(Marcus GE 2010) describes as *nested dialogues*. These types of contextualised conversations include a subjective reflection or para-ethnographic approach to life and society which is of vital importance also to the development of anthropological methodology (Marcus GE 2010). Based on my own fieldwork experiences, the various ethnographic encounters enabled a space for reflection, and in this way, part of the ethnographic endeavour consists of making people more conscious of their own lived experiences.

Field and home

Ethnography is first and foremost understood as a description of a society, a community or a social context, where events through contextualisation are being explained and theories generated. The main aim of this is usually to translate hitherto unknown practices and systems of thoughts and beliefs. These principles may be established in the anthropological project to an extent where no one truly questions or challenges them. A central question is therefore what creates a relevant and necessary context, in time and space. Fabian (Fabian J 2010) argues that while the presence of data in the field has been increasingly scrutinised, the presence of the fieldworker herself has also been given increased importance as a fundament for communication. This points to the need to acknowledge the contemporaneousness between the researcher and the research subject, and the connection between *field* and *home*, also in the written result; memory and choices are therefore significant throughout the research process. In Marcus` (Marcus GE 1998) approach to contemporary fieldwork, he concludes with a fundamental defence of anthropological ethnography. All fields are now more or less multi-sited, and subjects and objects can lead the fieldworker far outside disciplinary boundaries as well as the boundaries of the field itself. The politics and ecology of knowledge are central in the anthropological project, considering how everyday life, relations between institutions and subjects, dominance and resistance are our field of study. Marcus claims that ethnographic material has increasingly been replaced with mere theoretical reflections. He argues that the need for evidence needs to be re-established, that the material should not only be presented, but highlighted and worked through in order to represent the ethnographer's position and significance; this is a position I strived to accomplish in this study. Furthermore, Marcus states that after the cultural critique of anthropology of the 1980s, the discourse and debates themselves have been made relevant as ethnographic objects. Then there are the methodological reflections upon fieldwork as method, and Law (Law J 2004) argues that methods do not merely describe social realities

but are simultaneously involved in creating these social realities. Following this argument, methods are by nature always political, which raises questions as to what kinds of social realities we as researchers want to create. Most current methods look for clarity and precision, and some would claim that only poor research produces messy findings; the idea that things in the world might be fluid, elusive, or multiple in any way is thus unthinkable. Law argues that this is wrong, and it is time for a new approach. As many realities are in fact vague and ephemeral, the challenge is: if methods want to help shape the world, then they need to reinvent themselves and their politics to deal with mess (Law J 2004)**.**

The increased demand for interdisciplinary collaboration, particularly in major research projects, the fact that anthropologists like myself to a greater extent concentrate on phenomena in our own societies, and last but not least, the increased tendency for other disciplines to use anthropological methods and theoretical concepts, have all created challenges for anthropological boundaries. These are factors that challenge anthropology to stick to the disciplinary contribution, but to also reflect upon its uniqueness.

The ethical dilemma of anthropology

Doing social scientific work in a medical field implies being in a grey area, and as a social anthropologist I am probably more often inside this grey area than other researchers in this field. After all, anthropologists are among the very few that consequently move close to people to an extent where intimate details about their experiences and actions are made relevant for scientific discourse, and simultaneously have to consider genre demands implying *thick description*. I therefore had to ask myself how I could show the workings of the material without exposing the participants too much. I did not want to make the empirical data less thick or make the conversational and interactional partners in the field unavailable to the public eye. The demands for thick description make anthropologists hold on to "our" empirical material, the way "we" use it to make analytical projects possible and trustworthy, and as holistic and experience-near as possible**.** However, with the "slow death" of written ethnography for the benefit of article-based dissertations, I somehow had to make thick descriptions that were adapted to the journals and to this thesis. This has most definitely challenged the need for thick descriptions, and as my material was comprehensive I have questioned whether I did make the right selection of empirical presentations. Nevertheless, I have tried to show my workings, and let the participants´ stories breathe in an attempt to implement the situated reflexivity which was accessed through presence and conversation. Secondly, I do want my research to be available to the general public, because I believe it is

important for future mental health care. I am therefore in a unique position between the demands for privacy and the need for publicity. Because this balance has been reflected upon from an anthropological point of view, it has hardly been part of a principal and practical interesting discussion (Strange V 2003). To my knowledge, within the medical disciplines, issues of privacy are taken into consideration to a greater extent. For example, written consent forms from all participants before and after interviews and the possibility for participants to read the written text are more or less standard procedures. Some anthropologists would feel gagged having to operationalise their ethical research guidelines in the same way as medical researchers do. Such a practice does not only interfere with the demand for availability and good data, but also with the desire to understand new perspectives, create new insights, and make good analysis of interesting connections. These connections are not necessarily something the participants identify or agree that I establish. But as long as I do not violate the participants' privacy or cause problems, I must allow myself to separate this from the question of whether my analyses have a place in the public sphere or not. Leading on from this, the question I initially set out with was not necessarily how it was possible to perform ethnography partially in a clinical setting and in peoples´ homes, but more how I could ensure that the study was included in a production of knowledge without anyone having to pay an unacceptable price for it. I nonetheless had to implement all the necessary health research requirements, and in my experience, letting the participants read the transcripts provided even richer data, and thus widened the horizon of the research process more than limiting it.

Moving towards a sensory ethnography

It is possible to understand the anthropologist not only as mediator but also as medium, since she uses herself as an analytical instrument, a tool of knowledge. How is that knowledge, which is not only conceptual and verbal but to an even greater extent comes from the senses, bodily knowledge, emotions, and intuition, processed and mediated? The process of mediation can be taken up in different stages of fieldwork. In the initial phase we start to learn about our partners in the field and their world(s). How is the field mediated to us and how do we process the information gathered? Knowledge is not only mediated but often "filtered" through ethnographic seduction (Robben ACGM 1996), and the active participation of our interlocutors influences the outcome of our research (Holstein JA and Gubrium JF 2004). What is then our role as mediator, and how should we understand our relationship with other mediators, e.g. key participants in the field? This does not only raise

questions of representation, what and how to convey to our academic and local audience, but also aims to explore what happens to the anthropologist as a medium.

Also, when dealing with matters of emotion as in this study, basic questions of definition and scope remain unresolved: Where do emotions begin and end? How should we identify and analyse them? How to write about them? Ethnographic fieldwork, as pioneered by Malinowski, offers powerful insights into the place of emotion in social life, but emotions are peculiarly difficult to capture in the generalising format of an ethnographic summary. Beatty (Beatty A 2014) argues that semantic, structural, and discourse-based approaches tend to miss what is most important, i.e. what counts for the persons concerned and therefore what makes the emotion. Beatty reviews the conceptual and methodological issues and concludes that only a narrative approach can capture both the particularity and the temporal dimension of emotion, restoring verisimilitude and fidelity to experience. My attempt has been to unite such a narrative approach with the ethnographic encounter and thus contribute to the production of narrative identity within the participants´ stories.

Is it the case that the entire ethnographic project implies a certain way to view societies, as integrated wholes, consistent, communities, objects, groups, and that individual traits therefore disappear? As if ethnography is being caught up by its gloomy history? And that this is the reason why we should or must recodify ethnography, which I was partly doing in this study. We must therefore ask ourselves how we work as researchers, and how do we "perform" theory as well as ethnography in these moments? Are we in fact lost in transition or headed towards a new ethnographic understanding? There are undoubtedly many that will claim that the conditions for doing anthropology have changed in such distinct matters, making the future look rather sad for anthropologists; anthropology depends on interdisciplinarity, the relationship between Self and Other has changed drastically, and the ethical challenges of doing ethnography in new settings, as I have attempted to portray, can overshadow ethnography itself. As anthropologists, we might need to re-establish the confidence in anthropology as perhaps the first human science of this era that lives with its own tradition and builds new forms of authority as well, based on interdisciplinary participations of various kinds. According to Marcus (Marcus GE 1998), a strong internal politics of anxiety accompanies this transition, but that has always existed to some degree in anthropology as in every generational transition which reflects unfulfilled personal longings and power shifts played out as familial drama. Marcus underscores this by stating that what

matters is that anthropology`s peculiar dual relation of a fragmented core tradition and experiments on its borders should be sustained with vitality, open-mindedness, curiosity, and above all, tolerance for complex organisation in the production of knowledge. Anthropologists succeed in adapting to new conditions by doing what has always been "our" asset, namely openness and time when dealing with the field, freedom to go in depth with details and address thematically the methods in neighbouring disciplines that are less suitable. As I have attempted to show in this part, and through the fieldwork this thesis is based on, ethnography is something continuously in the making - dynamic and flexible -and with the possibility to be reinvented if necessary.

As demonstrated, anthropology contributes useful contextual, relational and subjective perspectives on illness and healing. The methodological findings reflected upon can also give direction to an anthropology of the future, where psychiatric "phenomena" like emotions can be explored as a sociocultural field as much as cognitive matters per se.

Implications for clinical practice and further research

The study raises several questions which may have implications for clinical practice at the outpatient clinic for mental health in Northern Troms and similar clinics. Some of these are outlined in a post-doctoral project I have developed based on the findings from this PhD study, which has been granted funding from the Northern Norway Regional Health Authority (Helse Nord RHF).The project will focus on what a cultural perspective can add to diagnostic practice, also aiming to understand how illness becomes diagnosis. A cultural perspective can help psychiatrists and psychologists become aware of the hidden assumptions and limitations of current psychiatric theory and practice. In Norway, the International Classification of Diseases (ICD10) (World Health Organization 1992) is being used as a diagnostic tool for clinicians, but it does not contain a cultural formulation as does the DSM-5 (American Psychiatric Association 2016). There is currently an ICD-11 under a revision (WHO, 2015), which implies that questions focusing on cultural and local implementation issues regarding the interpretation of codes will be central. Whilst diagnostic tools such as the DSM and ICD are constructed within a Western context, and by many (Van Ommeren M 2003) assumed equally applicable to other cultures, emotions, thoughts and behaviour can be expected to vary by culture (Kleinman A 1988). Symptoms may be similar regardless of culture, but as this study has proven, interpretations and descriptions vary depending on cultural contexts. Uncritical application of standard diagnostic criteria cross-culturally might therefore yield

misleading or erroneous diagnoses where such criteria are locally inappropriate. This may represent a considerable threat to patient safety and thus to the quality of mental health care. New approaches appropriate for treating the increasingly diverse populations seen in mental health services around the world can be identified (Kirmayer LJ and Minas H 2000). The last revision of the nosology of the American Psychiatric Association, DSM-5 (American Psychiatric Association 2016), includes a Cultural Formulation Interview (Lewis-Fernández R, Aggarwal NK et al. 2016) that aims to help clinicians contextualise diagnostic assessment. A related approach to cultural assessment involves cultural consultation involving interpreters and cultural brokers to develop a cultural formulation and treatment plan that can assist clinicians in the diagnostic process (Kirmayer LJ, Guzder J et al. 2014).

The question of whether one should consider an actual integration of traditional healing at the clinic has not been examined thoroughly in the three articles, but tentative data indicates that the participants are more focused on acceptance of their use of traditional medicine than the possibility to actually meet with a *reader* at the clinic. In light of the findings, there are several challenges and consequently intriguing problems involved in the idea of such an integration which would be interesting to explore. What a clearer focus on gender would imply would also be fruitful to pursue in further research, particularly in regard to the use of CAM modalities.

Closing remarks

The traditional medicine practice of r*eading* is an example of a phenomenon that is mutually influenced by the cultural and spiritual interactions in this region. Laestadianism represents a religious aspect of the practice which makes *reading* versatile: both pragmatic *and* spiritual in the everyday life of the participants in this study.

The personal accounts of the participants constitute an anthropology of mental health care patients trying to come to terms with both their personal and local past, and perhaps to face an uncertain future in terms of how their mental health but also their context is part of an unofficial, public negotiation. The cultural story framing Northern Troms is an example of how all stories are never told in a vacuum, even the covert ones. The challenges of human beings are often historically and culturally situated, and these stories are therefore of crucial importance in creating and developing mental health care, particularly in regions like Northern Troms where one should focus on using the resources the local communities can

provide. We must also address patients` need to be at home in their own stories, and not risk a potential positive therapeutic outcome by patients having to adapt to the therapists` life world.

In a constantly changing world where CAM modalities are growing in number and use, the study shows that TM is still firmly anchored in this region. TM is also a "place of origin" in terms of how the participants navigate the different medical systems available to them, in particular in regard to the competence the various therapists possess. As such, the participants confirm the *reader* as an archetype. More knowledge about contextualised experiences of mental health, including the use of TM, can be of vital importance to optimise the merging of system offers and patient needs and resources within a North Norwegian mental health care context in the future. At a time where increasing migration between cultures is common and individuals generally have more possibilities to relate to their individual spiritual choices and practices, the goal to provide good mental health care in a culturally sensitive and safe manner might be one of the major challenges of the next decades.

This addresses the high importance of culture sensitivity in mental health care, as the patients report feeling less vulnerable in encounters involving a *reader* than in clinical encounters in conventional mental health care. However, when focusing on culturally sensitive and safe treatment for patients in this context, one should bear in mind that not making "culture" relevant in all clinical situations can also be a way of demonstrating cultural sensitivity.

This study can provide mental health care workers with knowledge of the importance of understanding social and cultural processes associated with mental problems in efforts to help patients (Kirmayer LJ 2012). The knowledge generated can be transferable to other cultural contexts, and also to members of religious communities different from the culturally dominant communities. Developing knowledge and education about "alternative worldviews" and (concealed) local trauma is highly relevant for the future. At the outpatient mental health care clinic of Northern Troms, such knowledge is needed, also in clinical encounters with refugees with various traumatic backgrounds who are offered asylum in the community. Keeping these matters in mind, we should still, as Sobo (Sobo EJ 2009) points out, not be deluded by culture. Cultural aspects undoubtedly make a considerable impact on peoples` lives, but other factors also make a difference in this context and can affect mental health and the experience of affliction equally, such as social class, gender issues, Norwegian

regional policy with the status of Northern Troms as a peripheral region (Holtedahl L 1986, Johansen E 2012). To deal with this multifaceted reality, an emphasis on narrative competency can be equally important as cultural competency; or rather, one should not exclude the other. As Charon (Charon R 2001), argues, effective practice of medicine requires narrative competence, which she defines as "*the ability to acknowledge, absorb, interpret, and act on the stories and plights of others*". Here, a key question is which epistemic stance is needed. Orange (Orange DM 2011), inspired by Gadamer (Gadamer HG 1976) suggests a hermeneutics of trust. Orange notes:

"*A profound sense of belonging - belonging to world, belonging to conversation, belonging to tradition and history - pervades Gadamer`s (1976, p. 13) philosophical hermeneutics: There is always a world already interpreted, already organised into its basic relations, into which experience steps as something new, upsetting what has led to our expectations and undergoing reorganisation itself in the upheaval. Misunderstanding and strangeness are not the first factors, so that avoiding misunderstanding can be regarded as the specific task of hermeneutics. Just the reserve is the case. Only the support of the familiar and common understanding makes possible the venture into the alien, and lifting up of something out of the alien, and thus the broadening and enrichment of our own experience of the world".*

This position includes reflections upon the role of non-pathologising, of bearing witness, and acceptance of the building of trust in the clinical encounter (Rowe R and Calnan M 2006)**.** For mental health care patients in general, and in complex contexts specifically, being taken seriously, without suspicion in regard to one's story and experience is the first step in creating trust and a sense of belonging in the clinical encounter.

References

(2003). LOV-2003-06-27-64 Lov om alternativ behandling av sykdom mv; English Act relating to the alternative treatment of disease, illness, etc.
Adelson N (2005). "The Embodiement of Inequity: Health Disparities in Aboriginal Canada." Canadian Journal of Public Health **96**: 45-61.
Alaszewski A and Brown P (2007). "Risk, uncertainty and knowledge." Health, Risk & Society **9**(1): 1-10.
Alraek T, Borud E and White A (2011). "Selecting acupuncture treatment for hot flashes: a delphi consensus compared with a clinical trial." Journal of Alternative & Complementary Medicine **17**(1): 33-38.
American Psychiatric Association. (2016). "Diagnostic and Statistical Manual of Mental Disorders (DSM-5)." Retrieved 08.02., 2017, from https://psychiatry.org/psychiatrists/practice/dsm.
Andersen KB, Persen S and Miller BH (2015). Multiple Views from Finnmark. Idioms of Sámi Health and Healing. Miller BH. Edmonton, Polynya Press**:** 83-103.

Andersen V (2019). Gratulerer, Romsa. Nordlys, Nordnorsk Debatt. Tromsø, Nordlys.
Andrews M, Squire C and Tomboukou M (2013). Doing Narrative Research. London, SAGE Publications Ltd.
Antonovsky A (1987). Unraveling the mystery of health: How people manage stress and stay well. San Francisco, Jossey-Bass.
Antze P and Lambek M (1996). "The Medicaliazation of Memory". Tense Past. Cultural Essays in Trauma and Memory. Antze P and Lambek M. New York, Routledge.
Asad T (2003). Formations of the Secular: Christianity, Islam and Modernity. Stanford, CA

Stanford University Press. .
Aspaas J and Henriksen AM (2002). Kulturaksept mobiliserer pasienten. English: Cultural accept activates the patient. Kultuvradohkkejupmi árjjasmahttá pasieantta. Tromsø, Universitetssykehuset Nord-Norge**:** 1-11.
Bakken K, Melhus M and Lund E (2006). "Use of hypnotics in Sámi and non-Sámi populations in Northern Norway." International Journal of Circumpolar Health **65**(3): 261-270.
Beatty A (2014). ""Anthropology and emotion"." Journal of the Royal Anthropological Institute **20**(3): 545-563.
Bergh A and Bjørnskov C (2011). "Historical trust levels predict the current size of the welfare state " KYKLOS **64**(1): 1-19.
Bhabha HK (1994). The Location of Culture. London, Routledge.
Bjørklund I (1978). Kvæn - same - norsk: En sosial-antropologisk analyse av "De tre stammers møte". In English: Kven - Sami - Norwegian: An anthrological analysis of "the encounters of the three tribes". MA, University of Tromsø.
Bjørklund I (1985). Fjordfolket i Kvænangen: fra samisk samfunn til norsk utkant 1550-1980. English: Fjord people in Kvænangen: from Sami communities to Norwegian fringe 1550-1980. Tromsø, Universitetsforlaget.
Bjørklund I (2000). Sápmi - a nation in the making. In Norwegian: Sápmi - en nasjon blir til. Tromsø, University of Tromsø.
Blix BH and Hamran T (2015). Helse- og omsorgstjenester til samiske eldre: Temahefte. English: Health and Care Services for Older Sami: Booklet. Tønsberg, Tromsø, Forlaget aldring og helse/ Senter for omsorgsforskning Nord, UiT Norges Arktiske Universitet.
Bongo BA (2012). Sámi people do not talk about health and illness. Sámi understandings and communication of health and illness. A qualitative study of Sámi culture. (In Norwegian: Samer snakker ikke om helse og sykdom. Samisk forforståelseshorisont og kommunikasjon om helse og sykdom. En kvalitativ undersøkelse i samisk kultur). PhD, Universitetet i Tromsø.
Bradbent ND (2010). Lapps and labyrinths: Saami prehistory,colonization, and cultural resilience. Washington, Smithsonian Institution.
Brainard J (2001). I Remember (new edition, 4th printing 2005) [1970]. New York, Granary Books.
Brostrøm BT (2014). Omdømmebygging og konkurransedyktige stedsidentiteter i et ruralt perspektiv. En analyse av tiflytteres stedsforståelse og effekter av omdømme-og identitetsbyggings prosjekter. In English: Image-building and identity of place in a rural perspective. MA, UiT The Arctic University of Norway
Bruusgaard D and Efskind L (1977). "Befolkningens syn på og bruk av folkemedisin. En landsomfattende intervjuundersøkelse. English: The population's belief in and contact with folk-medicine. A nation-wide interview survey." Tidsskr Nor Laegeforen, **97**(27): 1385-1388.
Byrne A (2015). On Literature and Philosophy. The non-fiction writing of Naguib Mahfouz. Chicago, The University of Chicago Press.
Charon R (2001). "The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust." JAMA **286**(15): 1897-1902.
Clandinin JD and Connelly FM (2004). Narrative inquiry: Experience and story in qualitative research. San Francisco, CA, Jossey-Bass.
Cotton ME, Nadeau L and Kirmayer LJ (2014). Consultation to remote and Indigenous communities. Cultural Consultation. New York, Springer.
Csordas T (1999). Embodiment and cultural phenomenology. Perspectives on embodiment: The intersections of nature and culture Weiss G and Haber H. New York, Routledge.

Douglas M (2013). Hopes and Horror. An ethnographic study of a German community in Chile. PhD UiT The Arctic University of Norway.
Efskind L and Johansen AT (1976). "Folkemedisin og overnaturlig helbredelse. English: Folk-medicine and supernatural healing. A study in the Alta region." Tidsskr Nor Laegeforen **96**(30): 1582-1586.
Ellis C (2007). "Telling secrets, revealing lives: relational ethics in research with intimate others." Qualitative Inquiry **13**(1): 3-29.
Eriksen TH (2007). Globalization. The key concepts Oxford University Press.
Eriksen TH (2008). Globalisation. Eight key-concepts (In Norwegian: Globalisering. Åtte nøkkelbegreper). Oslo, Universitetsforlaget.
Fabian J (2010). "Ethnographic and Memory". Ethnigraphic practice in the present. Melhus M, Mitchell JP and Wulf H. Oxford, Berghahn.
Feuchtwang S (2010). Ritual and Memory. Memory. Radstone S and Schwarz B. New York, Fordham University.
Frank AW (2013). The wounded storyteller: body, illness, and ethics Chicago, University of Chicago Press.
Frøystad HK (2003). Conception of "real" fieldwork and its impossibility in Norway (in Norwegian: Forestilling om det "ordentlige" feltarbeid og dets umulighet i Norge). Close places, new spaces (In Norwegian: Nære steder, nye rom). Rugkåsa M and Thoresen KT. Oslo, Gyldendal Akademiske.
Gadamer HG (1976). On the Scope and Function of Hermeneutical Reflection 1967. Hans-Georg Gadamer: Philosophical Hermeneutics. Linge DE. Berkley, MA University of California Press.
Gadamer HG (1993). Truth and Method. New York Sheed & Ward.
Giddens A (1990). The Consequences of Modernity. Stanford, CA, Stanford University Press.
Gobo G (2008). Doing ethnography. Los Angeles, Sage Publications.
Goffman E (1974). Frame analysis: An essay on the organization of experience. London, Harper and Row.
Good BJ (1994). Medicine, Rationality and Experience: An Anthropological Perspective. Cambridge, Cambridge University Press.
Groleau, D., Young A and Kirmayer LJ (2006). "The McGill Illness Narrative Interview (MINI): an interview schedule to elicit meanings and modes of reasoning related to illness experience." Transcultural Psychiatry **43**(4): 671-691.
Hansen L (2008). Storm på kysten. In English: Storm along the coast. Tromsø, Margmedia.
Hansen LI and Olsen B (2004). The history of the Sami until 1750 (In Norwegian: Samenes historie fram til 1750). Oslo, Cappelen Akademiske Forlag.
Hanssen B, Grimsgaard S, Launsø L and Fønnebø V (2005). "Use of complementary and alternative medicine in the Scandinavian countries." Scandinavian Journal of Primary Health Care **23**(1): 57-62.
Harris A and Guillemin M (2011). Developing sensory awareness in qualitative interviewing. A portal into the otherwise unexplored qualitative health research. London, Sage Publications.
Hendry J (1993). Wrapping Culture: Politeness and Presentation in Japan and Other Societies. Oxford, Clarendon Press.
Henriksen AM (2010). Bloodstopping: Stories of reading, healing, helpers, and signs (In Norwegian: Å stoppe blod: Fortellinger om læsing, helbredelse, hjelpere og varsler). Oslo, Cappelen Damm.
Holliday A (2007). Doing and writing qualitative research. London, Sage.
Holmboe O, Iversen HH, Sjetne IS and Skuldal KE (2011). The Commonwealth Fund survey among sicker adults: Results from a comparative survey in 11 countries. In Norwegian: Commonwealth Fund-undersøkelsen i 2011 blant utvalgte pasientgrupper: Resultater fra en komparativ undersøkelse i 11 land. Oslo, Nasjonalt kunnskapssenter for helsetjenesten.
Holstein JA and Gubrium JF (2004). "Active Interviewing". Qualitative Research: Theory, Method and Practice. Silverman D. London, Sage.
Holtedahl L (1986). Hva mutter gjør er alltid riktig: om å være kvinne og mann i en nordnorsk bygd i 1970 årene. In English: What mother does is always right: Being female and male in a North Norwegian community in the 1970s Oslo, Universitetsforlaget.
Hovland A (1996). Modern indigenous people: Sami youth in the 90s (In Norwegian: Moderne urfolk: Samisk ungdom i 90-årene). Oslo, Cappelen Akademiske Forlag.

