



Facing the Challenges of Cultural Competency in Swedish Mental Healthcare

Johan Wedel | Senior Lecturer in Social Anthropology, University of Gothenburg

ABSTRACT In Sweden today, with its multifaceted and diverse population, there are increasing demands on the healthcare system to offer culturally competent care to reduce health disparities. Healthcare professionals are expected to be culturally sensitive and competent in clinical encounters to meet the diverse needs of patients/clients, who may belong to various refugee or minority groups. Based on two case studies, the Somali-Swedes and the Sami people in Swedish Sápmi, I discuss some of the multifaceted and complex challenges in Swedish mental healthcare. It is argued that an anthropologically informed approach, and the role of the anthropologist as mediator and educator, may contribute to equal, effective, and sensitive forms of holistic, non-essentialist, culturally competent mental healthcare.

Keywords: culture, applied anthropology, medical anthropology, cultural competence, mental healthcare

Introduction

In today's world, there are increasing demands for culturally responsive, flexible, and sensitive mental health services to reduce health disparities and meet the varied needs of patients (Schouler-Ocak et al. 2015; Kirmayer 2012a). This is particularly important considering the widespread, global stigma of mental health problems (Kleinman 2009). Sweden is no exception. With its diverse population, there are great needs and challenges for the mental healthcare system. The indigenous Sami reindeer herders for example, have less trust in psychiatry and primary healthcare than the general population. According to the Swedish Sami Parliament, the reason for this is largely because of a lack in cultural competence among healthcare personnel. The parliament therefore expresses a need for culturally competent and adaptive care (Sametinget 2016; Daerga et al. 2012; see also Sametinget 2017). The Swedish Care Handbook also addresses the importance of cultural competence and states that culturally competent care means avoiding ethnocentrism and putting the needs of each individual in focus (Vårdhandboken 2018).

Healthcare and social institutions in Sweden and around the world are today developing a transcultural perspective which is commonly defined as an insight into, and consideration of, cultural perceptions of both professionals and clients in encounters and treatments as well as cultural competence, understood as an ability to apply this insight into practice and to bridge differences. There is a generally held belief that cultural competence is important when meeting people with different values, ideas, perceptions, and lifeworlds in mental healthcare settings. Many medical and nursing schools in the west offer courses and teach cultural competence. Overall, there is a growing understanding that people's

cultural conceptions should be taken into account, especially as health care services should be ethically sound and effective (Kirmayer 2012a, 2012b; Abrams and Moio 2009).

However, this focus on cultural values and perceptions sometimes lead healthcare institutions and medical/nursing schools to understand and deal with culture in a simplistic, essentialist way as synonymous with ethnicity, nationality, and language. This is also reflected in the medical literature. Consequently, it is taken for granted that certain cultural beliefs, values, and practices will directly influence or determine individual behaviour (Kleinman and Benson 2006; Garneau and Pepin 2015; Kirmayer 2012a). The problem with this approach is that when not acknowledging the diversity within a particular group, socioeconomic and socio-political factors, living conditions as well as dynamics between communities and societal/global institutions, culture becomes something static, stable over time, homogeneous, and socially conservative. The complexities, conflicts, and uncertainties within a certain group or community are thereby downplayed or hidden. In addition, the larger societal order, including characteristics such as economic inequalities, poverty, gender relations, racial prejudice, social marginalisation, systematic discrimination, and imbalances of power, remains unquestioned and obscured. The result is a view of cultural competence as a technical skill, separated from economic, physical, political, historical, and social contexts, and with stereotypical representations of individuals and groups (Kleinman and Benson 2006; Garneau and Pepin 2015; Kirmayer 2012a; Schouler-Ocak et al. 2015).

Alternative concepts that better include trust, self-reflexivity, self-critique, power imbalances, and health inequalities in healthcare encounters, have been suggested to replace cultural competency. These include cultural humility (Tervalon and Murray-Garcia 1998), culturally tailored care (Kohn-Wood and Hooper 2014), and cultural safety (Curtis et al. 2019). Although cultural safety has been particularly useful when examining and understanding power imbalances (Josewksi 2011), it has also been criticized for emphasizing patients' vulnerabilities instead of their strengths (Kirmayer 2012a). All these concepts including cultural competency, "draws attention to certain dimensions of intercultural work while downplaying or obscuring others" (ibid: 160).

In a non-essentialist perspective, culture is regarded as a flexible, negotiable, hybrid, evolving, and ongoing inter-human process of shared meanings. This means a focus on how an individual, who is seen as an agent in a broader perspective, interacts in many different contexts, networks, and groups (Garneau and Pepin 2015; Carpenter-Song et al. 2007; Kirmayer et al. 2014; Miklavcic and LeBlanc 2014). From this dynamic viewpoint, culture is seen as "fluid, situated and negotiable intersubjective systems of meaning and practice relevant to specific social contexts" (Kirmayer 2012b: 252). An anthropologically informed understanding of cultural competence in healthcare therefore means self-awareness and an ongoing inquisitive learning process. In mental healthcare, it implies a constant questioning of common practices and psychiatric notions with a special focus on the impact of social, economic, physical, historical, political, religious, and existential conditions on individual mental health and wellbeing.