Howell SL (2001). Self-conscious kinship: some contested values in Norwegian transnational adoption. Relative values: New directions in kinship studies. Franklin S and McKinnon S. London, Duke University Press.
Hsieh HF and Shannon SE (2005). "Three approaches to qualitative content analysis." Qual Health Res **15**.
Hætta AK (2010). Secret knowledge: The management and transformation of traditional healing knowledge in the Marka Sámi villages, University of Tromsø.
Hætta AK (2015). Secrecy in Sámi Traditional Healing. Idioms of Sámi Health and Healing. Miller BH. Edmonton, Polynya Press**:** 25-45.
Imerslund B (2008). Kvenske personnavn i Nordreisa. In English: Kven names in Nordreisa. Storslett, Nordreisa kommune.
Imerslund B, Lindgren A-R and Hiltunen P (1993). Finske stedsnavn i Nordreisa. In English: Finnish place names in Nordreisa. Storslett, Nordreisa kommune.
Jackson M (1982). Allegories of the Wilderness: Ethics and Ambiguity in Kuranko Narratives, African Systems of Thought. Bloomington, Indiana, Indiana University Press.
Jackson M (2004). Politics of storytelling: Violence, Transgression and Intersubjectivity Copenhagen Copenhagen, Museum Tusculanum Press
Johansen E (2012). Northern Troms as a post-colonial community. Coastal Sami and Kven revitalization (In Norwegian: Nord-Troms som postkolonialt samfunn. Sjøsamisk og kvensk revitalisering). Where is North Norway headed? An institutionalized perspective of people and region (In Norwegian:. Hvor går Nord-Norge? Et institusjonelt perspektiv på folk og landsdel). Jentoft S, Nergård JI and Rørvik KA. Stamsund, Orkana Akademiske.
Johanson A (1981). "Fieldwork in social anthropology: From observation to data (In Norwegian: Feltarbeid i sosialantropologien: Fra observasjon til data)." Antropolognytt **2**.
Järvinen M (2005). Interview in an interactionist concept frame [In Danish: Interview i en interaktionistisk begrepsramme]. Qualitative methods in an interactionst perspective. Interview, observations and documents (In Danish: Kvalitative metoder i et interaktionistisk perspektiv. Interview, observasjoner og dokumenter). Järvinen M and Mik-Meyer N. Copenhagen, Hans Reitzels Forlag.
Keddell E (2009). "Narrative as Identity: Postmodernism, multiple ethnicities, and narrative practice approaches in social work." Journal of Ethnic and Cultural Diversity in Social Work **18**(3): 221-241.
Kiil MA (2015). The paradox of Home: Understanding Northern Troms as a therapeutic landscape. Idioms of Sámi health and Healing Patterns of Northern traditional healing series. Miller B. Alberta, The University of Alberta Press.
Kiil MA and Salamonsen A (2012). "Barriers of Trust: Transcultural experiences within conventional mental health service." European Journal of Integrative Medicine **4**: 157-158.
Kiil MA and Salamonsen A (2013). "Embodied health practices: The use of Traditional Healing and Conventional Medicine in a North Norwegian Community." Academic Journal of Interdisciplinary Studies **2**(3): 483-488.
Kiil MA, Sexton R and Sørlie T (2010). "Sensicam (Cultural, Self-help and CAM Sensitive Psychiatric Treatment Approach - An Interventional Study)." Department of Clinical Medicine, University of Tromsø(Unpublished research protocol).
Kirmayer LJ (1996). "Landscapes of memory: Trauma, Narrative, and Dissociation". Tense Past. Cultural Essays in Trauma and Memory. Antze P and Lambek M. New York, Routledge.
Kirmayer LJ (2012). "Rethinking cultural competence." **49**(2): 149-164.
Kirmayer LJ, Guzder J and Rousseau C (2014). Cultural Consultation: Encountering the Other in Mental Health Care. New York, Springer.
Kirmayer LJ and Minas H (2000). "The future of cultural psychiatry: an international perspective." Canadian Journal of Psychiatry **45**(5): 438-446.
Kleinman A (1980). Patients and healers in the context of culture. Berkeley, CA, University of California Press.
Kleinman A (1988). Rethinking psychiatry. From cultural category to personal experience. New York City, Free Press.
Kristiansen R (2005). Sámi religion and laestadianism (In Norwegian: Samisk religion og læstadianisme). Bergen, Fagbokforlaget Vigemostad & Bjørke.

Kristoffersen AE, Fønnebø V and Norheim AJ (2008). "Use of complementary and alternative medicine among patients: classification criteria determine level of use." J Altern Complement Med **14**(8): 911-919.
Kristoffersen AE, Sirois FM, Stub T and Hansen AH (2017). "Prevalence and predictors of complementary and alternative medicine use among people with coronary heart disease or at risk for this in the sixth Tromsø study: a comparative analysis using protection motivation theory." BMC Complementary and Alternative Medicine **17**(1): 324.
Kristoffersen AE, Stub T, Melhus M and Broderstad AR (2017). "Prevalence and associations for use of a traditional medicine provider in the SAMINOR 1 Survey: a population-based study on Health and Living Conditions in Regions with Sami and Norwegian Populations." BMC Complementary and Alternative Medicine **17**(1): 530.
Kumbamu A, Geller G, Leppin A, Fernandez C, Tilburt J and Koenig B (2018). "Contending Worldviews in the Clinical Encounter: An Empirical Study of Complementary and Alternative Medicine Deliberations in Contemporary Medical Oncology." **24**(9-10): 996-1002.
Kvale S (1996). Interviews. An introduction to qualitative research interviewing. Thousand Oaks California, Sage.
Kvale S, Brinkmann S, Anderssen TM and Rygge JF (2009). Det kvalitative forskningsintervju. English: The Qualitative Research Interview. Oslo, Gyldendal akademiske forlag.
Kvernmo S (2014). ""Tiden er et skip som ikke kaster anker"; Utvikling av helse- og sykdomsbildet og helsetjenester i den samiske befolkningen. English: "Time is a ship which doesn't let go of the anchor". Development of overview of health and illness and health services among the Sami population." Utposten **43**(6): 39-43.
Langås-Larsen A, Salamonsen A, Kristoffersen AE, Hamran T, Evjen B and Stub T (2017). "“There are more things in heaven and earth!” How knowledge about traditional healing affects clinical practice: interviews with conventional health personnel." International Journal of Circumpolar Health **76**(1): 1398010.
Langås-Larsen A, Salamonsen A, Kristoffersen AE, Hamran T, Evjen B and Stub T (2018). "”We own the illness”: a qualitative study of networks in two communities with mixed ethnicity in Northern Norway." International Journal of Circumpolar Health **77**(1): 1438572.
Langås-Larsen A, Salamonsen A, Kristoffersen AE and Stub T (2018). "“The prayer circles in the air”: a qualitative study about traditional healer profiles and practice in Northern Norway." International Journal of Circumpolar Health **77**(1): 1476638.
Larsen AL, Hamran T and Foss F (2014). "Mellom profesjonell og folkelig kunnskap : en kvalitativ studie av helsepersonell sin kunnskap om og håndtering av "læsing" i en norsk-samisk kommune. English: Between professional and popular knowledge: A qualitative study of health personnel's knowledge and handling of "læsing" in a Norwegian-Sami municipality." Vård i Norden **34**(4): 53-57.
Law J (2004). After Method: Mess in Social Science Research. London, Routledge.
Leder D (1990). The Absent Body. Chicago and London, The University of Chicago Press.
Leder D (1992). The Body in Medical Thought and Practice. Maryland, USA, Kluwer Academic Publishers.
Leder D (2016). The Distressed Body: Rethinking Illness, Imprisonment, and Healing Chicago, University of Chicago
Lewis-Fernández R, Aggarwal NK, Hinton L, Hinton DE and Kirmayer LJ (2016). DSM-5 Handbook on the Cultural Formulation Interview. Washington DC, American Psychiatric Publishing.
Lupton, D. (2003). Medicine as Culture. Illness, Disease and the Body London, SAGE.
Madden R (2013). Being ethnographic. A guide to the theory and practice of ethnography. London, Sage Publications Ltd.
Malterud K (2011). Kvalitative metoder i medisinsk forskning. En innføring. English: Qualitative methods in medical research. An introduction. Oslo, Universitetsforlaget.
Marcus GE (1998). "Sticking with Ethnography through Thick and Thin". Ethnography through Thick and Thin. Marcus GE. Princeton, New Jersey, Princeton University Press.
Marcus GE (2010). Notes from Within a Laboratory for the Reinvention of Anthropological Method. Ethnographic practice in the present. Melhus M, Mitchell JP and Wulff H. Oxford, Berghahn.
Marquez GG (1970). One Hundred Years of Solitude. London, Jonathan Cape.
Mathiesen P (1990). "Ethnicity and pattern: Past and present." Acta Borealia **7**(1): 5-13.

Mathisen SR (1986). Folkemedisin og folkelige behandlere i det nordlige Norge. English: Folk medicine and popular therapists in Northern Norway. Bergen, Etno-folkloristisk institutt, Universitetet i Bergen.
Mathisen SR (1989). "Faith Healing and Concepts of Illness. An Example from Northern Norway." Temenos **25**: 41-47.
Mathisen SR (2000). The folk medicine in Northern Norway; cultural community and ethnic division (In Norwegian: Folkemedisin i Nord-Norge. Kulturelt fellesskap og etniske skiller. Sámi folk medicine in Norway today (In Norwegian: Samisk folkemedisin i dagens Norge. Altern I and Minde GT. Tromsø, Senter for samiske studier, Rapport fra seminar i regi av Institutt for sosiologi og Senter for samiske studier. **Vol 9:** 13-15.
Mattingly C (2010). The Paradox of Hope. Journeys through a Clinical Borderland. Berkeley, University of California Press.
Mattingly C and Garro CG (2000). Narrative and the Cultural Construction of Illness and Healing. Berkely, University of California Press.
McIllfatrick S, Sullivan K and McKenna H (2006). "Exploring the ethical issues of the research interview in the cancer context " European Journal of Oncology Nursing **10**: 39-47.
Mehus G (2002). "Har du ringt nån?" En belysning av læserens betydning for den syke, med bakgrunn i 4 fortellinger fra Nord-Norge. English: "Have you called someone?" An account of the reader's significance for the sick patient, based on 4 stories from Northern Norway. MA, Universitetet i Tromsø
Miller BH (2007). Connecting and correcting: Case study of Sámi healers in Porsanger. Leiden, Netherlands, CNWS Publications.
Miller BH (2015). Idioms of Sámi Health and Healing. Patterns of Northern Traditional Healing Series. Alberta, The University of Alberta Press.
Mol A (2008). The logic of care: Health and the problem of patient choice. London, Routledge.
Myrvoll M (2010). The word of God is all that counts. Of continuity and rupture in Sámi understanding of reality. In Norwegian: Bare gudsordet duger. Om kontinuitet og brudd i samisk virkelighetsforståelse. PhD, University of Tromsø.
Myrvoll M (2015). Traditional Sámi Healing. Heritage and Gift of Grace. Idioms of Sámi Health and Healing, Patterns of Northern traditional healing series. Miller M. Alberta, The University of Alberta Press.
Nergård JI (2000). "Læstadianismen-kristendom i et samisk kulturlandskap. English: The Laestadianism-Christianity in a Sami cultural landscape." Vekkelse og vitenskap: 207-223.
Nergård JI (2005). Det skjulte Nord-Norge. English: The secret Northern Norway. Oslo, Cappelen Akademisk Forlag.
Nergård JI and Eriksen J (2006). Den levende erfaring: En studie i samisk kunnskapstradisjon. English: The lived experience: A study of Sami knowledge tradition. Oslo, Cappelen akademisk.
Norges offentlige utredninger. English: Official Norwegian Paper (1998). Alternativ medisin, English: Alternative medicine NOU1998:21. Utredning fra et utvalg oppnevnt av Sosial og helsedepartementet april 1997. Avgitt til Sosial og helsedepartementet 15. desember 1998. Oslo, Statens forvaltningstjeneste. Statens trykning.
Northern People. (2010). "Laestadianism beliefs and community." Retrieved 09.07, 2010.
Nymo R (2011). Health care systems in Sámi communities in Northern Nordland and Southern Troms. Everyday practices. In Norwegian: Helseomsorgssystemer i samiske markebygder i Nordre Nordland og Sør-Troms. Praksiser i hverdagslivet. PhD, University of Tromsø.
Nymo R (2015). Everyday Life Between Knowledge Systems in the Markebygd Areas. Idioms of Sámi Health and Healing. Miller BH. Edmonton, Alberta, Polynya Press**:** 157-182.
Okely J and Callaway H (1992). Anthropology and Autobiography. New York, Routledge.
Olsen T and E. AK (1999). With a pinch of salt: Managing health and identity in a multi-cultural setting (In Norwegian; Med en klype salt: Håndtering av helse og identitet i en flerkulturell sammenheng). Bodø, Nordlandsforskning.
Orange DM (2011). The suffering stranger: hermeneutics for everyday clinical practice. New York, Routledge/Taylor &Francis Group.

Overing J (1998). Is an Anthropological Translation of the "Unhome" Possible or Desirable? . Intellectual Traditions in Movement, Amsterdam School for Cultural Analysis Yearbook. Bal M. Amsterdam, ASCA Press.
Penkala-Gawęcka, D. and M. Rajtar (2016). "Introduction to the special issue 'medical pluralism and beyond'." Anthropology & Medicine **23**(2): 129-134.
Pink S (2009). Doing Sensory Ethnography. London, Sage Publications Ltd.
Polanyi M (1966). The Tacit Dimension. Chapter 1: Tacit Knowing. Gloucester, Peter Smith.
Pope C and Mays N (1995). "Qualitative Research: Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research." BMJ **311**: 42-45.
Popkin RH and Stroll A (1981). Philosophy made simple: A complete quide to the world's most important thinkers and theories. New York, Heinemann Professional Publishing Ltd.
Rapport N and Dawson A (1998). Migrants of Identity. Perceptions of Home in a World of Movement. London, Berg.
Rapport N and Overing J (2007). Social and Cultural Anthropology. The Key Concepts. London, Routledge.
Richardson L (2003). Writing: A method for inquiry. Collecting and Interpreting Qualitative Materials. Denzin INK and Lincoln YS. Thousand Oaks, CA, Sage.
Ricoeur P (1991). "Narrative Identity." Philosophy Today **35**(1): 73-81.
Rimmon-Kenan S (2002). Narrative Fiction Contemporary Poetics. London, Routledge.
Robben ACGM (1996). "Ethnographic Seduction, Transference, and Resistance in Dialogues about Terror and Violence in Argentina." Ethos **24**(1): 71-106.
Rose K (1994). "Unstructured and semi-structured interviewing." Nurse Researcher **1**(3): 23-32.
Rowe R and Calnan M (2006). "Trust relations in healthcare: The new agenda." European Journal of Public Health **16**: 4-6.
Ruby J (1980). "Exposing yourself. Reflexivity, anthropology, and film." Semiotica **30**(1-2): 153-179.
Rydving H (2004). The End of Drum-Time: Religious Change among the Lule Saami, 1670s–1740s. Uppsala, Uppsala Universitet.
Salamonsen, A. (2016). "Use of complementary and alternative medicine in patients with cancer or multiple sclerosis: possible public health implications." Eur J Public Health **26**(2): 225-229.
Salamonsen A and Ahlzen R (2017). "Epistemological challenges in contemporary Western healthcare systems exemplified by people's widespread use of complementary and alternative medicine." Health **22**(4): 356-371.
Seikkula J (2011). ""Becoming dialogical: Psychotherapy or a way of life?" " Australian and New Zealand Journal of Family Therapy **32**: 179-193.
Sexton R and Stabbursvik EAB (2010). "Healing in the Sámi North." Culture, Medicine, and Psychiatry **34**(4): 571-589.
Sexton R and Sørlie T (2008). "Use of traditional healing among Sami psychiatric patients in the north of Norway." International Journal of Circumpolar Health **67**(1): 135-146.
Sexton R and Sørlie T (2009). "Should traditional healing be integrated within the mental health services in Sámi areas of northern Norway? Patient views and related factors." International Journal of Circumpolar Health **68**(5): 488.
Smith LT (1999). Decolonizing Methodologies: Research and Indigenous Peoples. Dunedin NZ, University of Otago Press.
Sobo EJ (2009). Culture and Meaning in Health Services Research. An Applied Approach. London, Routledge.
Statistics Norway. (1995). "Helseundersøkelsen 1995. English: Health Survey 1995." Norges offisielle statistikk Retrieved 10 December, 2018, from https://www.ssb.no/a/publikasjoner/pdf/nos_c516/nos_c516.pdf.
Statistics Norway (SBB). (2018). "Municipality Statistics Nordreisa (In Norwegian: Kommunefakta Nordreisa) " Retrieved 20 June, 2018, from ssb.no/kommunefakta/nordreisa.
Statistisk sentralbyrå (SSB). English: Statistics Norway (SSB) (2012). Samisk statistikk 2012. Urbefolkningen i tall - samisk statistikk. English: Sami Statistics 2012 Indigenous people in numbers - Sami statistics. Statistics Norway (SSB), Samfunnspeilet. Oslo, Statistics Norway. **3**.

Steinsbekk A, Rise MB and Johnsen R (2011). "Changes among male and female visitors to practitioners of complementary and alternative medicine in a large adult Norwegian population from 1997 to 2008 (The HUNT studies)." BMC Complementary and Alternative Medicine **11**: 61.
Steinsbekk, A., J. Adams, D. Sibbritt and R. Johnsen (2010). "Complementary and alternative medicine practitioner consultations among those who have or have had cancer in a Norwegian total population (Nord-Trondelag Health Study): prevalence, socio-demographics and health perceptions." Eur J Cancer Care (Engl) **19**(3): 346 - 351.
Strange V (2003). "An appropriate question? The propriety of anthropological analysis in the Australian political arena". The ethics of anthropology: debates and dilemmas. Caplan P. London, Routledge.
Sutton D (2001). Remembrance of Repasts: An Anthropology of Food and Memory. New York, Berg.
Svensson G (2015). "Exchange and Change in Northern Norway: On Reciprocity in Nature Based Tourism." Tourism Culture & Communication **14**(3): 169-182.
Svensson G (2016). Negotiating Norms in Nature: The moral landscape of outdoor recreation and nature based tourism in North Troms. PhD, UiT The Artic University of Norway.
Sørlie T and Nergård JI (2005). "Treatment satisfaction and recovery in Saami and Norwegian patients following psychiatric hospital treatment: A comparative study." Transcultural Psychiatry **42**(2): 295-316.
The World Medical Association (WMA) (2013) "Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects 1964 (Revised 2013) 24.05.".
Thornquist E (2003). Vitenskapsfilosofi og vitenskapsteori - for helsefag. English: Philosophy of science in health science education. Bergen, Fagbokforlaget Vigmostad & Bjørke AS.
Tilburt J and Geller G (2007). "Viewpoint: The Importance of Worldviews for Medical Education." Academic Medicine **82**(8): 819-822.
Toombs SK (1987). "The meaning of illness: A phenomenological approach to the patient-physician relationship." The Journal of Medicine and Philosophy **12**: 219-240
University Hospital of North Norway (2017). "Outpatient Clinic for Mental Health Care in Northern Troms. In Norwegian: Senter for psykisk helse Nord-Troms."
Van Manen M (2014). Phenomenology of practice, Meaning-Giving Methods in Phenomenological Research and Writing. Walnut Creek, CA, Left Coast Press, Inc.
Van Ommeren M (2003). " Validity issues in transcultural epidemiology." Br J Psychiatry **182**: 376-378
Whitley R, Kirmayer LJ and Groleau D (2006). "Understanding Immigrants' Reluctance to Use Mental Health Services: A Qualitative Study from Montreal." The Canadian Journal of Psychiatry **51**(4): 205-209.
Wilson S (2008). Research is ceremony: Indigenous research methods. Halifax & Winnipeg, Fernwood Publishing.
World Health Organization. (1992). "ICD-10 Classifications of Mental and Behavioural. Disorder*:* Clinical Descriptions and Diagnostic Guidelines." Retrieved 10.10, 2015, from http://www.who.int/classifications/icd/ICDRevision.pdf
World Health Organization (2013). "Traditional medicine strategy: 2014-2023." Geneva
World Health Organization (WHO). (2014). "Traditional Medicine: Definitions." Retrieved 10 December, from http://www.who.int/medicines/areas/traditional/definitions/en/.

Article I:
In between coffee and God: Mental health and emotional landscapes in Northern Norway

Mona Anita Kiil, Department of Clinical Medicine, Faculty of Health Sciences, UiT The Arctic University of Norway

Keywords: Mental health, Nerves, Embodiment, Culture, World War II, Ethnography, Northern Norway.

She said she didn't want me to suffer the same fate as our father. He took his own life, you know.

Jacob, a man in his mid-seventies, has been a patient of the mental health outpatient clinic in Northern Troms for the last seven years. He has been diagnosed with depression and anxiety disorder. We spoke on the phone before our first meeting, and he told me that his sister had "forced him" to get help, and that was how he became a patient at the clinic.
Before he retired, Jacob worked on a fishing boat, usually for two weeks at sea at a time. During our first meeting, Jacob told me his difficulty was *nerves* and that his *nerves* were the reason for receiving treatment at the clinic.
Nerves was a term that recurred regularly during my ethnographic fieldwork among patients using the clinic. The term *nerves* was used in several ways: as a way to describe anxiety and depression, to express experiences and communicate about emotions and illness, and also to describe Nordreisa[15], for example by saying "there are lots of *nerves* here", as if the local context was having *nerves*.
This article aims to investigate how poor mental health can be embodied in this context, and if the phenomenon of *nerves* can add meaning to this question. I will first give a brief overview of the empirical background and the methodological approach of this study, before sharing passages from the story of one of the participants, Jacob. Finally, themes made

[15] The municipality where the clinic was located.

relevant in Jacob's story will be discussed by exploring theoretical perspectives of embodiment.

C**onceptualising *nerves***

Nerves should, according to Foss (2002), be understood as a polysemic phenomenon, used as a cultural term and negotiated within a local context. In medical anthropology *nerves* are recognised within the category of folk illness or as a culturally interpreted syndrome with or without diagnostic equivalents in Western medicine (ibid; Davis, 1983; Scheper-Hughes, 1994; Low, 1994; Davis & Joakimsen, 1997). *Nerves* are often identified as an embodied idiom of distress, as social character and as a method of impression management (Guarnaccia & Farinas, 1988; Davis & Low, 1989). How *nerves* manifest as symptoms include similarities across various cultural contexts; *nerves* can be expressed as stomach pain, prickling in the skin, dizziness, headache, anxiety, sleep problems, withdrawal, worry, anger or concentration problems (Sluka, 1989; Foss 2002). As such, *nerves* can be equated with the ICD-10 and DSM-5 diagnostic categories of anxiety, depression, and somatic disorders (2015, 2013). However, *nerves* are best understood as an ambiguous illness category (Ngokwey, 1995), which allows for an understanding of *nerves* as a resource or tool, e.g. by expressing resistance in in asymmetrical relations of power, whether of a social or political character (Davis, 1997; Rebhun, 1993). The concept of *nerves* is thus a horizon, or space, for understanding mental health individually as well as grasping the therapeutic landscape of Northern Troms (Kiil, 2015).

Northern Troms: an historical backdrop

Northern Troms has been a multi-cultural region for centuries, populated by Norwegians, Sami and a small minority of Kvens, who are largely descendants of Finnish immigrants who arrived in the area before the 19th century from Finland because of war and famine. The municipality of Nordreisa, where the clinic is situated and most of the fieldwork took place, has, like most of the coastal communities in the region, a majority population of ethnic Norwegians and also inhabitants with mixed Sami, Kven and Norwegian backgrounds.

The religious awakening today known as Laestadianism came to Northern Troms from the 1840s (Kristiansen, 2005). Laestadianism was originally based on the teachings of Martin Luther but has over time become separated into various fractions, some of which are known

to be very conservative in regard to moral and theological issues. The Laestadians are members of the (Lutheran) Church of Norway, yet the Laestadian congregations function as independent religious denominations. To my knowledge, there are many elements of Sami culture to be found in Laestadianism, and in Northern Troms it can thus be easier to identify cultural belonging through religion than ethnicity per se.

To prevent a Soviet advance, Hitler applied the "scorched earth policy" in Finnmark and Northern Troms in the autumn of 1944, so that by force, 75 000 inhabitants were evacuated from their homes, and mainly moved to the still occupied south of Norway. Some defied the order and hid from the Germans.[16] After the burning, there were few material memories of the past, including material manifestations of the Sami and Kven legacy (Bjørklund, 2000). The process of assimilation of Sami and Kvens, which started around 1850, escalated after the war. Those evacuated to the south while in this vulnerable situation simultaneously encountered a more typical Norwegian and mono-linguistic society. When they returned home, the need to master the Norwegian language was even more urgent, as the bureaucracy surrounding the rebuilding of the region was extensive and dominated by the Norwegian state (ibid). People drew the conclusion that the assimilation policy was now crucial for successful local life; one needed to master the Norwegian language and understand the cultural norms of the majority.

The events surrounding the burning and evacuation have not been properly recognised or given status as a national trauma, but remain in the shadow of the Norwegian resistance movement, the liberation and national rebuilding of Norway after World War II.

Method and methodology: the kitchen table approach

This article is based on ethnographic fieldwork conducted in Nordreisa from April 2011 until November 2012 among twelve patients who were receiving treatment at the outpatient clinic for mental health care in Northern Troms. The data mainly consists of in-depth interviews and participant observation, but also a number of ethnographic interviews with the patients, traditional healers, therapists and staff at the clinic and people in the local communities. The participants were men and women between the ages of 22-74 years. The interviews were

[16] "The Germans" is the common term (emic) used by the locals who experienced World War II, and is equivalent to "Nazi Germany", German soldiers or troops.

audio-taped and transcribed verbatim. Hand-written notes were sometimes taken during, and always after, the interviews. The main themes for the interviews were the participants' life story, being a patient in conventional mental health care, and reasons for and experiences from the use of traditional healing. The analysis was not based on interviews in which *nerves* were addressed explicitly, but the term emerged spontaneously during conversations and thus became relevant to pursue.

Most of the data collection took place in the participants' kitchens, where sitting and sometimes standing, while making and drinking coffee was a vital part of the conversation and interaction between us. As Pink (2009) notes, even if little analytical attention has been paid to the universal human practice of sitting, it is a sensory embodied practice for the interviewer and interviewee just like eating and walking are. In what on the surface might seem to be a relatively straightforward interview situation, a new layer of complexity is introduced if we pause to consider the meanings that might be invoked through the material and sensorial environment. There are, moreover, good reasons why many interviews consist of sitting and talking. These are not simply qualitative interview conventions but cultural practices, sometimes part of everyday routines or storytelling and other oral narrative traditions. Thus, when conducting "sitting and talking" type interviews, it is useful to first gain some idea about local cultural conventions regarding these practices, such as what one should do and not do, while sitting and talking/listening. In the participants' homes this often included listening to certain programmes on the radio, the making and drinking of coffee, eating open sandwiches or cake, watching the participant knit or prepare fishing equipment, and in some cases restless movements like tapping one's foot or drumming with one's finger. Occasionally we would end up talking about minor things not relevant to the topic at all, while at other times, we would simply share a silence.

Memories as sensory ethnography

A familiar smell from my own childhood comes to me from Jacob's kitchen. Klara, Jacob's older sister, is visiting and making blood pancakes. I remember clearly the last time I ate them; it was on a rainy summer's day spent with my grandmother. I was 12, and there was sugar on them, just like the one Klara hands to me. Jacob says: "This is food we eat with a kind of religious devotion."

Klara says:

> The very moment our father and the neighbour had finished the slaughtering, my mother was there to get the blood, and there would be blood pancakes for the rest of the week.
> Real everyday food that kept us going!

As Klara is leaving, I observe Jacob from a close distance, sitting at his kitchen table. I listen to his subtle remarks on the heavy snow that might tear down the porch roof and his worries about the cat that has been missing for several days now. These everyday comments blend in with Jacob's story.

The smell of the coffee and the general atmosphere also remind me of being in my late grandfather's house, and I find myself simultaneously in Jacob's and my grandfather's kitchen. My awareness of this creates a homely atmosphere and reveals an implicit understanding of Jacob's story as part of nostalgia, which was present in me during these meetings. After we had met a couple of times, I told Jacob of the resemblance to being in my late grandfather's kitchen. Afterwards, I sensed that his way of telling became more intimate. Jacob's private coffee ceremony gave connotations to my fieldwork in the Gambia, in West Africa (2009) and the public ceremony of making *attaya*, a strong green tea, served and shared in tiny glasses, usually only among men.

As with the Gambian men in the streets of the village of Kololi, Jacob's coffee-making is much more than merely preparing a drink; I realise that for Jacob, the coffee makes the narrative possible. It opens and closes the conversation, yet without any clear boundaries; it makes his stories flow and somehow embody his memories. I was a witness to Jacob's testimony, and being there and listening to this old man's struggles did make an impact on me; I was clearly affected emotionally.

As with all ethnographic fieldwork, my time spent in Northern Troms generated new questions through an increased contextualised understanding. In between the clearly formulated problems at hand, which were worked out in an attempt to explore mental health and the use of traditional healing in Northern Troms, a world of in-between(s) emerged. According to Stoller (2009), it is the anthropologist's fate to always be between things, whether these are concepts, cultures or even realities. Rather than lament this, Stoller celebrates the creative power of the between, showing how it can transform us, changing our conceptions of who we are, what we know, and how we live in the world. The *in-between* can therefore refer to both a methodological and empirical position; for myself as the

researcher and for the participants and their stories, this represents close consideration for all the "in-betweens" regarding systems, cultures, health and illness.

General ethics

The study was approved by the Regional Ethical Committee. The patients gave written consent to participate. The citations used in this chapter have been approved by the participants. All participants have been given pseudonyms, and other personally identifying information has been altered.

Jacob, the everyday philosopher

Jacob's house is located at the end of a road in a quiet neighbourhood, with only a few older houses nearby. Except for the entrance, his house is surrounded by forest, and only a slight view of a small store room and a stream is visible from his kitchen window. Inside Jacob's kitchen is where all our meetings took place. The kitchen itself carries its own story. A collection of recognisable items from the 1950s and 1960s, not displayed as a modern, retro-style choice by Jacob, but as an authentic expression of someone living a low-consumption and non-materialistic lifestyle. In this sense, his kitchen somehow becomes a bold statement of his own reference to himself as being "a simple soul".

Jacob makes coffee the old way. He boils it in a kettle. "Nothing beats boiled coffee," he states. Filtered coffee does not taste the same, he says convincingly. He is taking his time when making coffee, as if it is a ritual where he (on some level) communicates with the water while he pours it, the coffee which he handles determinedly, the kettle which looks rough and worn-out and yet he wipes off the excess water in a gentle way, almost as if the kettle is an extended part of his body. Jacob is the master of ceremony, and I am his audience. The grating radio on the windowsill works as a prop in this setting.

This kitchen is Jacob's domain. On one of our meetings, he discovers that he has run out of bread and cheese. The subsequent trip to the grocery store is a manifestation of the kitchen being Jacob's sanctuary. I notice a different Jacob, the *nerves* that up until now had been more a topic than a reality, are suddenly present. When I ask him about it, he says:

"I guess I carry them [his *nerves*] with me. Maybe other people can notice them even if I don't want them to. I guess it's just in my body".

A farmer's son

Jacob is from Nordreisa and has lived his entire life here. In his own words, being the son of a farmer paved the way for a life of hardship:

> My father took over the farm from his father. My grandfather was also from around here, and his parents as well. Farmers, fishermen, you could say we're a family with dirt under our finger-nails (Jacob smiles). It can be a good life at times – but hard. I remember my father always being out in the farmhouse, or in the fields, or sometimes out fishing. Even when he had the chance to relax, he kept on doing something. My father was a restless soul, not much of a talker. My mother used to come out to the farmhouse to milk the cows, other than that she was in charge of the house. We were taken care of, you know with food and clothes and other necessities. She was distant in her own way though, serious, like my father. And they would punish us if we didn't obey, as they said. It was always without any drama, really. It just happened. They didn't swear, we didn't cry. It was all about keeping it together. I still remember the sound of my father's belt when he fetched it from the storehouse. He never wore that belt, it was just for punishment. Inside the house, next to the fire-place there were birch twigs which my mother would spank our bare bottoms with whenever she found it necessary. She too did it quietly, always saying that it was in the name of the Good Lord. The birch twigs were just hanging there, to warn us against disobedience. But I don't blame them.
>
> They did their best. And times were tough back then. I guess fate decided that I was to be the son of a farmer.

Jacob nods his head, as if he is confirming the story to himself.

Ebb and flow

Jacob has a small boat he uses occasionally. On this late September day he wants to take the boat in for the coming winter, and I offer to help him. While I am parking the car, I notice Jacob in front of me, in his overall and wellingtons. It crosses my mind that from behind Jacob seems solid as a rock, yet his eyes tell a different story. "Perhaps you'd like a trip out," Jacob asks me. I am thrilled, both to be out on the fjord, and to see Jacob like this. He manoeuvres the boat with experience, and even though we do not talk much, there is this moment that we share. After we have stored the boat, Jacob stands looking out over the fjord.

“The fjord can fool you,” he says. “It looks calm, like now, and next thing you know the waves are coming to get you”.

Later on in his kitchen, I ask if the way he described the fjord could be similar to the way he felt about his *nerves.* He nods:

“Kind of. But the waves are never truly out of me. I guess you can say it’s like ebb and flow”.

Jacob draws an imaginary circle in the air:

“And this ebb and flow is everywhere here, not only inside me, it’s all around”.

He continues:

> When I sense this wave of *nerves* in the body, I like to be near the sea. Or in the forest. I will call the *reader*[17], or my sister calls him, and he somehow calms my inner storm. One time I was out on the fjord fishing, the weather changed in an instant, from crystal clear water it suddenly blew up to a gale. My sister got so worried, so she called the reader. He calmed the sea. I got home safely. I tell you, the good readers, they can cure just about anything around here.

Dreaming of doomsday

Jacob told of his younger brother´s recurring nightmare throughout their childhood:

> My brother sometimes woke me up at night, but mostly he would talk about it during the day if we got into some kind of trouble and he got emotional. Dreaming of doomsday, that’s a dream from the devil himself. You know that if you start dreaming it you’ll be in trouble somehow. The dream gets under your skin, it can make you go crazy. My father used to say that if you dreamt of doomsday, somebody had cast a spell on you[18], and you’d better watch out.

Stories regarding this specific dream also appeared in, or more correctly, in between, the stories by the other participants, and both Jacob and the other participants talked about it as a dream which had created substantial suffering in people’s everyday lives. All the participants who mentioned this dream said that it exclusively took place when they were “at home”, not

[17] Traditional healer who provides spiritual guidance and support related to illness and crisis.
[18] “Ganne” in Sami, also used in the Norwegian language in the North of Norway.

necessarily in their own house, but in their local area, as they would never dream it while in other locations.

Faith and fear

Jacob would occasionally refer to his upbringing, which was within what is considered the most conservative Laestadian congregation in the region:

> As a youngster, I wasn't fond of going to the meetings, but they [his parents] made me. I felt lost there, and quite frightened, to be honest. It felt like a dark place, all this talk of sin somewhat got under my skin. I liked the sense of community, though, and sometimes made friends with other kids. I actually met my wife at one of those meetings [Jacob chuckles].

His wife had passed away nine years ago, from heart disease. Jacob would refer to her when he spoke, giving me the distinct impression that they were very close.

Jacob said that he sometimes prays, but does not consider himself a Laestadian, perhaps not even a "real" Christian, as he said:
"But I do carry it with me, you know. This faith. And faith can be found in different places, even out there" [Jacob nods towards the forest].

Being at war

Jacob fills his kitchen stool with a silent presence. He never raises his voice, he speaks quietly yet clearly. On this particular day, he opens up to parts of an untold story:
"I don't know if it's the warm coffee we're drinking, or the things we've talked about recently, but now I remember how cold we actually were".
Jacob is referring to the autumn of 1944. He was only seven years old when "the Germans" evacuated Northern Troms and Finnmark, after burning down most of the land. As they are leaving their house, Jacob and his siblings witness all the animals on their farm being shot in front of the farmhouse and their home is put on fire, as were the neighbours' homes. A dreadful scene unfolds: chaos, people and animals crying. Determined not to leave home, Jacob's family go into hiding. An uncle on his father's side is dedicated to the resistance movement, and there is no question about the family following orders and moving south. The next few weeks immediately after the evacuation were literally spent on the run. The family

hides in the mountains, sleeping in a cave before finding a *gamme*[19] where they stay until they successfully manage to flee across the border to Sweden. Along the way, a baby brother dies.

> We were of course frightened. And hungry. Well, what can I say. Those were hard times. Later on, we were staying in a big, white house. The house was a lot nicer than ours, and they wore better clothes than us, I remember that well. It must have been a priest and his family, it's like I can recall the priest's collar. Anyway, when the war was over and we returned home, nothing was left. Everything had been burned. It was quite some time before our new farm was ready, and life continued. Anyway, there wasn't any talk about these events afterwards - it was just something that had happened, and there were people who had suffered greater losses than us, they [Jacob's parents] said.
>
> One thing is for sure: the war stayed with us long after freedom came. Maybe it's still staying. My father used to talk about the war, the Nazis. People like Baalsrud[20]. But what actually happened to our family during this time was never a topic, no, we never talked about it. I guess it was well hidden in the closet, so to speak, and yet it was still an important part of our life.
>
> I realise it now, when I talk about it, that they [Jacob`s parents] swept it under the carpet.

Jacob gets up from his kitchen chair and walks around restlessly. He stretches a curtain and looks out of the window, and says he has never talked about this before.

"It is kind of strange, isn't it, you had to come all the way from the university to make me talk about my memories of the war!"

Eventually, Jacob lets me in on the memory of his late son.

"Johannes was a good son. And he was all we had. Always very quiet, he did not make much fuss of himself. But I never saw it coming".

Jacob grabs his cup of coffee and takes a long sip. He looks calm, yet at this moment I sense his presence as heavy. Jacob clears his voice:

---

[19] Gamme in Norwegian, in Sami: goahti. A traditional ground hut.

[20] A freedom fighter from the Norwegian resistance movement who managed to escape the Germans through a somewhat spectacular flight from Northern Troms to Sweden. The Baalsrud memorial march is arranged annually.

“I found him out there”.

Jacob nods his head in the direction of a storeroom behind the house.

“I could hardly open the door, all the pieces of wood we had stacked earlier that autumn were on the floor. I guess he climbed on some of it, before he did it. Who would have thought that my own son would suffer the same fate as my father”.

Jacob’s eyes seem frozen to the window in front of him. He sighs:

“Not everyone manages to stay on the sane side”.

A legacy of *nerves*

Through Jacob’s story, a landscape of hidden wounds penetrates the surface. Jacob introduces us to several stressors which can explain why *nerve*s and mental illness seem to be present in the landscape of Northern Troms, and his story emphasises how it is probably the sum of all these which creates distress. Based on experiences like Jacob’s, can we understand *nerves* as poor mental health being embodied in Northern Troms? Can *nerves* become an identity? Has the region’s socio-cultural and political backdrop created a continuous trauma, a suffering *in* and *over* time, which has been reproduced through generations and never seems to be completely healed? From a critical medical anthropological perspective, this position gives resonance to *nerves* as an embodied idiom of distress in this region, and Jacob`s description of his *nerves* as *ebb and flow* manifests the in- between state of *nerves* which indicates such an ambiguous illness category. *Nerves* are seemingly a way to communicate emotions, and the local trauma is thus communicated through the presence of *nerves*. In this way, Jacob and the other participants left me with the impression that *nerves* were a legacy to them, and to the place.

Emotional landscapes

Knowledge of places is closely linked to knowledge of the self, to comprehending one’s position in the larger scheme of things, including one’s own community, and to securing a confident sense of who one is as a person (Basso 1996). According to Arendt (1958), and as portrayed through Jacob’s story, storytelling is never simply a matter of creating either personal or social meanings but an aspect of “the subjective in-between” in which a multiplicity of private and public interests are always problematically at play. In this sense, collective memory can be about sharing emotional landscapes (Kahn, 1996).

Details about the doomsday dream, which Jacob mentioned, were not revealed by any of the participants. The dream was referred to as something implicit and I understood it as an expression of local knowledge: perhaps a shared emotional landscape which somehow transcends time and space. This dream can be understood as a local expression of the embodied pain accumulated by *nerves*. Could this dream be seen as a result of a distinct moralism deriving from conservative Laestadianism, which can add to the understanding of *nerves*? Then again, is this actually a dream, or is it a conception, or even a myth that people relate to just as much in their everyday, awake life as in dreams? Could dreaming of doomsday in fact be an expression of collective memories as something dynamic and situated, as the dreaming could be connecting to Sami epistemic practice and knowledge traditions? In this light, dreaming of doomsday can be seen as partly (re-)connecting to a past of Saminess by enacting and performing collective memories (Taussig, 1993), as a social fact (Odner, 1995), but also as an extension of the inner room, where wounds in the collective consciousness, according to Jung (1991), are anchored. *Nerves* can thus be a way to canalise and deal with nostalgia for a somewhat lost heritage (Lock, 1990). In any case, I find Jacob's story to be an example of how knowledge, memories and wisdom (Basso, 2000) sit in both people and places, and how home thus appears as both emotional and cultural.

The knowing body

According to Skultans (2000), an anthropological perspective would suggest that culture-bound syndromes are to be found in all societies and that they point us towards the weak points within the social fabric: the areas where social demands on the individual are conflicting and paradoxical. Culture-bound syndromes such as *nerves* often lead us to the core values of a society, and also demonstrate how definitions of deviancy are essential to the identity of a community. One could therefore ask whether silencing and concealing sentiments is a core value, or a coping strategy in Northern Troms, as a result of the history attached to the region, and *nerves* thus an expression of an embodied protest against assimilation, evacuation and marginalisation? Could *nerves* in fact be understood as an arena for making sense of suffering, or at least as a tool to manage the past?

Jackson (1982) promotes the idea of influencing understandings through bodily techniques rather than verbal elaboration. He focuses on the "the knowing body", the body as lived life and its insistence on meaning. This position corresponds with Bourdieu's (1990) discussion of the body as a "reminder". Bourdieu believes this has general validity for human beings;

memories are *in* the body, and his concept of habitus includes this. With habitus, or the idea of bodily internalisation of habits and patterns of actions, Bourdieu wishes to transcend the dichotomous split between body and soul, between the physical and the cognitive. If we open up to the possibility of seeing place as body, memories would, in a Bourdieuan sense, be *in* the place, and *nerves* a general condition rather than an individual method for dealing with and expressing emotions. As *nerves* are contextualised, they are simultaneously being de-personalised. This is in line with the concealment of emotions, as described in Jacob's story, and thus *nerves* can, paradoxically, be a form of self-mastery (Briggs, 2001). Then again, could it be that a society's lack of a collective dialogue about collective trauma individualises trauma, so that people troubled with *nerves* have to deal with it on their own and in silence? Is this an extension of a Sami culture that tends to keep silent about problems and see depression as weakness, or is this "just" family culture? The family, as a unit, could also be viewed as a knowing *body*, as Jacob, like most participants, would refer to *nerves* as something "running in the family". This was also confirmed by the head of the clinic, who said that some families were more at risk of or vulnerable to poor mental health:

"We know which families they [the patients] come from, we know their family history. Sometimes it seems like a vicious circle, they are unable to escape".

Concluding remarks

In between the life world of Jacob, his experiences with traditional healers, spirituality and everyday life, lies the story of how people in Northern Troms negotiate their lives and identities in between past and present, and how their stories reveal local trauma. I have argued that the participants' stories provide an understanding of *nerves* as an embodied idiom of distress in the region. *Nerves* appear closely connected to people's experiences from the assimilation process and the expulsion from their homes during World War II. The continuous concealment surrounding these events creates trauma but also insights for the people in Northern Troms; through *nerves*, identities are being negotiated.

Jacob's story shows that *nerves* can be an open and harmless category, and therefore accessible and usable for people, and that *nerves* is a concept which manifests the *in-between*: a condition between health and illness. When embodied poor mental health is to be dealt with in conventional mental health care, treatment and clinicians must therefore take into account such contextualised experiences as revealed through Jacob's story. It is not a matter of indulging in nostalgia, nor of reminiscing about the past, but rather understanding

and raising awareness of the package of experiences both presented and hidden in the clinical encounter, which underlines the importance of understanding psychopathology within a cultural framework.

References

Arendt, H. 1958: *The Human Condition*. Chicago: University of Chicago Press.

Basso K.H. 1996: *Wisdom Sits in Places. Landscape and Language among the Western Apache*. Albuquerque: University of New Mexico Press.

Bjørklund, I. 2000: *Sápmi - en nasjon blir til* (Sápmi - a Nation in the Making). Tromsø Museum.

Bourdieu, P. et al. 1998: *Masculine Domination*. Stanford, California: Stanford University Press.

Briggs, J.L. 2001: *Never in Anger. Portrait of an Eskimo Family*. London: Harvard University Press.

Davis, D. 1983: *Blood and Nerves: An Ethnographic Focus on Menopause*. St. John's, Canada: Memorial University of Newfoundland Institute of Social and Economic Research.

Davis, D. 1997: Blood and Nerves Revisited: Menopause and the Privatization of the Body in a Newfoundland Postindustrial Fishery. *Medical Anthropology Quarterly*, *11*(1), 3-20.

Davis, D., & Joakimsen, L. 1997: Nerves as Status and Nerves as Stigma: Idioms of Distress and Social Action in Newfoundland and Northern Norway. *Qualitative Health Research*, *7*, 370-390.

Davis, D., & Low, S. 1989: *Gender, Health, and Illness: The Case of Nerves*. New York: Hemisphere.

DSM-5 2013: *Diagnostic and Statistical Manual of Mental Disorders.* American Psychiatric Association.

Foss, N. 2002: Nerves in Northern Norway: The Communication of Emotions, Illness Experiences and Health Seeking Behaviors. *Qualitative Health Research*, *12*(2), 194-207.

Guarnaccia, P., & Farias, P. 1988: The Social Meanings of *Nervios*: A Case Study of a Central American Woman. *Social Science & Medicine*, *26*, 1223-1231.

ICD-10, 2015: *International Classification of Diseases*. World Health Organization.

Jackson, M. 1982: Allegories of the Wilderness: Ethics and Ambiguity in Kuranko Narratives, African Systems of Thought. Bloomington, Indiana: Indiana University Press.

Jung, C.G. 1991: *The Archetypes and the Collective Unconscious.* London: Routledge.

Kahn, M. 1996: Your Place and Mine. Sharing Emotional Landscapes in Wamira, Papua New Guinea, in Field, S. and Basso K. *Sense of Place*. Santa Fe, New Mexico: School of American Research Press.

Kiil, M.A. 2009: To Move with the Times. A study of Polygyni*es* in The Gambia (Å bevege seg med tiden. En studie av polygyni*er* i Gambia). Master Thesis, University of Tromsø, Norway.

Kiil, M.A. 2015: The Paradox of Home. Understanding Northern Troms as a Therapeutic Landscape, in Miller, B. *Idioms of Sami Health and Healing*. Patterns of Northern Traditional Healing Vol 2. University of Alberta Press.

Kristiansen, R. 2005: Sámi Religion and Laestadianism (*Samisk religion og læstadianisme*). Bergen, Norway: Fagbokforlaget Vigemostad & Bjørke.

Lock, M. 1990: On being Ethnic: The Politics of Identity Breaking and Making in Canada", or, Nevra on Sunday. *Culture, Medicine and Psychiatry,* Volume 14, Issue 2, pp.237-254.

Low, S. 1994: Embodied Metaphors: Nerves as Lived Experience. In T. J. Csordas (Ed.), *Embodiment and Experience: The Existential Ground of Culture and Self* (pp. 139-162). New York: Cambridge University Press.

Ngokwey, N. 1995: Naming and Grouping Illnesses in Feira (Brazil). *Culture, Medicine, and Psychiatry*, *19*, 385-408.

Rebhun, L. A. 1993: Nerves and Emotional Play in Northeast Brazil. *Medical Anthropology Quarterly*, *7*, 131-151.

Odner, K. 1995: Samisk identitet (Sami Identity). *Norsk Antropologisk Tidsskrift* (Norwegian Journal of Anthropology), *6* (2):127-138.

Pink, S. 2009: *Doing Sensory Ethnography*. London: SAGE Publications Ltd.

Scheper-Hughes, N. 1994: Embodied Knowledge: Thinking with the Body in Critical Medical Anthropology, in R. Borofsky (Ed.), *Assessing Cultural Methodology* (pp. 229-242). New York: McGraw-Hill.

Skultans, V. 2000: Remembering and Forgetting: Anthropology and Psychiatry: The Changing Relationship, in Skultans, V. and Cox, J. 2000: *Anthropological Approaches to Psychological Medicine, Crossing Bridges.* London: Jessica Kingsley Publishers

Sluka, J. 1989: Living on their Nerves: Nervous Debility in Northern Ireland. In D. Davis & S. Low (Eds.), *Gender, Health, and Illness: The Case of Nerves* (pp.127-152). New York: Hemisphere.

Stoller, P. 2009: The Power of the Between: An Anthropological Odyssey. University of Chicago Press.

Taussig, M. 1993: *Mimesis and Alterity: A Particular History of the Senses*. New York: Routledge.

Confirmation

I hereby confirm that Universitetsforlaget has accepted Mona Anita Kiil`s chapter contribution "I mellom kaffe og Gud. Psykisk helse og følelsemessige landskap i Nord-Troms", to be published in the book "*Kulturen som pasient. Uvanlige møter for vanlige folk*", edited by Jens-Ivar Nergård and Piers Vitebsky. The tentative date for publishing is September 1st, 2018.

Per Robstad
Editor in Chief
M: 909 20 518

Universitetsforlaget AS
Sehesteds gate 3, PB 508 Sentrum, 0105 Oslo

Article II

What is at stake in the clinical encounter? Mental health care and belonging in a local community in Northern Norway

Mona Anita Kiil (corresponding author)
Department of Clinical Medicine, UiT The Arctic University of Norway
E-mail: mona.kiil@uit.no

Trine Stub, The National Research Centre in Complementary and Alternative Medicine (NAFKAM), Department of Community Medicine, UiT The Arctic University of Norway
E-Mail: trine.stub@uit.no

Tone Seppola-Edvardsen, Department of Community Medicine, UiT The Arctic University of Norway
E-mail: tone.seppola-edvardsen@uit.no

Abstract

Introduction: Based on the stories and statements from patients visiting a conventional mental health clinic in a mixed ethnic area in Northern Norway, we identified a strategy of being careful about what information to share with the therapists at the clinic. In this article, we investigate what is at stake in the patients` encounters at the clinic, and what makes this carefulness a reasonable strategy for them. We will discuss this by comparing the participants' stories of experiences within conventional medicine with their experiences from their use of traditional medicine, as these alternatives were frequently compared by the participants.

Method: Ethnographic fieldwork were performed among the 61 participants. Special emphasis was placed on data from 12 patients visiting a mental health clinic in Nordreisa, Northern Norway, which included repeated in-depth semi-structured interviews. The data were transcribed verbatim and the analysis of the material was conducted according to thematic content analysis. Some codes were predefined and others were defined during the analysis.

Findings: Visiting the conventional mental health care clinic, the participants experienced that their local worldview and ways of handling social relations, death and illness in everyday life could be misunderstood by the therapists. They emphasized the difference between being diagnosed and being understood. The participants understood their health problems as part of life itself, and seeking help from *readers* and traditional medicine was a way of "managing on one's own".

Conclusion: The participants in this study experienced a need to protect themselves by being selective in sharing health information with conventional health care therapists, as this information could be misunderstood and used against them, leading to the wrong diagnosis and treatment. *Readers*, on the other hand, stood for respect and understanding in terms of individual health complaints, the local culture and the community. Thus, it is important for conventional mental health therapists to increase their knowledge and understanding of patients' lives, cosmology/ontology and how their illness is experienced individually in their particular life context.

Keywords: Mental health, Traditional medicine, Sami, Kven, Laestadianism, Ethnicity, Culture, Belonging, Ethnography, Northern Norway.

Introduction

…my advice is don`t tell them too much… even if they are friendly…it`s usually not in your best interest.

This statement, referring to her relation to conventional mental health therapists, was given by one of the participants in this study. In this article we will investigate the reasons for this carefulness, as explained by the participants.

This study was based in the outpatient mental health care clinic[21] in Northern Troms, Norway. This region covers a substantial geographical area with sparsely populated communities and has been multi-cultural for centuries as people have moved across regions and national borders. When people speak of ethnicity in the region, it is usually the Norwegians, Sami and Kven (descendants of Finnish-speaking immigrants) that are seen as relevant ethnic groups. In the coastal areas, such as Nordreisa where the clinic is situated, the population sees itself as predominantly Norwegian, probably strongly influenced by the forced assimilation of the Sami and Kven people. Many have ancestors from all three ethnic groups. Consequently, the concepts of ethnic groups and cultural identity are understood as complex within the region.

The aim of the Norwegian state policies before World War II was the forced assimilation of the Sami and Kven/Finnish-speaking populations. Since World War II, state policies have slowly changed towards integration. Of particular interest in this shift is the considerable focus on the concepts of *roots* and *belonging* in the post-colonial Western world beginning in the 1960s and 1970s, and with Sami revitalisation activism starting in the same period. The complexity of the region is also mirrored in how the forced assimilation policy has impacted different geographical areas to various extents (Eidheim H 1997). Today people with Sami and Kven ancestry living in the coastal areas consider themselves as mainly Norwegians or simply as "a mix", maybe influenced by earlier stigmatisation and assimilation policies where the Sami and Kven languages and cultures were seen as not part of, or even a threat to, the developing Norwegian society (Thuen T 1995). Today, cultural differences are not often observable or made relevant (Kramvig B 2005, Olsen KOK 2010) and earlier research has

[21] Hereafter, the clinic.

explained this by individual experiences of stigmatisation, discrimination and subsequent psychological distress (Eidheim H 1992, Minde H 2003, Hansen KL and Sørlie S 2012).
In Northern Troms, traditional medicine[22] is commonly used. The WHO definition (World Health Organization 2013) of TM is: the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.
This is a medical system consisting of age-old practices including herbal medicine, bloodletting, the stopping of blood, moxa burning, cupping, and *reading* (Mathisen SR 1989, Myrvoll M 2010). In this article, the main focus will be on what is locally called *reading*, also referred to as *curing* or *blowing* within the region. Reading is a form of TM and describes the treatment conducted by a healer when he or she reads a healing prayer for illness (Mathisen SR 2000, Hætta AK 2015, Myrvoll M 2015).
Northern Troms has been little explored in terms of research on the use of TM. Research from other areas with a Sami or mixed population has examined continuity and changes in the Sami worldview, and how this affects the use of TM (Miller BH 2007, Sexton R and Sørlie T 2008, Myrvoll M 2010, Nymo R 2011), how Sami people manage health and therapeutic relations (Bongo BA 2012), how knowledge about the use of TM affects clinical practice (Langås-Larsen A, Salamonsen A et al. 2017), and the role of family when using TM (Langås-Larsen A, Salamonsen A et al. 2018, Langås-Larsen A, Salamonsen A et al. 2018). Furthermore, which coping strategies psychiatric patients applied in their maintenance of health (Andersen KB, Persen S et al. 2015), *reading* as a coping strategy, and part of a safety net in cases of illness and disease among elderly people (Nymo R 2011, Nymo R 2015), the use of TM as a way of keeping control over matters of health and illness, and the importance of having a family member able to stop bleeding (Myrvoll M 2010, Myrvoll M 2015), and TM understood as practical help in daily life, a caring public health measure and an expression of the Christian practice and faith in Northern Norway (Henriksen AM 2010).

Reading as local management of everyday life, health and illness

Reading is the speaking of words from the Bible with the intention to heal through activating healing energies. In this belief, healing is generated from the power that comes with the

[22] Hereafter, TM.

words. *Reading* is thus understood as using God's power, not the healer's own energy; as one of the *readers* in the study stated, "I pray for the ill, and the rest is up to God, our Father." *Reading* is understood as spiritual guidance and support during challenging times in life; it is a kind of prayer directed towards a specific problem. *Reading* is most commonly used for various emergencies, related to mental and physical illnesses as well as natural phenomena; the ability to stop blood or calm the sea has e.g. been closely related to the practice of *reading* (Henriksen AM 2010). Family members, neighbours or friends often contact a *reader* on someone`s behalf. The *readers* do not charge payment for their services as these are considered *gifts of grace* and performing *reading* a calling and duty to share with people in the community, which also demonstrates the religious aspect of the tradition. *Reading*, as an unofficial health care system, is solidly anchored in this region and has influenced how health and illness have been dealt with, centuries before Western medicine was made available (Myrvoll M 2010); this is particularly relevant in communities with a historically large Sami population (Mathisen SR 1989). The *readers* who participated in the study told the first author that although they often treat conditions like toothache and backache, they now find more people contacting them because of mental distress.
Reading is part of the cultural and spiritual interactions in the region. As Laestadianism plays a significant role in the practice of *reading* we will give a short presentation of this movement in the following.

Laestadianism in Northern Troms

Founded by the Swedish Lutheran minister Lars Levi Laestadius (1800-1861), Laestadianism was introduced to the northern parts of Norway from Northern Sweden starting from the 1840s, spreading through Norwegian fishermen, the nomadic Sami, and the many Finnish-speaking migrants to Northern Norway (Kristiansen R 2005). The Laestadian congregation is operated as independent religious denominations, but Laestadians are also members of the State Church of Norway and use these churches for gatherings. In terms of moral issues, Laestadian congregations are known to be conservative. Laestadius was of Sami family background and focused on how the Sami population managed illness and crisis in everyday life, and he often referred to traditional healing in the Sami culture in his many writings (Læstadius LL and Posti P 2002). Contrary to Norwegian priests at the time, Laestadius accepted the use of *reading*, perhaps because the practice gives resonance to the emotional spirituality that is a central part of Laestadianism (Nergård JI 2000).

Laestadianism may have helped to reduce or remove some of the ethnic boundaries in the region, as within the congregations the collective identity of being Laestadian has been emphasised more than the individual member's cultural identity.

Against this background, we argue that the participants bring individual and collective memories and experiences into their encounters with TM as well as the conventional mental health care. These include memories and experiences of stigmatisation and devaluation by the authorities of their own or ancestors' languages and culture. They have a history of managing on their own within their local community and within their local congregation and traditional worldview and belief system. Their managing on their own also includes managing health and illness within the local community and its social relations.

Aim

Based on the participants` attitudes about having to be careful with what to share with the therapists at the conventional mental health clinic, our aim with this article is to investigate what is at stake for the patients in their encounters with the therapists. We will do this by exploring the participants' encounters with conventional therapists as well as the traditional healers understood as *readers*, as frequent basis of comparison used in the participants` stories.

Method

This qualitative study draws on data from the first author's PhD that sought to investigate the inhabitants' cultural perspectives on mental health in Northern Troms, Norway. A qualitative study may provide a deeper understanding and more detailed knowledge of important issues in health and care, especially in situations where we have sparse knowledge of our phenomenon of interest (Holliday A 2007, Fontana A and Frey JH 2008); this was the rationale for using this research design.

Design

In this study we used ethnographic fieldwork; data was collected at the outpatient mental health clinic in Northern Troms and in the participants´ homes. The study included in-depth semi-structured interviews with the participants as well as participant observation in the participant`s homes, when they were visiting family members, doing shopping, going fishing, visiting the clinic, visiting complementary and alternative therapists (for e.g. acupuncture or homeopathy) visiting *readers*, etc. Much of the data was thus obtained when participating in everyday life and small talk, and when exploring and discussing relevant topics with the

participants. In addition, the data evolved from the researcher's process of learning and understanding within the field, much resembling a socialisation process (Blaikie N 2000).

Ethnography

Ethnography is a qualitative research method that seeks to understand cultures, institutions, and societies by referring the researcher to the same social environment as the participants. Ethnography is a kind of direct research that values face to face contact with the participants. Thus, the ethnographer must participate in other people's lives, experiences, and daily activities in order to truly understand their lives (Madden R 2013). This approach is called participant observation, and here the researcher is both a researcher and a research tool. Ethnographic interviews are an important part of ethnography and may be understood as *non-arranged interviews*, resembling a normal conversation (Holliday A 2007). In this study, the first author performed fieldwork with 61 participants (see the participant section).

Semi-structured interviews

The semi-structured interview is a well-suited qualitative research approach because the method may generate follow-up questions and promotes the possibility of eliciting nuanced answers and *comprehensive* information (Kvale S 1996). Moreover, the setting is informal and may encourage the participants to tell their story in their own manner (Malterud K 2011). The participants in this study were encouraged to share (with the researcher) how they coped with mental health challenges, and how they related to the different therapists they visited at the clinic.

Thematic interview guide

The interview guide was developed based on a literature review (Kiil MA 2019) which aimed to draw attention to how people in this region understand mental illness and how they relate to different types of therapy. In addition, the first author received input from the therapists and the director at the clinic, who argued that patients in this region often brought specific lived experiences to consultations but perhaps did not voice these experiences at the clinic. The interview guide included the following themes: *childhood/growing up/adult life (family, working life)/major life changes (joys, sorrows, crises)/ significant persons/things you hoped for or dreamt of/understandings of illness (both in general and in particular your own illness)/experiences of your own health/understanding and experience of traditional healing/understanding and experience of alternative treatment/experiences of ethnicity and cultural belonging/experiences of spirituality or religion/experiences of the place or context/thoughts and wishes for the future.*

Setting

While the clinic serves four municipalities in Northern Troms, the majority of patients live in Nordreisa and hence most of the fieldwork was performed there. In this article, Nordreisa is the locus, also referred to as the community.

A total of 4,918 inhabitants live in the municipality of Nordreisa in Northern Troms (Statistics Norway (SBB) 2018). The majority are employed in tourism, trade, and health care services. The participants in this study receive treatment for their mental health complaints at a clinic that is a part of the General Division for Psychiatry at the University Hospital of North Norway in Tromsø (University Hospital of North Norway 2017). The clinic is situated at Storslett, the administrative centre of Nordreisa, where approximately half of the participants live. Other participants live in Kåfjord, Skjervøy, and Kvænangen, the neighbouring municipalities. An average of 450 patients annually receive treatment at the clinic. They are offered different treatment modalities such as art and cognitive psychotherapy and psychopharmacological and rehabilitation treatment.

Recruitment

The participants were recruited to the study in collaboration with the clinic. The researcher was given a list of possible participants, whom she contacted directly by phone. The participants received a letter of invitation including the aims of the study, the research procedures, and ethical information. In order to participate, they provided their written consent. The conventional therapists at the clinic, the complementary and alternative medicine (CAM) providers, and the *readers* were given oral information about the study by the researcher and then accepted orally to participate in the research.

Participants

A total of 61 participants participated in this research project. The sample consisted of the following groups:

- 12 patients from the clinic. These are the main source of empirical information for this article.
- 8 members of staff and therapists at the clinic.
- 5 *Readers.*
- 4 CAM providers.
- 32 inhabitants of the community.

In total, 36 semi-structured interviews were conducted with 12 patients from the clinic. However, the conversations and ethnographic interviews with the 49 other participants made an important contribution to the data analysis. This ethnographic work consisted of numerous conversations and ethnographic interviews with *readers*, CAM providers, therapists, and staff at the clinic as well as inhabitants of the community during a period of 18 months. The initial semi-structured interview was conducted at the clinic. All remaining interviews with the patients took place in their homes or other places outside of the clinic. The 12 patients were diagnosed with anxiety and/or depression. They included both genders and were between 22 to 74 years old. Eleven of the participants were using TM and one participant claimed to have unknowingly received traditional healing. Seven participants (six women, one man) claimed that they had used CAM modalities at least once.

Analysis

The interviews were conducted, tape-recorded, and transcribed by the first author (Kvale S 1996). The researcher took notes throughout the fieldwork, and always after each interview. These reflexive notes were considered in the analysis process (Madden R 2013). The main themes were identified using thematic content analysis (Hsieh HF and Shannon SE 2005). The data was read several times and the research team discussed the various steps of the analysis process. The coding was performed by the first author. She started out with predefined themes based on the interview guide. The themes were altered according to what emerged from the material as well as the research question. The quotations were printed in Norwegian before being translated into English. The following four themes emerged from the analysis: *ethnic and cultural ambiguity, experiences of encounters, differences in how participants related to and told about their illness in the clinic and at home, and the importance of* e*mpathy and understanding.*

In the findings section we will present parts of stories that represent these themes, as told by the participants. "I" refer to the first author.

Findings

Ethnic and cultural ambiguity

Whenever conversations with participants circled around ethnicity or culture in the region, the participants would express ambiguity in terms of belonging, as one participant (male, 69) explained:

> Being a bit of this and a bit of that (Norwegian, Sami, Kven) is maybe what this place is all about, but we don`t really talk about it. It`s just the way it is.

Most participants would point to a rather problematic relationship with expectations from others about having a specific Sami identity, as one participant (female, 33) stated almost in anger when confronted with the distinct Sami legacy in the community:

> Why do people always think we're all Sami people here? There are no real Sami people here!

On the other hand, matters concerning the Kven culture seemed much easier to deal with, as illustrated by the following quotes:

> The Kven heritage is something to be proud of. Can you imagine the hardship our ancestors went through just coming here? They were real hardworking people, now that's something to be proud of. (Male, 47)

Another perspective of this theme arose via a female (54):

> My family is Kven. That's for sure, I found out some years back while doing a bit of ancestry research. Not that I know how it feels to be Kven, it`s not so different from being Norwegian I guess, but it`s good to know my roots even if I don`t consider myself as Kven. People around here tend to think we`re all Sami people, I guess we can be a bit Sami too but other than being Norwegian I believe I'm mostly Kven.

At a later stage of the fieldwork, this participant stated the following while we were discussing ethnicity:

> Anyway, more than anything, well I would say I'm a *good* Norwegian.

The first Kven festival in the northern hemisphere, Baaski[23], has been arranged in Nordreisa since 2007. I participated in the Baaski festival twice during the fieldwork. My impression, as an outsider, was that the atmosphere surrounding concerts and storytelling events had a nostalgic feel, and I experienced it almost like an ode to hardship and courage. Positive affiliations with a Kven identity were manifested through participation in this festival as expressed by one of the participants (female, 54):

> The first time I went to Baaski, it was like a home-coming… it all made sense to me. I got this sensation of being on solid ground, you could say.

I also spoke with other people who expressed similar feelings about being at the festival.

[23] Baaski is the Kven name for a small boat which was previously used to transport equipment and goods across the Reisa river.

During the course of this PhD, Baaski has developed into a whole week of Kven cultural arrangements, also in the neighbouring municipalities.

To sum up, a Sami identity seems more challenging to promote than a Kven identity, but there is also great ambiguity in choosing or stating a specific ethnic identity per se. Both Sami and Kven identities seem remote compared to the idea of being Norwegian, and the most popular ethnic identity, next to Norwegian, is being "mixed", both as an individual and to describe the local community of Nordreisa.

Experiences of therapeutic encounters

When the participants initially were asked about their anxiety or depression disorder and how they managed everyday life in light of this, they would often generalise and refer to life itself, or to a "community experience" more than an individual experience, as illustrated by one participant (male, 74):

> Illness is one thing, but you know, life has always been hard around here. I guess we just manage in our own ways…yes, we find our own ways to manage life.

The common use of traditional healing practices in the region seems to be the starting point for understanding mental health encounters in this community. The participants stated that the use of traditional healing was deeply interwoven in the community, and that it was practised in a humble and quiet way. *Reading* is part of everyday life and seems like a signature of local knowledge, as one participant (female, 63) said:

> Calling the *reader* is nothing special really, it happens every day around here; small stuff, big things, we usually call the *reader* before anything else…it`s about who knows things… we know what really works, and who can help in different types of crisis. There's a *reader* for any situation, there's nothing they cannot help with…

In the participants' stories, the encounters with *readers* were described as being characterised by respect and trust, as elaborated by another participant (male, 49):

> I don`t need to hide anything from the *readers*. They know how we think about life and death around here. They are not here to diagnose me… the *readers* I use, they just simply understand me. I don`t need to use that many words to describe what is bothering me at the time, whatever it is... some of them have known me since I was a little kid, yes, they know my family, know our history, our ordeals.

On the other hand, the conventional therapists at the clinic were related to differently, as this participant expressed (female, 57):

> But of course, the clinic is more like a proper treatment, I guess. Still, it can make you feel naked, you understand? …In my experience, the therapists at the clinic that come from around here are the best ones, they know what life is like around here, but it can also be difficult to be 100% honest with them since they know who you are, know about your family, and such things. And talking is not always an easy task for us here, we're brought up to keep things in the closet…and there's a lot of talking in therapy, right?

She continues:

> The problem with many of them (conventional therapists) is that they seem more focused on diagnosing you than listening to your story. I used to think I would never find a therapist I could get the right connection with. For years I quit all treatment at the clinic… then after a major crisis I went through it came to a point where I just couldn't bear it anymore. I decided to try treatment at the clinic again, I guess I was lucky to meet a therapist that understands what's normal around here, still, I mind my words…

This view was elaborated by one of the other participants, Birgit (41):

> Even some of the local therapists don`t understand us... it`s like once they go off to study… to become doctors, so… they take in a lot of new knowledge, no doubt, and of course lots of important stuff you need to know as a doctor... but at the same time it´s like all they actually *know* is drained out of them… yes, you know, the things we know about in this area…I think it`s a loss. It`s a shame, really. But what can we do, we just need to cope in our own way…make sure the devil doesn`t have his way, so to speak. But I will say this… my advice is don`t tell them too much… even if they are friendly…it`s usually not in your best interest. But, me, I'm lucky I met Lillian though, my therapist for the past five years. She's from Nordreisa, but she has lived in other places…I feel she understands *here*…and she understands me, I don`t feel that she's judging me…I trust her. I really do. She knows the *reader* I use, and I don´t have to hide anything from her. It`s a relief. It really is.

At a later stage of the fieldwork, Birgit tells me another story which could explain this type of worry/frustration:

> Do you know that I've been admitted to Åsgård[24]? After a tough time…a very heavy depression, I guess… well, my father came to see me. He passed away 13 years ago but he visits from time to time, I was young when he left, he's checking up on me, you know, Birgit smiles. But he knows when it`s time to come, when I am really struggling…that`s when he comes. He usually knocks on the front door, I think it`s his way of letting me know I can decide if I want his company or not…she smiles…but I always let him in. Of course I do. We talk…we sit by the kitchen window, I make him coffee. It helps me, comforts me. And I made the mistake of telling my therapist this, I thought I could…I mean, he encouraged me to open up more, because I've always held back…and I did, eventually. It`s a long story…well he (conventional therapist) believed I was psychotic and I had to go by ambulance to Åsgård. It was such a drama, horrible...that whole episode made things so much worse for me, in so many ways, it was not only about being hospitalised…and afterwards, one thing led to another… I tried to take my own life while I was admitted at the hospital, all I wanted to do was to jump out of that window…and then I had to be on this very bad medicine for a long time, and everything just got messed up…in my head, right…all of that made me feel mentally ill, really…it sounds strange, but I didn't actually feel mentally ill before that…it was more about having bad nerves.

These experiences point to the patients expressing a need to "guard" themselves in clinical encounters in terms of displaying their stories, beliefs and practices. Other participants made comments such as "I often leave out certain parts of my story when talking to a conventional therapist", and people in the community voiced opinions such as "we know that what *we* believe is normal around here is abnormal for outsiders". "It can be totally insane," one said. When I tried to grasp how the participants made distinctions between the encounters with conventional therapists and *readers*, I would typically get answers like that of a male (68), whose response to my question "In your experience, what do you see as the main difference between therapists at the clinic and *readers?"* ran as follows:

> We`re used to managing on our own, that`s how things have been around here for as long as we can remember, one way or the other, I guess it won`t change.

He thus sees the use of TM/readers as a way to manage on one's own, within one's local community and social relationships, without involving the state-funded health care system.

[24] Regional psychiatric hospital, part of the University Hospital of North Norway in Tromsø. The statement also indicates that she thought the clinic could have provided the first author with access to her patient record.

An example of how people in the community were "managing on their own", became evident one day in Ragnar`s kitchen. Ragnar (69) had been reluctant to count himself as a user of TM even though I had heard him speak with a *reader* over the phone and through his stories I had also sensed that he sometimes practiced traditional healing himself, without being able to grasp the details. Ragnar was not much of a talker, he often spoke in metaphors and could come across as secretive. Despite this, I understood that he appreciated my company, which encouraged me to spend considerable time with him during the fieldwork. Our encounters often involved few words, but through presence and interactions, his short comments on my stories or items from the local newspaper, he "told" me his story. Inside Ragnar`s kitchen there is a certain type of quietness. The air feels both heavy and light at the same time, it is as if time has stood still, as if this is all there is to the universe. On one very cold day in late February, the following scene unfolds in Ragnar`s usually quiet kitchen:

Ragnar is boiling eggs and coffee. I am reading out loud from the local newspaper about a *reader* in Lyngen[25] who has written a chronicle about his concern that mental distress, in his view, is on the increase in the region. Obviously, this is a highly interesting topic for me. Ragnar is paying attention, and I sense that this is my moment to finally have a more in-depth discussion with him, when someone enters Ragnar`s front door. All of a sudden, a young man wearing construction worker clothes is standing in the kitchen. His yellow jacket is partly covered in blood. Outside someone is waiting for him in a car. The smoke from the car mixes with the outside cold, forming a "frozen cloud" outside the kitchen window.

> They said you could help me, help me stop the blood, they said I should come to you, oh my God, it´s just pouring out of me, the man says. He holds his one arm over the other.

Ragnar grabs a chair and tell him to sit down. Ragnar holds his arm firmly, and I can see his lips moving slightly. After what seems like forever, but in reality is only a minute or so, I notice that there is no more blood coming out of the young man´s arm. I notice a distinct line on the man`s arm where the blood has stopped running.

> So there you have it, Ragnar says, and without further ado the man helps clean up the blood that has been spilt on the floor. He says thank you and tells Ragnar he should not hesitate to contact him if he ever needs some practical help around the house. Not to worry, Ragnar answers, around here we help one another, that`s the way it is. The man leaves, and as the car drives off the "frozen cloud" appears to follow them. I am

[25] Neighbouring municipality to Nordreisa.

> left quite stunned by the whole experience, I have never witnessed this before. Immediately it feels somehow exotic and spiritual, but then I get a sensation of the whole scene being very natural and not mysterious at all. By this time, Ragnar is back in the kitchen, without words, continuing making coffee as if nothing has happened. I find it hard to hide my reaction to this scene, I feel emotional and somewhat childish, I exclaim a wow, and I say to Ragnar: What was that happening? Ragnar answers: That was nothing. Ragnar does not seem eager to elaborate on the theme but later that day while I am helping him carry pieces of wood to a store-room, I manage to discuss it a bit further. Ragnar tells me what happened is just a natural thing. That he just happens to have the ability to stop blood, a skill that was passed on from his grandmother. He says he was initiated in this tradition at the age of 16, at a time when his grandmother was critically ill and expected to pass away. My grandmother was worried she would be the last from our family, from a long line of blood-stoppers, but for several years there were two of us practising. I believe she was more skilled than me though, she knew others things as well. I am just a simple soul, you know, Ragnar chuckles.

These findings show how the participants experience a need to guard or protect themselves by being selective in what to share from their private life in encounters with therapists at the mental health clinic. They have experienced that their local worldview and ways of handling social relations, death and illness in everyday life may be misunderstood by "outsiders". Such outsiders may be therapists, even local therapists, if their scientific knowledge has "drained out of them" their local knowledge. Sometimes the therapists are perceived as more occupied with diagnosing than with understanding the patient, and misunderstanding can result in the wrong diagnosis and treatment. The local *readers* and their care are seen as completely different. They are part of the local community and are seen to stand for respect and understanding in relation to the individual, the local culture and the community. Health problems are seen as part of life itself, and seeking help from *readers* within the community is seen as a way of "managing on one's own", in contrast to using the public health care system.

Even though the risk of being misdiagnosed and mistreated is a severe threat in itself, there also seem to be other risks involved in patients' encounters with the mental health clinic.

Discussion

Local belonging and the question of ethnicity in Nordreisa

In the following, we will discuss some factors that can shed light on these risks.

In this study, questions regarding ethnicity were an integral part of the overall PhD project protocol. Ethnicity, as such, was addressed as a theme in interviews and conversations throughout the fieldwork.

As we have seen in the section on "Findings", ethnicity was a topic surrounded by ambiguity. The participants expressed reluctance towards choosing any other ethnicity than being Norwegian and would rather call themselves mixed, both as individuals and as a collective identity for Nordreisa. Some expressed irritation towards outsiders expecting the inhabitants to be "all Sami", stating "there are no real Sami people here". Being categorised as Sami was thus not popular, and Sami also seemed to be understood as a narrow category that could not include any of the inhabitants of the area. On the other hand, a Kven heritage or roots within the Kven culture was "something to be proud of". But when it came to proclaiming Kven ethnicity, being Norwegian, or even a "good Norwegian", was underlined as the preferred ethnicity.

In the coastal communities of Nordreisa and Skjervøy, there has been no wave of Sami revitalisation as has been observed in neighbouring Kåfjord and part of Kvænangen, where it has been witnessed since the early 1960s (Mathiesen P 1990). Two examples of the difference between neighbouring municipalities in how they promote collective ethnic identities are illustrated by the ethnic festivals in Nordreisa and Kåfjord, where one ethnicity is promoted, perhaps at the cost of another. In Kåfjord there is the Sami Riddu-Riddu festival, which has become an important indigenous festival, and has enhanced pride and awareness of Sami belonging and heritage within the municipality. Nordreisa has the Kven Baaski festival which started later than the Riddu-Riddu festival and is smaller and receives less attention outside Nordreisa. There seemed to be a general opinion among the inhabitants of Nordreisa that the Kven culture had been in the shadow of the Sami culture, and therefore needed to be highlighted in the public sphere. In the participant`s stories and the way people in the community of Nordreisa generally spoke of ethnicity, we may detect an opinion of Sami identity as less favourable, though filled with ambiguity; many simultaneously wanted to both acknowledge and distance themselves from a Sami identity.

In her article, Kramvig (Kramvig B 2005) draws attention to how public discourses frame and pave the way for the identity categories that individuals may choose from. She argues

that, in Norway, the discourse on ethnicity "has become public, offensive and strongly influenced by the Sami-Norwegian dichotomy" (2005: 1, our translation). She notes that it is not "the categories themselves that exercise the power, but the abstractions that are made within them" (2005: 8, our translation).

The reluctance of the inhabitants of Nordreisa to being placed within ethnic categories other than Norwegian may be understood in the context of the quite recent history of forced assimilation, where Sami and Kven/Finnish-speaking ethnicity and culture have been stigmatised and looked upon as less desirable for the individual as well as broader society. The "good Norwegian" is in this context probably a good citizen within the modern, Norwegian welfare state. Due to the dichotomy mentioned by (Kramvig B 2005), being something else than Norwegian in this area means being a Sami. In the context of the Sami revitalisation, with its focus on ethnic boundaries, and rights to land and water, the Sami category may be seen as too narrow to be relevant, or it is understood as only covering the nomadic way of life of the reindeer herders. It may also give associations to being outdated and the opposite of a modern Norwegian, in terms of attitudes and way of life. The Sami category may be seen as a threat to a Norwegian, Kven or a mixed belonging, also because of the dichotomy within public discourse and because the Kven and mixed categories are not seen as relevant. In this way, being categorised as having another ethnicity than Norwegian contains a risk of being abstracted within a category that includes associations and understandings of who people are, their way of life and worldviews. This perception is out of the control of the categorised person, and in the light of history, may be prejudiced and even stigmatising.

As a consequence, members of the community may employ different strategies to protect and guard themselves from being placed within unwanted ethnic categories by simply saying they are a mix or Norwegian. As expressed by several of the participants, they "should be Norwegian at the clinic, but at home they could be mixed".

In this way, we may say that the participants influence the presentation of Self through concealment and information control, in line with Goffman's perspective (Goffman E 1963).

Normality in everyday life and disease at the clinic

Because this study was designed as ethnographic fieldwork, the first author aimed to grasp the participants' illness and everyday life through meeting them in their homes. However, all participants wanted to meet with her at the clinic for the first meeting. They argued that this

was due to practical matters related to their appointments. In the course of the fieldwork, the first author realised that the reason could be more complex than only about practicalities. In a discussion with the Head of the clinic, she said she believed that this was an example of what she referred to as an "upbringing" in the conventional health system (= an acquired skill in dealing with the system). She did not elaborate what she specifically meant by this expression, but through further inquiries on later occasions this "upbringing" in the system seemed to be about people in the region demonstrating particular behaviour when dealing with the conventional health system.

In the first semi-structured interviews at the clinic, the participants' answers were relatively short and concentrated on information that we can expect to be relevant in a clinical context, like symptoms, diagnosis, the different types of therapy offered, the quality of the different therapists and their professions, the use of medication in general and the different types of medication specifically, and also practical aspects of visiting the clinic such as travel, parking and general facilities in the building. We may thus argue that the participants' responses were influenced by this "upbringing" in the "system" (clinic) that had taught them what aspects of their illness and status as a patient it would be relevant to disclose in a setting where science and health authorities defined the situation.

After the first meeting between the first author and the participants at the clinic, all participants were open to the idea of her visiting them at home, as the first meeting seemed to have created trust between them. The participants also stated that it was an advantage that the researcher was not a local, and that she was not a therapist by profession. In their homes, the interaction developed from conversations which could resemble semi-structured interviews to natural everyday talk as time went by. As the parties got to know each other better, the participants would talk about life and illness in a more detailed manner and describe their experiences and emotions more thoroughly.

When the first author met the participants in their homes, their main focus was on everyday life activities, their concerns for their family, hopes and thoughts about the future, changes in the community, etc. These were themes which emerged naturally when we talked and interacted. When they told their stories in their homes, aspects of life which could shed light on their mental illness were most important to them.

As such, everyday life is a key concept in understanding the participants` social relations and their relationships with therapists. The concept of everyday life can, according to (Gullestad M 1989), be understood as composed of two dimensions, where one is tied to daily chores

and organisation, while the other is everyday life as experience and life world. These two are of course intertwined in real life. The dimension of experience connects everyday life to culture in a broad sense, understood as "interpreted reality".

In their stories "at home", illness was understood and connected to, and part of, life events. An example of this is Elsa`s story. She had struggled with depression since adolescence, or as she stated: "from the time she had dreamt of doomsday", which she also referred to as "the evilness". After that event, she believed her life had taken a very negative direction and given her "bad nerves", as she said. An example of a life event that had impact on her "nerves" was a miscarriage when she was younger. Later she had been diagnosed with severe depression, and she had attempted to commit suicide three times.

During one visit to Elsa`s house the first author witnessed Elsa receiving a disturbing phone call from her daughter. Her daughter lived in another part of Norway, and was calling Elsa from hospital after experiencing a late miscarriage. This event reactivated memories in Elsa, from the time when she had given birth to a still-born baby. This made Elsa phone a *reader* at once, something the first author had witnessed with participants on several occasions before. On the phone she was talking about how she knew something like this would affect her daughter, that her daughter was caught in her (Elsa`s) destiny because of the episode she referred to as "the evilness" which Elsa experienced when she was 17 years old. Elsa believes she is to blame for her daughter`s misfortune. She is asking the *reader* whether she should have interfered somehow, for instance by warning her daughter. I am not able to hear what the *reader* says, but afterwards Elsa is significantly calmer. She tells me that the reader has comforted her that the miscarriage was out of her control and not her fault, and simply just a part of God`s will. When I ask Elsa if she has discussed "the evilness" with therapists at the clinic, she says no, "if they don`t already consider me crazy, then that would be a final confirmation."

In the patients´ everyday life world, *reading* represented both a practical everyday tool and a multi-dimensional understanding of life. *Reading* seemed simultaneously to be down-to-earth and connected to spirituality. It was used broadly, both for emergencies like toothache and the stopping of blood but also in a soothing manner, as a comfort for worries and anxiety, for instance.

As we have seen in the other stories, participants consciously hold back information at the clinic about their use of *reading* and their understanding of the possibility of being in contact with the souls of the dead. Elsa`s story underlines this, and illustrates how the participants

experience lack of control over how their local worldview and cosmology will be understood in the clinical encounter. She feels quite certain that it will categorise her as insane, or put into more clinical terms, give her a psychiatric diagnosis.

The findings indicate that the participants related to their anxiety and depression disorders as an interwoven part of everyday life when they talked about them at home. At the clinic, however, they seemed to distance themselves from this interwoven position and more often adopt the therapists` disease perspective, which, according to Kleinman (Kleinman A 1980), to a greater extent focuses on functional ruptures in biological and/or mental processes. Following Schultz (Schutz RE 1975), life world is the world of human experience, and as the participants in this study believe that their life world cannot be understood in the clinical encounter, there is clearly a disruption between life at home and life at the clinic.

The holistic cosmology of home seemed to disappear when facing the clinical world and they seemed to have an understanding of the ontology of home not being valid at the clinic.

In contrast to the holistic life world at home, the clinic seemed to represent the reductionist worldview where categories such as symptoms and diagnosis dominate. This categorisation involves a lack of understanding of the participants' life world, which leads to a lack of control when they are in the clinical world and in a worst case scenario may expose the patients to the risk of misdiagnosis.

Good care as empathetic open-mindedness

In care studies, "the study of the good" has become a "way to study health care practices" (Pols J 2018). Pols points to the study of values in ethics as an inspiration to this approach, as ethics asks "How do people try to achieve something good? And how do things and technologies as well as social norms bring value to practice? Furthermore, what are the effects of this?" (Pols J 2018). In the encounters with the clinic, even though some patients experience that it might be helpful, there seem to be obstacles to the benefits it can bring. Not only does there seem to be a lack of value, it might even be threatening as they may experience misdiagnosis and hence improper treatment with the risk of worsening their illness. The effect of this seems to be a reluctance to seek, or maybe an avoidance of, help at the clinic. Patients find that the treatment at the clinic can make them feel "naked", and the best advice to others would be: "Don't tell them too much" as it is "usually not in your best interest". Consequently, their own experiences are passed on as advice to others, and in this

way personal experiences can become part of collective experiences and collective ways of evaluating the clinic as well as comparing with *readers* and others who provide care.
In her book, (Mol A 2008) "The Logic of Care" emphasises the social and temporal aspect of care as she argues that good care is shaped from collaborative work of trying out solutions based on knowledge and technologies. The aim is to handle illness well within the complexity of everyday life, and what is good has to be tried out and shaped underway. This is not an easy task, she argues, as it "gives ample occasion for ambivalences, disagreements, insecurities, misunderstandings and conflicts" (Mol A 2008).
In Northern Troms, an ambivalence may be seen in the inhabitants' use of alternative health care providers. In the patients' stories, we hear that the clinic is compared to the *reader*, who is considerably more trusted than the average therapist at the clinic. In the comparison of the two, we see that the participants point to their illness as only one of several hardships in life, and also part of life itself. As part of managing on their own, they seek help from a *reader*, as there is a *reader* for any situation, which was mentioned by most participants. They thus seek help within social relations and local society instead of using the official health care system, represented by the clinic, even though the clinic, in the words of one participant is "more like a proper treatment, I guess". By this, he is probably expressing how the clinic represents the public and officially recognised health service, and biomedical science. On the other hand, this may also be part of the problem, as the focus and way of handling things at the clinic feel unfamiliar. There is a lot of talking in therapy, some mention, and as people in this area are used to keeping private matters to themselves, they argue that this approach of talking adds to the feeling of being naked. The "naked feeling" is not elaborated in the stories, but may suggest an uneasy feeling of being unprotected, unsafe or exposed. Most participants also commented on the therapists` focus on diagnosing the patients, more than listening to their story. In the worst case, the patient may find that the therapist misinterprets stories, with the patient risking forced hospitalisation and heavy medication, with associated consequences. This feeling of unease and distrust that several participants mention is in strong contrast to the complete trust they express about the *readers*. "They are not here to diagnose me… the readers I use, they just simply understand me". The patients emphasise the difference between being *diagnosed* and *understood*. Of course, giving a diagnosis can be part of, or a result of, understanding somebody, but it does not necessarily include understanding the patient.
This difference can be seen as corresponding to the difference between a focus on disease and a focus on illness, where disease is "the medically defined pathology" and thus part of

biomedical science and its paradigms, while illness is the "subjective experience of ill health", thus as experienced by the patient (Blaxter M 2000). Rudebeck (Rudebeck CE 2001) points out how physicians in consultations tend to "*observe* the symptom presentation and judge whether it falls within the preconceived disease categories, rather than share it" (: 1). He argues that physicians could be better at linking understanding and diagnosis by combining medical knowledge and understanding with bodily empathy. This will make it easier to understand how the patient experiences his body within his life. Halpern (Halpern J 2001), who is also a physician, argues for her colleagues to use empathy as "a form of emotional reasoning" and "imagining *how* it feels to experience something, in contrast to imagining *that* something is the case" (: 85), as this can make the physician better able to help the patient. Along the same line, but within psychiatry, Seikkula (Seikkula J 2011) is known for his dialogical approach to psychotherapy. He sees dialogue as the way humans live and experience intersubjectivity, and thus understand each other. "In open dialogue *listening and responsively responding* becomes more important" (Seikkula J 2011). In joint meetings, where also family members of the patient are included, the aim is to gain "understanding about the actual crises and the life of our customers" (Seikkula J 2011). This is thus an understanding of therapy much like Mol's notion of good care as a joint process of trying out ways to adapt the treatment to the patient's complex life (Mol A 2008). Seikkula's approach could have the potential to increase patients' trust in therapists, if it actually helps therapists to be empathetically open-minded to the patients´ local life and knowledge. Interestingly enough, Seikkula does not mention challenges connected to cultural differences, even though he states that he has mainly practiced this method in Western Lapland, Finland, where we would expect Sami culture and cosmology to be present among the patients. But as he points to systematic studies showing favourable outcomes of the approach of open dialogue on psychosis (Seikkula J 2011) we may expect that the dialogical approach also includes elements of cultural understanding.

As we have seen, the participants in our study distinguished between the scientific knowledge held by the therapists at the clinic and the knowledge and understanding of local life held by the *readers*. But this seems to be not only a matter of knowledge, as locals who have become therapists seem to have lost something: "it's like all they actually *know* is drained out of them", as one participant comments. This shows how knowledge about a local worldview or cosmology is not enough when a scientific worldview predominates, and other worldviews are in danger of becoming signs of illness. The therapist must not only have knowledge of, but also be empathetically open-minded to the existence and role of, local cosmologies in

patients' everyday lives. This can help in judging whether actions are signs of illness and delusion or reasonable forms of behaviour within the local cosmology.

In connection to the discussion above, it is important to note that the participants` experiences that have led to a lack of trust in conventional psychiatry have taken place within their individual and common local history of being stigmatised. Local culture and history have been seen as inferior to the "Norwegian" culture by society at large. Knowledge of the Finnish and Sami languages, once an important skill in the area, has disappeared, due to forced assimilation policies as well as ideas of different languages and cultures as of little value and even a threat to becoming a "good Norwegian". Local cosmology, which for instance contains the possibility of being in contact with the spirits of deceased family members and others, has been seen by broader society as superstition, belonging to an outdated Sami tradition, and in opposition to science and a modern worldview.

This issue is also addressed by (Cotton ME, Nadeau L et al. 2014) in their article about mental health services in remote and indigenous communities in Canada. They argue that "contemporary health services in Indigenous communities often repeat and perpetuate the hierarchical, paternalistic and even racist attitudes of the colonial process. Clinicians have a tendency to assume they understand the nature of the problem and the best intervention, to the exclusion of indigenous ways of knowing and healing" (Cotton ME, Nadeau L et al. 2014). Cotton et al. also point to the role of traditional healing as cultural maintenance or revitalisation, also in connection to spirituality and identity. Unavoidably, then, the question is raised of "how best to integrate or achieve the effective coexistence of mainstream mental health services and traditional or indigenous healing systems" (Cotton ME, Nadeau L et al. 2014). Should there be an integration of TM into the conventional system, or should they remain separate?

Based on our study, we would argue that it is conventional medicine that needs to find a good way to relate to TM, and not the other way around. The patients today express a general distrust in the conventional mental health care clinic and therapists, and this will most likely stand in the way of providing good care at the clinic. The exceptions are the local therapists who are said to understand the local community as well as the individuals within it, and who do not "judge" the patient. The TM represented by the *reader* does not seem to have to relate to conventional medicine to be trusted. It operates within its own, holistic sphere, and is probably also dependent on this sphere, where local everyday life, social relations, common history, and its own values and rules about commitment and secrecy are important aspects of it. This would suggest that integration between the conventional mental health services and

reading is not possible, as they are based in two completely different spheres and ontologies, or ideas of what is real in our world. When conventional medicine sometimes offers *readers* a place within their team, they have in our opinion misunderstood what *reading* fundamentally is about. Practising empathetic open-mindedness can also include *not* integrating TM but paying respect to and appreciating the boundaries that are naturally there. This is, however, part of a larger discussion which we will not elaborate on in this article.
To sum up, based on the participants` experiences, we would argue that "good" care in terms of empathetic open-mindedness and understanding is at stake in this context.

Implications for practice and further research

The study underlines the need for these patients to belong to and receive treatment within both the conventional mental health care system and through TM. An implementation of the DSM-5 Cultural Formulation Interview (Lewis-Fernández R, Aggarwal NK et al. 2016), alongside the methodology used in this study, could be a beneficial tool to demonstrate cultural sensitivity when encountering this group of patients within the conventional mental health care system.
We would thus argue for the importance of having anthropological perspectives and tools as part of the curriculum in relevant educational paths of psychiatric personnel, as well as offering compulsory courses on this topic to personnel that are already working within the field. As we see it, cultural knowledge and self-reflectiveness can increase therapists' ability to be empathetically open-minded to how patients experience and relate to illness in their local, everyday life. In connection to the promising results of the dialogical approach (Seikkula J 2011), it would be interesting to examine how cultural aspects are addressed in this approach in Finnish Lapland.
The value of managing on one`s own clearly has a positive influence on health strategies as a resource tool through informal networks of care, including the use of *reading*. A question to explore in further research could thus be whether this can also reduce the need for conventional mental health care.

Conclusion

As a conclusion, based on the stories and comments from the participants and inhabitants of the local community, we would argue that "good" care in terms of empathetic open-mindedness and understanding is at stake in this context. To the patients, the lack of

understanding may imply being placed within categories they do not acknowledge: ethnic, cultural and diagnostic. The participants thus make efforts to protect themselves from being categorised. At stake is their control over how they are interpreted and treated by others, as categorisation may have unwanted impacts and results in different settings.

At the clinic the participants experienced a need to protect themselves by being selective in what health information they shared with conventional mental health care therapists, as this information could be misunderstood and used against them with the consequence of being misdiagnosed and mistreated. The *readers* on the other hand stood for respect and understanding in relation to individual health complaints, the local culture and the community.

Accordingly, it is important for conventional mental health therapists to increase their knowledge and understanding of their patients´ life, cosmology/ontology and how their illness is experienced individually, within their life. A fundamental part of this understanding must be to increase the therapists' (and other health professionals') self-reflectivity and thus understanding of *their own* ontology, cosmology and standing in the world, both as a professional and a fellow human being.

Acknowledgements

Heartfelt thanks to all participants in this study, in particular the patients who warmheartedly opened their homes and their stories to the first author. Thanks to the clinic for providing access and insights to the field, and the *readers* who revealed new layers of understanding, also of our own "universe of meaning". The publication charges for this article have been funded by a grant from the publication fund of UiT The Arctic University of Norway.

Ethics

The study was approved by the Regional Ethical Committee (REK Nord) and the Norwegian Centre for Research Data (NSD), Project No. 190510. Written informed consent was obtained from all participants before the fieldwork started, and all participants were informed that they could withdraw from the study at any time.

Descriptions and quotes used in this publication have been approved by the participants. All names have been given pseudonyms, and personally identifiable information has been altered. The study meets the standard of the Helsinki Declaration of 1975 (The World Medical Association (WMA) 2013).

Funding

This work was supported by the Research Council of Norway under Grant No. 190510.

Disclosure Statement

The authors report no conflict of interest.

References

Andersen KB, Persen S and Miller BH (2015). Multiple Views from Finnmark. Idioms of Sámi Health and Healing. Miller BH. Edmonton, Polynya Press**:** 83-103.
Blaikie N (2000). Designing Social Research. Cambridge, Polity Press.
Blaxter M (2000). Health. Cambridge, Polity Press.
Bongo BA (2012). Sámi people do not talk about health and illness. Sámi understandings and communication of health and illness. A qualitative study of Sámi culture. (In Norwegian: Samer snakker ikke om helse og sykdom. Samisk forforståelseshorisont og kommunikasjon om helse og sykdom. En kvalitativ undersøkelse i samisk kultur). PhD, Universitetet i Tromsø.
Cotton ME, Nadeau L and Kirmayer LJ (2014). Consultation to remote and Indigenous communities. Cultural Consultation. New York, Springer.
Eidheim H (1992). Stages in the development of Sami selfhood. Oslo, University of Oslo.
Eidheim H (1997). Ethno-political development among the Sami after World War 2. Sami culture in a new era: The Norwegian-Sami experience. Gaski H. Karasjok, Davvi Girji.
Fontana A and Frey JH (2008). The Interview from Neutral Stance to Political Involvement. Collecting and Interpreting Qualitative Materials. V. Knigth. London, SAGE Publications**:** 115-159.
Goffman E (1963). Stigma. Notes on the Management of Spoiled Identity. London.
Gullestad M (1989). Kultur og hverdagsliv. På sporet av det moderne Norge. In English: Culture and everyday life in Norway. Oslo, Universitetsforlaget.
Halpern J (2001). From detached concern to empathy: humanizing medical practice. Oxford, University Press.
Hansen KL and Sørlie S (2012). "Ethnic discrimination and psychological distress: A study of Sami and non-Sami populations in Norway." Transcultural Psychiatry **49**(1): 26-50.
Henriksen AM (2010). Bloodstopping: Stories of reading, healing, helpers, and signs (In Norwegian: Å stoppe blod: Fortellinger om læsing, helbredelse, hjelpere og varsler). Oslo, Cappelen Damm.
Holliday A (2007). Doing and writing qualitative research. London, Sage.
Hsieh HF and Shannon SE (2005). "Three approaches to qualitative content analysis." Qual Health Res **15**.
Hætta AK (2015). Secrecy in Sámi Traditional Healing. Idioms of Sámi Health and Healing. Miller BH. Edmonton, Polynya Press**:** 25-45.
Kiil MA (2019). Home and trust. An ethnographic study of mental health and the use of traditional medicine in a north Norwegian community. PhD, UiT The Arctic University of Norway.
Kleinman A (1980). Patients and healers in the context of culture. Berkeley, CA, University of California Press.
Kramvig B (2005). "The silent language of ethnicity." European Journal of Cultural Studies **8**(1): 45-64.
Kristiansen R (2005). Sámi religion and laestadianism (In Norwegian: Samisk religion og læstadianisme). Bergen, Fagbokforlaget Vigemostad & Bjørke.
Kvale S (1996). Interviews. An introduction to qualitative research interviewing. Thousand Oaks California, Sage.
Langås-Larsen A, Salamonsen A, Kristoffersen AE, Hamran T, Evjen B and Stub T (2017). "“There are more things in heaven and earth!” How knowledge about traditional healing affects clinical practice: interviews with conventional health personnel." International Journal of Circumpolar Health **76**(1): 1398010.
Langås-Larsen A, Salamonsen A, Kristoffersen AE, Hamran T, Evjen B and Stub T (2018). ""We own the illness": a qualitative study of networks in two communities with mixed ethnicity in Northern Norway." International Journal of Circumpolar Health **77**(1): 1438572.

Langås-Larsen A, Salamonsen A, Kristoffersen AE and Stub T (2018). "“The prayer circles in the air”: a qualitative study about traditional healer profiles and practice in Northern Norway." International Journal of Circumpolar Health **77**(1): 1476638.
Lewis-Fernández R, Aggarwal NK, Hinton L, Hinton DE and Kirmayer LJ (2016). DSM-5 Handbook on the Cultural Formulation Interview. Washington DC, American Psychiatric Publishing.
Læstadius LL and Posti P (2002). Fragments of Lapp mythology. Part I: Doctrine of the Gods (In Swedish: Fragmenter i lappska mythologien: gudlära). San Antonio, USA, Agarita Press.
Madden R (2013). Being ethnographic. A guide to the theory and practice of ethnography. London, Sage Publications Ltd.
Malterud K (2011). Kvalitative metoder i medisinsk forskning. En innføring. English: Qualitative methods in medical research. An introduction. Oslo, Universitetsforlaget.
Mathiesen P (1990). "Ethnicity and pattern: Past and present." Acta Borealia **7**(1): 5-13.
Mathisen SR (1989). "Faith Healing and Concepts of Illness. An Example from Northern Norway." Temenos **25**: 41-47.
Mathisen SR (2000). The folk medicine in Northern Norway; cultural community and ethnic division (In Norwegian: Folkemedisin i Nord-Norge. Kulturelt fellesskap og etniske skiller. Sámi folk medicine in Norway today (In Norwegian: Samisk folkemedisin i dagens Norge. Altern I and Minde GT. Tromsø, Senter for samiske studier, Rapport fra seminar i regi av Institutt for sosiologi og Senter for samiske studier. **Vol 9:** 13-15.
Miller BH (2007). Connecting and correcting: Case study of Sámi healers in Porsanger. Leiden, Netherlands, CNWS Publications.
Minde H (2003). "Assimilation of the Sámi: Implementation and consequences." Acta Borealia **20**(2): 121-146.
Mol A (2008). The logic of care: Health and the problem of patient choice. London, Routledge.
Myrvoll M (2010). The word of God is all that counts. Of continuity and rupture in Sámi understanding of reality. In Norwegian: Bare gudsordet duger. Om kontinuitet og brudd i samisk virkelighetsforståelse. PhD, University of Tromsø.
Myrvoll M (2015). Traditional Sámi Healing. Heritage and Gift of Grace. Idioms of Sámi Health and Healing, Patterns of Northern traditional healing series. Miller M. Alberta, The University of Alberta Press.
Nergård JI (2000). "Læstadianismen-kristendom i et samisk kulturlandskap. English: The Laestadianism-Christianity in a Sami cultural landscape." Vekkelse og vitenskap: 207-223.
Nymo R (2011). Health care systems in Sámi communities in Northern Nordland and Southern Troms. Everyday practices (In Norwegian: Helseomsorgssystemer i samiske markebygder i Nordre Nordland og Sør-Troms. Praksiser i hverdagslivet). PhD, University of Tromsø.
Nymo R (2015). Everyday Life Between Knowledge Systems in the Markebygd Areas. Idioms of Sámi Health and Healing. Miller BH. Edmonton, Alberta, Polynya Press**:** 157-182.
Olsen KOK (2010). Identities, ethnicities, and borderzones; Examples from Finnmark, Northern Norway Stamsund, Norway, Orkana Akademisk.
Pols J (2018). A Reader’s Guide to the Anthropology of Ethics and Morality–Part III, Somatosphere.
Rudebeck CE (2001). Grasping the existential anatomy: the role of bodily empathy in clinical communication. Handbook of phenomenology and medicine. Dordrecht, Springer
Schutz RE (1975). "When freedom of information meets personal privacy." Educational Researcher **4**(10): 5-6.
Seikkula J (2011). " Becoming dialogical: Psychotherapy or a way of life? ." Australian and New Zealand Journal of Family Therapy **32**: 179-193.
Sexton R and Sørlie T (2008). "Use of traditional healing among Sami psychiatric patients in the north of Norway." International Journal of Circumpolar Health **67**(1): 135-146.
Statistics Norway (SBB). (2018). "Municipality Statistics Nordreisa (In Norwegian: Kommunefakta Nordreisa) " Retrieved 20 June, 2018, from ssb.no/kommunefakta/nordreisa.
The World Medical Association (WMA) (2013) "Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects 1964 (Revised 2013) 24.05.".
Thuen T (1995). Quest for equity: Norway and the Saami challenge. Social and economic studies / Institute of Social and Economic Research, Memorial University of Newfoundland, Canada, Institute of Social and Economic Research.

University Hospital of North Norway (2017). "Outpatient Clinic for Mental Health Care in Northern Troms. In Norwegian: Senter for psykisk helse Nord-Troms."
World Health Organization (2013). "Traditional medicine strategy: 2014-2023." Geneva

Article III:

Angels and Charlatans: Contrasts and tensions between different medical systems in a North Norwegian community

Mona Anita Kiil, Tone Seppola-Edvardsen, Trine Stub

Mona Anita Kiil

Department of Clinical Medicine, UiT The Arctic University of Norway

E-mail: mona.kiil@uit.no

Tone Seppola-Edvardsen

Department of Community Medicine, UiT The Arctic University of Norway

E-mail: tone.seppola-edvardsen@uit.no

Trine Stub

National Research Centre in Complementary and Alternative Medicine, Department of Community Medicine, UiT The Arctic University of Norway

E-mail: trine.stub@uit.no

Abstract

Background:

The region of Northern Troms, Norway, is characterised by a multi-ethnicity of Norwegians, Sami and Kvens. This ethnic and cultural mix has historically been challenged, particularly with the forced assimilation policies of the Norwegian government. Hence, the background of this region is complex and creates a particular therapeutic landscape. In addition to conventional medicine, traditional medicine and complementary and alternative medicine are commonly used among the population in this area.

Aim: The aim of the study was to explore how patients related to different medical systems in this region, particularly related to the evaluation and navigation between traditional medicine (in particular *reading*) and complementary and alternative medicine.

Method: This 18-month ethnographic study was based on fieldwork among 61 participants. However, the main source of information for this study was collected from a sub-sample of 12 patients from an outpatient mental health clinic in Northern Troms. The information was retrieved from 36 semi-structured interviews with these participants. The conversations and ethnographic interviews with the other 49 participants also had considerable impact on the data analysis.

Findings: The study findings demonstrate that the participants were quite capable of dual use of distinct medical subsystems, either simultaneously or sequentially. *Reading* made a significant contribution to their management of everyday life and mental distress because it was easily accessible within the community and represented a form of empathic care that had long been familiar in the area and used across social relationships. Principles of availability, familiarity, compassion and empathic care in traditional medicine can be experienced as incompatible with values attached to complementary and alternative practices, particularly regarding the degree of familiarity, empathic care and the use of payment within this medical system.

Conclusion: The participants in this study actively adapted their holistic health care to meet medical, cultural and spiritual needs. The widespread use of traditional medicine created a local system for evaluating the use of modalities in complementary and alternative medicine. It is, however, important to note that most encounters took place in between these spheres and that the use of traditional medicine also seemed to make participants more open towards the use of complementary and alternative medicine.

Keywords: mental health, traditional medicine, complementary and alternative medicine, medical pluralism, philosophy of care, values, ethnography, Northern Norway.

Northern Troms, Norway

This study was conducted in the municipality of Nordreisa in the region of Northern Troms, Norway. Northern Norway has a long tradition of mixed ethnicity and Nordreisa is shaped by an ethnic and cultural diversity consisting of the indigenous Sami population, the Kven people (ancestors of Finnish speaking immigrants) and the majority population of Norwegians (1). However, an extensive assimilation process of ethnic minorities in Norway started around 1850 and escalated during and after World War 2. The assimilation policy impacted the different geographical areas to varying degrees, resulting in people with Sami and Kven ancestry moving to coastal regions like Nordreisa, where many consider themselves as a mix between the three groups and simultaneously as Norwegians. (1). In the aftermath of World War 2, political resistance towards the assimilation policies created awareness of indigenous rights and a revitalisation of Sami culture emerged in the region. While the assimilation policies impacted the different geographical areas in similar ways, the Sami revitalisation process has not affected all communities in the same way.

From the 1840s, Laestadianism, a pietistic religious movement founded by the Swedish Lutheran Minister Lars-Levi Laestadius, was introduced in the region and has made a significant impact on the Sami, Kven and Norwegian communities (2). Laestadianism continues to have a solid position in the area today and is common across ethnic boundaries. It is known for its conservative attitude to theological and moral matters. *Reading* is commonly used by members of the congregations (3). Many *readers* are Laestadians by origin.

Against this background, we argue that the history of this region is complex and creates a particular therapeutic landscape (4) for the participants in this study.

Complementary and alternative medicine

In Norway, alternative medicine is understood as health- related treatment practised outside the established health services, and not by authorised health personnel. However, treatment within the scope of the established health services or provided by authorised health personnel

is also covered by the term alternative treatment when the methods employed are essentially used outside the established health services (Alternative Medicine Act §2: 2003-06-27-64) (5, 6) .

In Norway, the inhabitants receive treatment within the public health care system, while providers of complementary and alternative medicine (CAM) operate outside this system. Patients generally cover the costs of visiting a CAM provider themselves. Since these practices are unregulated, anyone can call him/herself a CAM provider and treat patients, as long as the patients are not harmed. However, most lay providers are members of a professional CAM provider organisation that requires a professional standard of medical and CAM-specific training. It is also possible for CAM providers to be registered as companies in the "Brønnøysund Register" and avoid paying 25% VAT for their health services {Brønnøysundregisteret. The Brønnøysund Register centre (7). To ensure patient safety, members of the organisations are required to take out insurance for any injury to their patients caused by the treatment.

The most commonly used CAM modalities in Norway are massage, acupuncture, naprapathy, reflexology, osteopathy, cupping and healing (8). Also among the CAM modalities offered in Norway is traditional healing/*reading*, a modality categorised as traditional medicine (TM). TM draws on a long history and is understood as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures […], used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (9). TM is defined as CAM in some studies and not in others (10). In this study, we understand TM as a system of its own and thus not part of CAM.

Traditional medicine in Northern Troms

There is a longstanding tradition in North Norwegian communities of treating both physical and mental illness locally through the use of TM (6). These practices have a solid position, particularly in areas with a large Sami population (11).

TM in this area includes treatments, theories and beliefs about health and healing based on the Sami cultural heritage. TM includes methods like healing, massage, cupping, blood-letting, the stopping of blood and moxa burning, using assets from plants, animals and humans as well as metals (12). *Reading* is deeply interwoven in these communities and

operationalised through informal networks of care. As an example of how people in this context continue to relate to and manage health from a traditional point of view, it is common to hear that "one sees the doctor to be diagnosed and the traditional healer to be cured" (4). Traditional healers are often contacted on behalf of the person experiencing illness or a crisis, rather than by the person contacting them directly. This attitude demonstrates the altruistic side of the practice, as it generates an ideology of care and compassion among the inhabitants and within the extended families (13). Kristoffersen et al. (14) note that TM is widely used, and people with a Sami background use more TM than non-Sami living in the same areas. Related themes that have been investigated include the overall use of CAM modalities in Norway (14), various aspects of trust related to the use of traditional healing (15), how Sami people deal with health and their therapeutic relationships (16) and how mental distress and identity are managed through the use of traditional healing (4). Other research has discussed the traditional healers' own perceptions of how traditional healing functions (3), the role of the extended family in the use of traditional healing (13), how the journey between traditional healing and CAM is navigated (17), and psychiatric patients` use of traditional healing (18). The interest in this article, however, focuses on the most commonly used traditional healing modality in Nordreisa, *reading*.

Reading

Reading is particularly related to the spiritual aspect of TM, and implies certain spiritual abilities (19). Different traditional healers are known to have different skills, and *readers* are considered particularly suited to treat mental health problems. The phenomenon of *reading* takes place discreetly and is not publicly promoted or advertised as the healers gain recognition through their skills. *Reading* does not involve payment as it is seen as a duty to help people in need. *Reading* is a type of prayer, spiritual guidance and support when a person experiences illness or a crisis; the *reader* uses quotations from the Bible with the intention to heal. The general belief is that it is not the actual words that heal, but the power of God that follows. Occasionally, *readers* combine reading with the use of other remedies; these can include natural materials such as stones, water and plant and animal products (3). *Reading*, seen as a gift of grace (20), is passed on from generation to generation within families, which implies that people in the region usually have a healer in their close or extended family. The use of *reading* can thus be seen as having both pragmatic and spiritual aspects and as an expression of medical pluralism in Norway.

Medical pluralism

In Norway, conventional medicine is the officially approved modality of treatment (6). Even though the authorities have chosen conventional medicine as the official form of health care for the Norwegian population, they cannot control which treatment modality patients choose or what they believe in (21).The concept of medical pluralism implies that in any community, patients and their relatives may resort to different kinds of treatment modalities, even when these have mutually incompatible explanations for the illness (22). Hence, medical pluralism exists in any setting where competing forms of systems of medical practices coexist (23). This demonstrates that medical systems do not exist in a vacuum, but rather reflect the social, ethnic and gender relations and inequalities of broader society (22). Hence, in Norway TM exists along with many other CAM modalities outside the dominant official health care services. There is limited research on the use of TM (including *reading*) and CAM in this region, particularly in regard to mental health.

Aim

The main aim of this article is to investigate how mental health care patients in Northern Troms evaluate and navigate between TM and CAM.

Method

This qualitative study sought to investigate different aspects of mental health encounters, focusing on the use of conventional mental health care, TM and CAM modalities. A qualitative approach can help the researcher to gain access to the views of participants, address how an intervention is used in practice and provide information about different aspects of a phenomenon (24); these were the reasons for adopting this research design.

Design

Using ethnographic fieldwork to frame the study, data was not merely collected at the outpatient mental health clinic in Northern Troms or in the participants' homes but evolved from a process of learning and understanding. This approach is comparable to a socialisation process. Data was obtained through participation in everyday events and small talk, and exploring and discussing relevant topics with the participants. In addition to ethnography, the study consisted of repeated in-depth semi-structured interviews.

Ethnography

Ethnography is a qualitative social science practice that seeks to understand cultures, societies or institutions by placing the researcher in the same social space as the participants in the study (25). Ethnography is typically face-to face, direct research. It is a practice that values the idea that to know the lives of other human beings, the ethnographer must participate in their lives and thus experience the same daily patterns as the other people. This approach is called participant observation. As a participant observer, an ethnographer is both within and outside of the research process; she is both a researcher and a research tool. Ethnographic interviews are a vital part of ethnography and can be explained as "non-arranged interviews", a type of informal conversation performed in a setting typical of a normal conversation (24). During a period of 18 months, the first author performed fieldwork with 62 participants (see the section on the participants).

Semi-structured interviews

Semi-structured interviews are well-suited as part of the methodological approach in this study, as open-ended questions have the capacity to generate follow-up questions and promote the possibility of nuanced and "rich" answers (26). This creates an informal setting and encourages the participants to tell their story at their own pace and manner (27). The original invitation to the participants was to ask them to tell about how they coped with mental health challenges, and how they related to the different categories of therapists they used, whether conventional, traditional and/or CAM.

Thematic interview guide

The interview guide was developed based on a literature review (28). In addition, the first author received input from the director and therapists at the clinic regarding suitable approaches and possible questions when interviewing the participants. The interview guide included the following themes: *childhood/growing up/adult life (family, working life)/major life changes (joys, sorrows, crises)/significant persons/things you hoped for or dreamt of/understandings of illness (both in general and in particular your own illness)/experiences of your own health/understanding and experience of traditional healing(reading)/understanding and experience of alternative treatment/experiences of ethnicity and cultural belonging/experiences of spirituality or religion/experiences of the place or context/thoughts and wishes for the future.*

Setting

The municipality of Nordreisa has 4918 inhabitants (29), the majority of whom are employed in trade, tourism, and health care services. The clinic, which is part of the General Division for Psychiatry at the University Hospital of North Norway in Tromsø, was officially opened in September 2006. Prior to this, starting from 1986, patients had received treatment at an outpatient mental health care clinic located in the basement of Sonjatun, a community centre for physical health care at Storslett (30). The clinic treats on average 450 patients annually and offers art and cognitive psychotherapy and psychopharmacological and rehabilitation treatment. Today, the clinic is situated at Storslett, the administrative centre of Nordreisa, where approximately half of the patients live. The remaining patients live in the neighbouring municipalities of Kåfjord, Skjervøy and Kvænangen.

Recruitment

Recruitment took place in collaboration with a coordinator working at the clinic. The researcher was given a list of names of patients who were willing to participate, and she contacted them directly by phone. The participants received letters of invitation including ethical information and information about the aim of the study and the research procedures. The patients provided their written consent to participate. In the case of the participation of the conventional therapists, the CAM providers and the *readers*, information and consent to participate were given orally.

Participants

A total sample of 61 participants participated in this ethnographic research project. The sample consisted of 12 patients, 8 staff and therapists from the clinic, 5 *readers*, 4 CAM providers as well as 32 local inhabitants. The main source of information for this article was collected from a subsample of 12 patients from the clinic. The information was retrieved from 36 semi-structured interviews with these participants. In addition, numerous conversations and ethnographic interviews were conducted with all participants, giving a total of 49 interviewees, in addition to the 12 patients, over a period of 18 months, which had a considerable impact on the data analysis.The interviews took place in the participants' own homes or elsewhere outside of the outpatient mental health care clinic to prevent the presumed "clinical feeling" from dominating the setting. The participants were selected on

the basis of their interest in participating in the project and not by any specific diagnostic criteria. The 12 patients were diagnosed with anxiety and/or depression disorders. They were between the ages of 22-74 and included both genders. Eleven of the twelve were consulting *readers*, while one participant stated that *reading* was used on her behalf, but that she did not actively seek it herself. She was also the youngest participant. Seven (six women and one man) stated that they had used CAM modalities at least once.

Analysis

The interviews were conducted and tape-recorded by the first author, who also made a verbatim transcription (26). Reflexive notes (25) were taken throughout the fieldwork, and always after each interview. All notes were considered in the analytical process. The main themes were identified using thematic content analysis (31). The first author read the data several times and discussed the various steps of the analysis process with the research team. The coding process was performed by the first author. She started out with predefined themes based on the interview guide. The themes were altered according to what emerged from the material as well as the research question. The quotations were printed in Norwegian before being translated into English. The following three themes emerged from the analysis: *medical pluralism as a starting point, opposing values, and separation of cosmologies.*

In the next section we will present parts of three main stories that represent these themes, as told by the participants.

Findings

Medical pluralism as a starting point

Brita, a 57-year-old woman from Nordreisa has been attending the mental health outpatient clinic for over a decade. When we first met at the clinic, she said, “This place is almost like home to me”, referring to her long history at the clinic and her experiences with many different therapists. Brita elaborates:

> I come from a long line of mental distress… you know, many people in this area have been struggling with their nerves, we’re still struggling…it took me many years and lots of courage to discuss this with my physician and to be referred to the clinic for help. I had to swallow my pride, so to speak, and my husband didn’t like me coming here. I think he was ashamed of me, maybe he still is. In my family, we don’t really talk about these things. Treatment here has helped me learn to deal with certain

> issues, and medicine has helped me at times…other times this medicine has made me more ill, almost like the anxiety is about to strangle me, particularly some of these pills (psychotropic drugs)... it's like something from the Devil himself.
> ...what really makes a difference in my life, dealing with all my troubles, is the *reader*. *Reading* is what helps the most, what feels safe and good, if you know what I mean. I believe that it's common for many people here see the doctor to get diagnosed, and then contact a *reader* to get help.
>
> …I've tried other things as well, acupuncture for instance, I believe these alternative things can help too… but it all depends on the therapist. If you don't know them, know about their skills, it can also be a negative experience. Sometimes you're not sure what their motives are, you can get the impression that it's all about making money out of ill peoples' misery…It's easier with the *readers*, we know *who know* things, there are no bad readers, only readers for different things. If a *reader* is good at curing toothache he might not be good for mental distress, but we know who are good and the *readers* know too, yes, also how good they are at different things, what they're able to do. The acupuncturist, homeopaths and other providers, it can be difficult to really know their abilities… if they don't come from here you just don't know about their skills.

In this story, Brita points to some of the core issues in the participants' experiences with and attitudes to *reading* and CAM. Brita's statement about seeing the doctor to get diagnosed, and the reader to get help is quite typical and seems to represent a common attitude toward conventional treatment and the way the local people position themselves between the different medical systems. The patients need to visit conventional care providers in order to get a diagnosis which provides social and financial benefits. Conventional care can also be of help to their illness, but there is a risk involved, as it can just as well make things worse, especially in the case of medication treatment. Accordingly, CAM and *reading* are less risky as they do not imply the use of psychotropic drugs.

Embraced by angels

Nils (69) led a solitary and sober life; he was a quiet type, always busy working at his farm. We would usually start our conversations in the farmhouse while he was working, and then move on to his kitchen, where his stories would come to life while Nils made coffee. In the following story, Nils tells about his experience with a *reader*. This story came after I had asked him about a photograph on top of a shelf in Nils' living room. The photograph showed a middle-aged man leaning on a tractor, wearing slightly dirty overalls over a t-shirt. The man looked quite tanned, had a charming smile, and had rolled tobacco in between his fingers. "It's my father," Nils said, "exactly how I remember him. That summer was the hottest we can recall around here".

> His (the *reader'*s) voice is always calm and he listens when you call, like you feel he's receiving you. He sometimes asks difficult questions, things that can stir up something in me, but I know it's necessary, you know, just to help as much as possible. The same day my father passed away, I phoned him and through his voice and his prayers, yes, his calmness, I felt a presence of my father in his kitchen. I was sitting there after the funeral agents removed his lifeless body from his bed upstairs. Talking with the *reader* brought great peace to me in a very difficult situation, it comforted me deep down inside, and made me feel sure that my father was free from all suffering in this world and ready to move on in his journey. This *reader*, I'd say, is like an angel without wings, he's helped so many people in the community. I don't know if angels actually exist, but this man is an angel to me, just like his father was an angel to my mother who suffered from depression all her life. The unselfishness, the care and giving nature of these *readers* are quite unique. You can only know this if you've ever been embraced by their compassion and felt the power of their care.

Nils' story is typical of how the participants and other people in the community often talked about *readers* in this context. The metaphor of "angels" was commonly used, and there was a general impression of gratitude of the reader's accessibility and contribution to the management of everyday life in the local community. This position was shared by Anita (54), a woman who worked in a local store:

> There's no doubt in my mind that God sent him (the *reader*) to me, he came into my life after I had a late miscarriage…I was so depressed, I didn't know which foot to stand on…to be honest, I just wanted to die. My mother had first called this *reader*, I didn't know about it, but later she took me to see him. I will never forget the warmth I felt in his presence, the warmth in his hands when he greeted me, and just love… it was pure love, even though he didn't know me. He gave of God's love, that's how I believe it is, God came through him…like he was an angel or something.

Separation of cosmologies

The clinic arranged excursions at times, and one such event was "The River Day". Together with patients and therapists at the clinic, I went on a boat trip on the river Reisa, the main river in Nordreisa.

> On a misty autumn day we're sitting by the bonfire, making traditional "bonfire coffee" with a kettle hanging over the fire. We are in a majestic and picturesque setting, surrounded by steep mountains, and a forest which is changing from green to yellow and orange right before our eyes. From the participants` relaxed behaviour and comments I understand that these excursions are much appreciated; one of the participants said, "When I come out here, it's like I leave my *nerves* back home, for a moment I feel free, it's a little break from all the difficulties".

The conversation circles around a number of topics, and when one of the participants tells us that his daughter who lives abroad is thinking about becoming a homeopath, I seize the opportunity to angle the conversation. I ask them what they believe is the most important difference between *reading* and what the participants often refers to as "alternative stuff" (CAM). One of the participants stated: "Some things are for people to deal with, other things are only for our Lord". This attitude is confirmed by the others sitting around the bonfire, with statements such as: "There are some things in this world you just need to accept, humans don't have all the answers", "*Reading* is part of divinity", "This alternative stuff is run by humans" and "I believe it's ok to use both *reading* and alternative stuff, but I think it's important to know the difference. I think you should be careful…". Another said: "Maybe the two shouldn't be mixed". Another characteristic of the relationship between *reading* and

CAM was connected to payment, as stated by several participants: “If we have to pay for it, it doesn’t belong here”.

As we can see, the participants understood *reading* as an expression of God and his ability to heal, while CAM on the other hand was the “work of humans”. CAM is accepted as an alternative but the participants underline that there is a fundamental difference. An important difference may be that CAM is given as a service and part of a business, while *reading* gives the participants a feeling of being part of a tradition (of healers) who care for them with great empathy and compassion. This gives them a sense of security, maybe comparable to the feeling of freedom expressed by the riverside, where the illness problems are left back home?

The charlatan healer

Eva, a 54-year-old woman diagnosed with depression and anxiety disorder, has lived her whole life in Nordreisa. Her house is situated a short drive from the administrative centre, surrounded by forest and close to the main river. She is always warm and welcoming when I enter her house, generously telling stories about the place, always with coffee and cake on the table. Her illness is usually not very present to me when we meet, but I notice a change in her voice and a trembling in her body when she tells me the following story:

> There was this travelling healer that came to Nordreisa. A self-proclaimed Christian healer. The healer’s visit here was advertised in the local newspaper a week beforehand, and people could come to the local hotel to meet this healer. I cut out the advertisement from the newspaper, I wish I could show you, but I must have thrown it in the bin. Anyway, I need to tell you that the night before this meeting I got this feeling as if I was sinking, these dark and creepy feelings came up on me, and that night I dreamt of doomsday. I went to the hotel with my younger sister, we were both struggling with quite severe mental problems at that time. Still to this day I don’t know what really went on in that hotel room. I have no words…it was a surreal experience, and really, very uncomfortable. When he put his hands on my head and prayed for me, it was the Devil touching me, there was no goodness there at all. Afterwards he asked for payment, it was quite a lot actually, but he pointed out that we should only give what we could afford and that he was a man of God, and that this was his calling in life. When we walked out of the hotel, it felt like my feet were

> going to tremble…it was as if he had taken something from me, taken something out of me. It's difficult to explain how it felt, it was a very strange and disturbing atmosphere in that room, like disaster was waiting to happen. It was truly horrible, you have no idea. A real charlatan that is who he was. I felt really ill for a long time after this, like someone had opened a great valley of wounds inside me.

Later during the fieldwork, Eva found the healer's newspaper advertisement in her kitchen drawer. It contained a photograph of the healer where he was holding his hands open with light coming from them, resembling religious images of Jesus Christ. He was also wearing a garment that resembled a *kofte* (traditional Sami costume). This appearance is common to some of the performers of what are sometimes called new age-defined practices, and accordingly, he was a CAM provider in this context. The text in the advertisement read: "Feel the Power of God".

In the advert, he appeared with a Christian image linked to ideals of *reading*. It thus appeared that the travelling healer aimed at operating in between the spheres of TM and CAM, selling services of *reading*. His clothes could be an attempt to evoke an image of belonging to the Sami healing tradition or having a local identity. On the other hand, he asked for payment, which is normal in the CAM field, but, as Eva commented, this would not be appropriate for a *reader*. Eva also found that he lacked warm hands, and the empathic caring that the participants recognise as a personal quality in *readers*. As a result, Eva experienced him as a false *reader*, not only lacking goodness, but even representing something evil and dangerous.

Summary of findings

The findings presented in this article indicate core issues in how the participants relate to the different medical systems based on needs and cultural values, as they emerged in the stories presented here, as well as in the stories of other participants. *Reading* was understood as an expression of God and his ability to heal and care for people. The core values in healing served as an inner compass that helped them to distinguish between *good* and *bad* treatment modalities and health providers. *Reading* made a significant contribution to the management of everyday life and mental distress because it was easily accessible within the community and represented a form of empathic care that had long been familiar in the area and used across social relationships. Some of the participants had used it since childhood. For the participants, an important distinction between CAM and TM was the use of payment for

CAM services. Payment placed CAM in another sphere, one of business, while the *readers*' acts were seen as belonging to a sphere of divinity, love, and pure altruistic values.

Discussion

Medical pluralism: a question of values?

Findings from this study demonstrate that people are quite capable of *dual use* of distinct medical subsystems, either simultaneously or sequentially (32). It was not unusual for a patient to be treated in the same period of time for the same or different health problems by a *reader* and a conventional mental health therapist. Moreover, patients actively adapted their holistic health care to meet medical, cultural and spiritual needs (33). Access to both conventional health care and TM was seen by the participants as an aid to have the best of two worlds: illness relief, cultural validation and improved sense of control of the disease process (34).

Critical medical anthropologists argue that national medical systems should be described as *plural* rather than *pluralistic* as conventional medicine enjoys a dominant status over both complementary medicine (e.g. chiropractic and naturopathy) and folk medical systems (African American spiritualism, *reading* in Northern Norway). In reality, plural medical system may be best described as *dominant* in that one subsystem within the larger complex of coexistent medical traditions generally enjoys a preeminent status over the others (35).

Treatment philosophy and values

How the participants relate to the different treatment philosophies can be an expression of local values. Kluckhohn (36) defines value as "a conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable which influences the selection from available modes, means and ends of action". According to Graeber (37), in order to grasp the notion of values, the keyword is *desirable*. What is considered desirable is not necessarily the things people want or wish for, because people can want most things. Values can therefore be understood as ideas of what people *should* want or wish for, and thus become criteria for what wishes are perceived as legitimate and eligible. Graeber thus makes a distinction between economic and non-economic values. In the present material, it appears that those who qualifies as "angels" are healers without economic motives, which implies that their practice has a distinct value. In contrast, the "demonising" behaviour of the "charlatan" is materialised and explained through an attraction to money and a lack of

empathy and understanding. Barth's (38) perspectives on values tie values to choices, and focus on circumstances for choice with the main purpose of achieving cultural integration. Considering the circumstances for choosing conventional, traditional and/or CAM treatment in Northern Troms, values can be evaluated differently depending on the sphere they belong to, which, according to Barth, would imply being considered within their social and cultural construction. In Northern Troms this can be understood through the practice of *reading* and how this seemingly creates a significant local belonging. As a result, values can be perceived as isolated units or phenomena in communities. Values can also be viewed in relation to the existing parameters in the given context, which in this case implies a distinction between money and care.

Genuine and false healing

Douglas' (39) classic analysis of how symbolic universes of meaning are structured, and of how our evaluations of reality are deconstructed through systems of value, gives resonance to the problems at hand in this study. She uses the dichotomy of purity and danger to grasp the essence of how different world views can be organised and understood. The stories presented in the present findings seem to constitute an awareness as to how the participants choose to manage mental health and negotiate their cultural values and identity. The participants demonstrated an understanding in how to navigate between "genuine" and "false" healing, based on core values connected to TM, such as skills in terms of bringing calmness and a sense of security to the users. Travelling healers, who were not acknowledged by the community even though people to a certain extent were open-minded to their potential healing abilities, belonged to an unknown category, one which represented profanity, danger and pollution to the purity and sacredness of *reading*. This was particularly noticeable in the story of the "charlatan" whom Eva perceived as trying to transgress the borders between CAM and *reading*. As there is no definite distinction between a religious and a secular world view according to Douglas (39), categories must be regulated and sanctioned, and in the case of Nordreisa, this seems to be done by the community itself through a mutual validation of cultural values.

CAM and TM

Even though CAM, in this data, is not perceived as "dangerous" in this context, it seems to belong to a different and more "messy" category, since the principles for evaluating the

providers' skills, sincerity and intentions do not correlate with those of *reading* and can therefore pose a threat. This is mainly due to the notion of payment. Whereas *reading* does not involve payment but is given freely as it is considered a calling and a duty to possess and share such abilities, CAM practices consist of out-of-pocket services. *Reading* may be seen as representing local community ideals of caring and reciprocity. When the local people help each other to find the right healer for specific problems, and help the person in need to get in contact and even accompany her to the healer, we may say that the local community provides its inhabitants with *good caring*, which, according to Mol (40), is the result of continuous collaborative work on attuning the tools available to peoples' lives with illness.

CAM, on the other hand, is understood as an individualised practice and a somehow isolated arrangement between the therapist and patient. The nature of the relationship with *readers* is different as they often run over long periods of time, sometimes an entire lifetime and even across generations, which places these relationships within common local history as well as family history. The category of travelling healers/CAM providers often lacks local affiliation and local social acceptance, which involves the possibility of being considered strangers or even intruders by the community.

CAM providers somehow disrupt the local value attached to *reading* of not promoting or advertising one's own abilities. Such promotion and advertising, which may be necessary to attract customers, clashes with the local worldview and can be an obstacle to achieving an inclusive status and recognition within the community. It is a kind of self-branding which does not belong in this context, and, as Douglas states, it can thus pollute the care they offer, according to the local worldview. However, it is important to keep in mind that people in this area do also use CAM modalities, and many have found CAM treatments that they combine with *reading* without compromising these "sacred" ideals. The values of care found within TM, as part of local knowledge and values, help people in the community to navigate the "jungle" of available treatments and are part of the local certification system which also promotes local values and identity (17).

To sum up, we may say that we can identify two main topics in the participants' stories in terms of evaluating the care provided by TM and CAM. The first topic is the therapists' *background*. To provide good care, the therapist must have the right skills and intentions. The

readers are the most trusted, as they are known to the community (41). This trust is based on accumulated experiences of good care through many years of practice, experienced by the participants as well as others in their social network. Sometimes the *readers*' skills have been passed down from their parents and grandparents, who also had been known and trusted in the community (42). If the reading failed, this was due to a lack of specific skills in a specific situation, and not due to any general lack of skills, or any wrong intentions. The participants expressed a more uncertain relation to the CAM therapists. The uncertainty was connected to their practice as well as the therapist herself, both could be new to the place and not well known or tried out by local people yet. Because the CAM providers' motives included earning money, their intentions in providing good care became more uncertain to the participants. Money also became a key feature of their activity fundamentally different from *reading*, as *reading* was seen as a divine act, powered by God, while CAM was simply a human activity, of uncertain motives.

When navigating within different CAM services and evaluating the care received, the participants emphasise the feelings they experience during consultations. The good care they experience from the *reader* "feels safe and good". It brings "great peace" and "comforts deep within". Feeling a loving contact with close ones who are dead is also part of what a *reader* can bring to the participants. Based on the descriptions, these good feelings are received through the *readers*' personality and way of interacting with the participants. The *reader* uses a "calm voice", is "listening", and pays "attention", participants note, and they also describe him[26] as unselfish, caring, compassionate and generous.

Even though the participants also underline that CAM practitioners can be of help, "it all depends on the therapist", they cannot be trusted as a group, and "one should be careful" when seeking their help. The participants recall bad experiences, including the feelings they experience in the consultation (and afterwards), which are used in the navigation between good and bad care. In this way, the bad experiences are used to mark the fundamental differences between CAM and TM, also in terms of the feelings they produce. The feeling of uncertainty is mentioned, as well as feeling "very uncomfortable" and afterwards feeling "really ill for a long time". The worst case scenario was described by the participant who experienced the opposite of divinity and goodness by the person she perceived as a charlatan: "It was like the Devil touching me, there was no goodness there at all".

[26] Most *readers* are male, but there are also female *readers;* however, to our knowledge, these are not common in Northern Troms.

Methodological limitations

This study design was qualitative and explorative and was designed to investigate the participants' attitudes and experiences with different treatment modalities in Northern Troms. The findings were thus based on the perceptions of the participants. The aim of the study was to add new knowledge and hypotheses for further important research about how to navigate between different treatment modalities, a field in which there is scant previous knowledge (43).

The role of the researcher is essential in qualitative research as the researcher is the most important tool. The researcher who collected the data kept these issues in mind and adjusted her assessments as needed. The researcher's integrity, which encompasses her knowledge, experience, honesty, and sense of justice, is crucial to ensure good quality of the research. Integrity and a critical attitude towards the work were evaluated and commented on by the research team on an ongoing basis.

Conclusion

The participants in this study reported relating to different medical systems in a pragmatic way and in accordance with their needs and values.

When facing mental distress and illness, the participants navigated according to values interwoven in *reading*, such as availability, familiarity, and compassionate and empathic care. As binary oppositions, "charlatans" and "angels" can portray the main contrasts and tensions between TM and CAM practices in Northern Troms. These different treatment practices seem to be subject to a local evaluation, strongly based on ideals and values which are partly seen as incompatible with money. The use of payment, advertising, and local knowledge are key words in understanding the process of evaluating and navigating between TM and CAM.

Furthermore, the participants seem to have an inner compass that helps them to distinguish between good and bad health care providers. "Angels" and "charlatans" represent extremes; it is important to note that most encounters take place in between these extremes and that the use of TM also seems to make participants more open towards the use of CAM modalities.

Acknowledgement

I wish to express my immense gratitude to all the participants in this study who revealed new layers of understandings of past and present, health and healing, and so selflessly shared their time and stories with me, the first author. Thanks also to the clinic for providing access and insights to the field.

The publication charges for this article have been funded by a grant from the publication fund of UiT The Arctic University of Norway.

Funding

This work was supported by the Research Council of Norway under Grant No. 190510.

Author contribution

Mona Anita Kiil initiated the project, performed the conceptualisation and designed the study. She conducted the ethnographic fieldwork, including all semi-structured interviews. She analysed the data and revised the manuscript critically for important intellectual content. Trine Stub analysed the data and provided important analytical and intellectual content. She commented on the revised manuscript several times. Tone Seppola-Edvardsen contributed important analytical and intellectual content. She commented on the revised manuscript several times. All authors approved and read the final version of the manuscript.

Author Information

Mona Anita Kiil holds a Master's degree in social anthropology. Tone Seppola-Edvardsen is a post-doctoral fellow with a PhD in Health Science. Trine Stub is a senior researcher and holds a PhD in Medical Science.

Ethical approval and consent to participate

The study was approved by the Regional Ethical Committee (REK Nord), Document No. 2009/494-14 (21.03.2011) and the Norwegian Centre for Research Data (NSD), Project No. 190510. Written informed consent was obtained from all participants before the fieldwork started. All participants were informed that they could withdraw from the study at any time, but none did so. All descriptions and quotes used in this article have been approved by the participants. All personally identifiable information has been altered. The study is in

accordance with the Helsinki Declaration of 1975 (44)**.** The author transcribed all the interviews verbatim.

Consent for publication

The participants have given their consent for publication.

Competing interests

The authors report no conflict of interest.

References

1. Nordreisa Kommune. Nordreisa Kommune. Historie og kultur. In English: Nordreisa Municipality. History and culture Nordreisa: Nordreisa Kommune; 2010 [cited 2018 9 December]. Available from: http://nordreisa.kommune.no.
2. Nyland LK. Splittelse og samhold i Læstadius fotspor. In English: Separation and unity in the fotsteps of Læstadius: settnordfra.no; 2016 [
3. Langås-Larsen A, Salamonsen A, Kristoffersen AE, Stub T. "The prayer circles in the air": a qualitative study about traditional healer profiles and practice in Northern Norway. International Journal of Circumpolar Health. 2018;77(1):1476638.
4. Kiil MA. The paradox of Home: Understanding Northern Troms as a therapeutic landscape. In: Miller B, editor. Idioms of Sámi health and Healing Patterns of Northern traditional healing series. Alberta: The University of Alberta Press; 2015.
5. LOV-2003-06-27-64 Lov om alternativ behandling av sykdom mv; English Act relating to the alternative treatment of disease, illness, etc, Helse- og omsorgsdepartementet (Ministry of Health and Care Services) 2002-2003 Sess. (2003).
6. Norges offentlige utredninger. English: Official Norwegian Paper. Alternativ medisin, English: Alternative medicine NOU1998:21. Utredning fra et utvalg oppnevnt av Sosial og helsedepartementet april 1997. Avgitt til Sosial og helsedepartementet 15. desember 1998. Oslo: Statens forvaltningstjeneste. Statens trykning; 1998.
7. Brønnøysundregisteret. The Brønnøysund Register Centre (Brønnøysundregisteret) 2011 [Available from: http://www.brregno/english/.
8. The National Research Center in Complementary and Alternative Medicine (NAFKAM). NAFKAM-undersøkelsen 2016, Bruk av alternativ behandling i Norge. English: The NAFKAM survey 2016. Use of complementary and alternative medicine in Norway Tromsø: Nasjonalt informasjonssenter for alternativ behandling (NIFAB); 2016 [cited 2018 10 December]. Available from: http://www.nifab.no/hva_er_alternativ_behandling/tall_og_fakta/nafkam_undersoekelsen_2016.
9. World Health Organization. Traditional medicine strategy: 2014-2023. Geneva 2013.
10. Kristoffersen AE, Fønnebø V, Norheim AJ. Use of complementary and alternative medicine among patients: classification criteria determine level of use. J Altern Complement Med. 2008;14(8):911-9.
11. Sexton R, Stabbursvik EAB. Healing in the Sámi North. Culture, Medicine, and Psychiatry. 2010;34(4):571-89.
12. Mathisen SR. The folk medicine in Northern Norway; cultural community and ethnic division (In Norwegian: Folkemedisin i Nord-Norge. Kulturelt fellesskap og etniske skiller. In: Altern I, Minde GT, editors. Sámi folk medicine in Norway today (In Norwegian: Samisk folkemedisin i dagens Norge. Vol 9. Tromsø, Senter for samiske studier: Rapport fra seminar i regi av Institutt for sosiologi og Senter for samiske studier; 2000. p. 13-5.
13. Langås-Larsen A, Salamonsen A, Kristoffersen AE, Hamran T, Evjen B, Stub T. "We own the illness": a qualitative study of networks in two communities with mixed ethnicity in Northern Norway. International Journal of Circumpolar Health. 2018;77(1):1438572.

14. Kristoffersen AE, Stub T, Melhus M, Broderstad AR. Prevalence and associations for use of a traditional medicine provider in the SAMINOR 1 Survey: a population-based study on Health and Living Conditions in Regions with Sami and Norwegian Populations. BMC Complementary and Alternative Medicine. 2017;17(1):530.
15. Kiil MA, Salamonsen A. Barriers of Trust: Transcultural experiences within conventional mental health service. European Journal of Integrative Medicine. 2012;4:157-8.
16. Langås-Larsen A, Salamonsen A, Kristoffersen AE, Hamran T, Evjen B, Stub T. "There are more things in heaven and earth!" How knowledge about traditional healing affects clinical practice: interviews with conventional health personnel. International Journal of Circumpolar Health. 2017;76(1):1398010.
17. Kiil MA. A room with a view. Navigating continuity and rupture within the traditional healing repertoire of Northern Troms In: Naskali P, Seppänen M, Begum S, editors. Arctic change and elderly exclusion: An interdisciplinary analysis London: Routledge; 2016.
18. Sexton R, Sørlie T. Use of traditional healing among Sami psychiatric patients in the north of Norway. International Journal of Circumpolar Health. 2008;67(1):135-46.
19. Nergård JI, Eriksen J. The lived experience: A study of Sámi knowledge tradition (In Norwegian: Den levende erfaring: en studie i samisk kunnskapstradisjon). Oslo: Cappelen akademiske; 2006.
20. Myrvoll M. The word of God is all that counts. Of continuity and rupture in Sámi understanding of reality. In Norwegian: Bare gudsordet duger. Om kontinuitet og brudd i samisk virkelighetsforståelse. Tromsø: University of Tromsø; 2010.
21. Ingstad B. Utvikling for hvem? Erfaringer og forskning bant utvalgte grupper i Botswana 1983 - 2012. In English: Developement for whom? Experiences and research among vulnerable groups in Botswana 1983 - 2012. Oslo: Kolofon; 2014.
22. Singer M, Baer H. Introducing medical anthropology. A discipline in action. 2 ed. Plymouth: AltaMira Press; 2012.
23. Hsu E. Pluralism. In: Kris Heggenhougen and Stella Quah, editor. International Encyclopedia of Public Health. 4. San Diego: Academic Press; 2008. p. 316-21.
24. Holliday A. Doing and writing qualitative research. London: Sage; 2007.
25. Madden R. Being ethnographic. A guide to the theory and practice of ethnography. London: Sage Publications Ltd; 2013.
26. Kvale S. Interviews. An introduction to qualitative research interviewing. Thousand Oaks California: Sage; 1996.
27. Malterud K. Kvalitative metoder i medisinsk forskning. En innføring. English: Qualitative methods in medical research. An introduction. 3. ed. Oslo: Universitetsforlaget; 2011.
28. Kiil MA. Home and trust. An ethnographic study of mental health and the use of traditional medicine in a north Norwegian community. Tromsø: UiT The Arctic University of Norway; 2019.
29. Statistics Norway (SBB). Municipality Statistics Nordreisa (In Norwegian: Kommunefakta Nordreisa) Oslo Statistics Norway (SBB); 2018 [cited 2018 20 June]. Available from: ssb.no/kommunefakta/nordreisa.
30. University Hospital of North Norway. Outpatient Clinic for Mental Health Care in Northern Troms. In Norwegian: Senter for psykisk helse Nord-Troms. 2017.
31. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15.
32. Romanucci-Ross L. The hierarchy of resort in curative practices: The Admiralty Islands. In: Landy D, editor. Culture, disease, and healing: Studies in medical anthropology. New York: Macmillan; 1977.
33. Salamonsen A. Use of complementary and alternative medicine in patients with cancer or multiple sclerosis: possible public health implications. Eur J Public Health. 2016;26(2):225-9.
34. Durie M. Maori knowledge and medical science. In: Incayawar M, Wintrob R, Wintrob LB, editors. Psychiatrists and traditional healers: Unwitting partners in global mental health. Chichester: John Wiley & Sons; 2009.
35. Penkala-Gawęcka D, Rajtar M. Introduction to the special issue 'medical pluralism and beyond'. Anthropology & Medicine. 2016;23(2):129-34.

36. Kluckhohn C. Culture and behavioral strategy. London: Free Press Paperback The Macmillan Company; 1952.
37. Graeber D. Toward an anthropological theory of value. The false coin of our own dreams. London: Palgrave; 2001.
38. Barth F. Are values real? Naturalism as challenge in anthropological attribution of values. In Norwegian: Er verdier virkelige? Naturalisme som utfordring i antropologisk verditilskrivelse. In: Barth F, editor. Manifestation and Process (In Norwegian: Manifestasjon og Prosess). Oslo: Universitetsforlaget AS; 1994.
39. Douglas M. Purity and danger: An analysis of the concepts of pollution and danger. London: Routledge & Kegan Paul; 1966.
40. Mol A. The logic of care: Health and the problem of patient choice. London: Routledge; 2008.
41. Mathisen SR. Faith Healing and Concepts of Illness. An Example from Northern Norway. Temenos. 1989;25:41-7.
42. Miller BH. Connecting and correcting: Case study of Sámi healers in Porsanger. Leiden, Netherlands: CNWS Publications; 2007.
43. Gobo G. Doing ethnography. Los Angeles: Sage Publications; 2008.
44. The World Medical Association (WMA). Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects 1964 (Revised 2013) 24.05.2013 2013 [cited 2013 24.05.]. Available from: http://www.wma.net/en/30publications/10policies/b3/.

Thematic interview guide

Basic data

- Age
- Place of birth
- Marital status, children
- Occupation
- Ethnicity
- Laestadian (family background)
- Diagnosis

Opening question

Could you please tell me about your life and your illness, in the manner of your choice?

Alternatively, if prompting is necessary:

Where would you start when telling me about your life?

Or: Do you remember the first time you felt ill and in need of help?

Relevant themes

- Childhood/growing up
- Adult life (family, working life)
- Major life changes (joys, sorrows, crisis)
- Significant persons
- Things you hoped for/dreamt of
- Understandings of illness (both in general and in particular your own illness)
- Experiences of own health
- Understanding and experience of traditional healing
- Understanding and experience of alternative treatment
- Experiences of ethnicity and cultural belonging
- Experiences of spirituality/religion
- Experiences of the place/the context
- Thoughts and wishes for the future

In closing

Is there something else you would like to say about your life before we end this interview?

How did you feel when speaking about your life in this manner?

Appendix 1

Ethical recommendation Regional Ethics Committee, REK nord

Fra: Regional komite for medisinsk og helsefaglig forskningsetikk REK nord

Til:
Tore Sørlie
tore.sorlie@unn.no

Dokumentreferanse: 2009/494-14
Dokumentdato: 21.03.2011

SENSIKAM: KULTUR OG CAM-SENSITIV PSYKIATRISK BEHANDLINGSTILNÆRMING -
EN INTERVENSJONSSTUDIE SENSIKAM: KULTUR OG CAM-SENSITIV PSYKIATRISK
BEHANDLINGSTILNÆRMING-EN INTERVENSJONSSTUDIE

REK Nord viser til deres søknad om prosjektendring av 14.02.2011

Formålet med prosjektet er at den behandling som i dag gis ved psykiatrisk poliklinikk ved Senter for psykisk helse i Nordreisa vil bli sammenlignet med resultatene av en noe endret behandlingstilnærming der pasientens kulturbakgrunn, deres forståelse av sine plager, hva de selv har gjort/kan gjøre for å bli bedre, deres bruk av lokale helbredelsesmetoder og deres forventninger til tilbudet ved poliklinikken vil bli sterkere vektlagt.

Endringen går ut på å bare bruke samtalebasert tilnærming, kvalitativ metode.
Tidligere metode inneholdt både spørreskjema og samtaler.

Det er også søkt om ny sluttdato.

Det rettslige utgangspunkt er helseforskningslovens § 15, første ledd, som oppstiller to vilkår. Dersom det er vesentlig endringer av et forskningsprosjekt og dersom endringene antas å ha betydning for deltagers samtykke, må det innhentes nytt samtykke etter § 13.

Hva som er vesentlig i henhold til § 15, må avgjøres i forhold til hva deltager har gitt samtykke til.

I gjeldende sak er formålet med studiet det samme som før. Metoden som nå utelukkende går på en samtalebasert tilnærming, ble også benyttet i det opprinnelig prosjektet. Metoden står beskrevet i informasjon til samtykkeerklæringen. Det står også utrykkelig i informasjonsskrivet at deltager har mulighet til å trekke seg fra prosjektet.

På denne bakgrunn anser REK at det foreliggende samtykket er dekkende for den endring det søkes om, endringen anses således ikke å være vesentlig, jf helseforskningslovens § 15 første ledd.

Ny sluttdato anses heller ikke som en vesentlig endring og går dermed klar av helseforskningslovens § 15.

Det bør gis informasjon om endring av metode til prosjektdeltagere som allerede har

samtykket. **Vedtak:**

Med hjemmel i helseforskningsloven § 10 og forskningsetikkloven § 4 godkjennes prosjektet. Vi ber om en revidert forespørsel merket med dato eller versjon nummer til vårt arkiv, hvor informasjon om at Sørli står som forskningsansvarlig institusjon, blir fjernet.

Forskningsansvarlig institusjon er i helseforskningslovens § 4e, definert som institusjon eller annen fysisk person som har det overordnede ansvar for forskningsprosjektet. Komiteen legger til grunn at forskningsansvarlig institusjon er Universitetssykehuset i Tromsø.

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 vesentlige endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK.

Det forutsettes at forskningsdata oppbevares forskriftsmessig.

Godkjennelsen gjelder til 31.12.2013

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 Veronica Sørensen
sekretariatsleder 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 e-post: post@helseforskning.etikkom.no

Appendix 2

Confirmation Norwegian Social Science Data Services

vedr. arkivering av forskningsdata fra prosjekt 190510

Annette K. Servan [annette.servan@nsd.uib.no]
Sendt: 10. mars 2014 10:17
Til: Kiil Mona Anita
Kopi: Tore Sørlie; dataarkivering@nsd.uib.no

Hei,

viser til telefonsamtale med Mona Kiil 10 mars der vi kom frem til at det ikke vil bli arkivert forskningsdata fra prosjekt 190510 "Cultural, Self-Help and CAM Sensitive Psychiatric Treatment Approach - An Intervention Study" da transkriberte intervju er blitt slettet.

Ta gjerne kontakt om noe er uklart eller dere har spørsmål angående arkivering av forskningsdata.

Vennlig hilsen,
Annette Kathinka Servan

Rådgiver
Norsk samfunnsvitenskapelig datatjeneste (NSD)
TLF: 55 58 89 28

Appendix 3

Letter of invitation with declaration of consent

Forespørsel om deltakelse i forskningsprosjektet

Kulturelle perspektiver på psykisk helse i Nord-Troms

Bakgrunn og hensikt
Dette er en forespørsel til deg som er bruker av Senter for Psykisk Helse i Nordreisa om å delta i en forskningsstudie som vil se på hvordan den enkeltes kulturbakgrunn kan virke inn på psykisk helse og behandling. I denne sammenheng vil vi undersøke hvordan den enkelte opplever og forstår sine egne psykiske plager, hva den enkelte selv gjør for å få det bedre og hvilken skolemedisinsk behandling (primærlege, hjemmesykepleie, spesialist, distriktspsykiatrisk poliklinikk, psykiatrisk sykehus eller annet) eller tradisjonell behandling (healing, læsing eller annet) den enkelte har hatt mest nytte av eller mener vil være den beste.

Terapeuter på klinikken og alternative behandlere i området vil også bli intervjuet om sine erfaringer og forståelser av hva som påvirker psykisk helse(arbeid) i Nord-Troms.

Studien vil bli utført i tidsrommet våren 2011 til høsten 2013, og ca.20 pasienter ved klinikken vil bli forespurt om å delta. Studien utføres av sosialantropolog Mona Anita Kiil som er ansatt som PhD-stipendiat ved Institutt for klinisk medisin ved Universitetet i Tromsø. Veiledere er dr. polit Nina Foss ved Institutt for helse- og omsorgsfag ved Universitetet i Tromsø og professor dr. med. Tore Sørlie ved Institutt for klinisk medisin ved Universitetet i Tromsø. Sørlie er også prosjektleder og Universitetet i Tromsø er forskningsansvarlig for prosjektet.

Hva innebærer studien?
Etter at din behandler ved Senter for Psykisk Helse i Nordreisa har gitt deg dette informasjonsbrevet, leverer de pasienter som ønsker å delta samtykkeerklæring for deltakelse i resepsjonen på klinikken. Mona Anita Kiil vil deretter ta kontakt med pasientene og gjøre intervjuavtale. Intervjuene vil kunne gjennomføres før, under og etter selve behandlingsperioden din, og tid og sted avtales etter pasientens ønske.
Intervjuene vil bli tatt opp på lydbånd.

Mulige fordeler og ulemper
En mulig ulempe med deltakelse kan være den ekstra tiden intervjuene medfører. Erfaringer fra lignende studier tilsier imidlertid at mange deltakere opplever det som interessant og bevisstgjørende å reflektere over egen situasjon og behandling på en slik inngående måte. Resultatene fra studien vil også kunne få betydning for utviklingen av gode og lokalt tilpassede helsetjenester i vårt område.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. All innsamlet informasjon vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode som vil være knyttet til en navneliste vil gjøre det mulig å sammenholde alle opplysninger som er registrert om deg, og denne vil oppbevares separat fra annen informasjon. Det er kun de personer som har det overordnede ansvar for studien (se nederst) som har adgang til innsamlet informasjon og navneliste. Behandlingspersonell har ikke slik adgang.

Lydbåndene med intervjuene vil bli oppbevart nedlåst i godkjent arkiv på universitetet i Tromsø, og vil bli slettet etter bearbeidelse av intervjuene og innen utgangen av 2013.

Før publisering av resultatene av studien vil den enkelte informant få tilsendt det som tenkes publisert fra intervjuene med vedkommende for kommentar og godkjenning.

23.03.2011[Sett inn korttittel på studien – Hoveddel - sett inn dato]

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 og få alle intervjudata som angår deg slettet. Dette vil ikke få noen konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. 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 Mona Anita Kiil pr. telefon 77 62 32 63 eller mona.kiil@uit.no.

Deltakerne beholder selv et eksemplar av denne forespørselen.

Samtykkeerklæring følger etter kapittel B.

Kapittel B - Personvern, økonomi og forsikring

Personvern
Opplysninger som registreres om den enkelte vil være alder, kjønn, diagnose, kulturell bakgrunn, arbeidssituasjon, psykiske plager, opplevelse av livskvalitet, livshendelser, helsehendelser, sosial støtte/nettverk, åndelige og religiøse forhold, bruk av selvhjelpsaktiviteter og alternative behandlingsformer, hva den enkelte mener om årsakene til plagene sine og hva som kan være til hjelp, den behandlingen som er blitt gitt ved klinikken, din tilfredshet med denne og hva som har hjulpet eller ikke av mottatt behandling i eller utenfor klinikken.
Kun stipendiaten og veilederne vil ha tilgang til denne informasjonen, din behandler på poliklinikken vil ikke ha tilgang til lydbånd eller notater. Alle som eventuelt får innsyn har taushetsplikt.

Forskningsgruppe Psykiatri ved Tore Sørlie, Institutt for klinisk medisin, Universitetet i Tromsø, er databehandlingsansvarlig.

Rett til innsyn og sletting av opplysninger om deg og sletting av prøver
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.

Studien er finansiert gjennom forskningsmidler fra Norges Forskningsråd.

Forsikring
Alle deltagende pasienter er forsikret, på samme måte som pasienter ellers, gjennom pasientskadeerstatning.

Informasjon om utfallet av studien
Alle pasienter vil ha tilgang til utfallet av studien.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Stedfortredende samtykke når berettiget, enten i tillegg til personen selv eller istedenfor

---

(Signert av nærstående, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 4

Declaration describing the independent research contribution of the candidate

Declaration of independence in relation to the PhD thesis of Mona Anita Kiil

"In Home we trust"

An ethnographic study of mental health and the use of traditional medicine in a North Norwegian community.

The thesis is based on the following articles:

Kiil. M.A. 2018: I mellom kaffe og Gud. Psykisk helse og følelsesmessige landskap i Nord-Troms, i Nergård, J-I og Vitebsky, P. (red.) *Kulturen som pasient. Uvanlige møter for vanlige folk.* Oslo: Universitetsforlaget

In English (English version of the article is also attached in the thesis):

Kiil, M.A. 2018: In between coffee and God. Mental health and emotional landscapes in Northern Norway. In Nergård, J-I and Vitebsky, P.(eds.) Culture as a patient. Unusual encounters for usual people. Oslo: Universitetsforlaget

The PhD candidate has contributed substantially to the formulation of research questions, design, data collection, analysis and article writing.

Kiil, M.A., Stub, T., Seppola-Edvardsen, T. 2018: What is at stake in the clinical encounter?Mental health care and belonging in a local community in Northern Norway. Submitted to International Journal of Circumpolar Health, June 16th, 2018.

The PhD candidate has contributed substantially to the formulation of research questions, design, data collection, analysis and article writing.

Kiil, M.A. 2018, Seppola-Edvardsen, T., Stub, T: Angels and Charlatans. Contrasts and tensions between different medical systems in a North Norwegian Community. Submitted to BMC Complementary and Alternative Medicine June 22, 2018.

The PhD candidate has contributed substantially to the formulation of research questions, design, data collection, analysis and article writing.

Tromsø, January 2019

Mona Anita Kiil	Tore Sørlie
PhD Candidate	Supervisor