A special challenge in this context is refugees' and indigenous peoples' mental health in psychiatry and primary healthcare. This is particularly true for the Somali-Swedes, who often experience a lack of understanding and prejudices in healthcare encounters (Wedel 2011), and the Sami people in Swedish Sápmi (Northern Sweden), who suffer from high rates of mental health problems (Sametinget 2016). In the following, my aim is two-folded.

I first discuss mental health in relation to these two cases,¹ as examples of this challenge. I then inquire into how an anthropologically informed view on cultural competence and anthropological practice, and the possible role of the anthropologist as mediator and educator, may contribute to holistic, non-essentialist, and inclusive culturally competent mental healthcare.

Mental health among Somalis in Sweden

Somalis are one of the largest refugee populations in the world with more than a million displaced people (UNHCR 2014). About 68,000 Somalis reside in Sweden (Statistiska Centralbyrån 2018) and many suffer from depression and anxiety (Wedel 2011, 2012a, 2014a, 2014b). During my eleven months of anthropological fieldwork in the north-eastern parts of Gothenburg from 2010-2011, I encountered considerable variation regarding people's health-related ideas and perceptions. For many, religion was of major importance and people generally found religiosity and spirituality, and especially Qur'anic reading, to be of significance when making sense of, and dealing with, mental health problems (cf. Mölsä et al. 2019; Johnsdotter et al. 2011). Some male teenagers were however less enthusiastic about religious therapies. One young man rejected Qur'anic reading by religious leaders, but added that he could not express his opinion openly as he feared that people would distance themselves from him.

In general, there was considerable stigma surrounding mental ill-health and a fear of being labelled as “crazy” or “mad” within the Somali community, especially if diagnosed with depression or other mental health problem (cf. Mölsä et al. 2010). I also found several non-Western illness explanations, such as *jinn* (spirit) possession, *isha* (the evil eye), *sixir* (witchcraft) and *inkaar* (imprecation). Moreover, people used various indigenous concepts for describing different stages and forms of mental distress. The most common were *welwel* (stress, worry, depression), *murug* (stress and anxiety; often related to social problems), *buufis* (severe depression; often related to longing and unfulfilled migration), *qalbijab/niyadjab* (“a broken heart”, depression, despair; commonly resulting from failed attempts to bring relatives to Sweden or because of being denied a Swedish permanent residence permit) and *waali* (insanity, spirit possession). These concepts were more or less unknown to the Swedish healthcare personnel (Wedel 2011, 2014b).

In addition, stress and worries were often related to economic obligations towards relatives in Somalia or the diaspora, or difficulties in finding work because of perceived racism in the job market. A man also complained that Swedish gender values could cause loneliness and depression for some men: “If you are a real Muslim, you should not live alone.

¹ The first case study focuses on ideas and experiences concerning mental health problems and healing among Somali-Swedes in Gothenburg, Sweden. Data collection, which took place during 11 months from 2010-2011, was based on participant-observation and included open and semi-structured interviews. These lasted from half an hour to an hour. A total of 25 Somali men and women were interviewed. Some of them were newly arrived, while others had lived most of their lives in Sweden. In addition, six biomedical health professionals (two medical doctors and four nurses) and two social workers were interviewed. The second case study focuses on ideas and experiences concerning mental health problems and healing among the Sami people in Swedish Sápmi. This study was based on a literary review as well as data gathered during two short field trips to Sápmi in 2019. Field data consisted of informal interviews with 11 Sami men and women. The interviews lasted from 15 minutes to an hour. One of the interviewees was a medical doctor and two were nurses.

You have to get married to avoid problems. The problem is that here in Sweden the women have a higher status and importance. They sometimes kick out the men” (Wedel 2011: 76).

When suffering from mental health problems, many of those I met during fieldwork expressed the importance of reading the Qur’an. A woman explained: “We live in Sweden where the soul doesn’t count and where people don’t believe there are forces that affect us, that can make us ill. But these forces exist. To become healthy we must work with the soul and read the Qur’an which can heal. These are incredible forces” (Wedel 2014b: 2353; see also McMichael 2002; Tiilikainen and Koehn 2011). A woman who was a refugee having left her two children in Mogadishu, also talked about reading the Qur’an to overcome her worries and problems:

Each day on the news, we hear about the chaos in Somalia. You hear about someone in another family who has lost her son or daughter. If I would sit and think about that every day I would become crazy [*waali*]. I don’t have the power to bring my children here today, but I wait and have patience. I read the Qur’an to gain strength. [In the Qur’an] there are stories about people who have gone through great difficulties and who overcame their problems. If you are strong in your faith, you know that all problems come and go. (Wedel 2014b: 2350)

People would often ask an imam or a *sheikh*, religious expert and healer, to read the Qur’an in the Arabic language, as they are experts in Qur’anic reading. In serious cases, an imam or *sheikh* and a group of people would recite the Qur’an in a mosque to expel troublesome spirits, *jinn*, from the patient.

Many Somali-Swedes mentioned prejudicial treatment in Swedish healthcare units and that it was common with misunderstandings. They also felt a lack of trust in clinical encounters and said that physical problems were sometimes diagnosed as “stress” or a demanding life situation, instead of being examined properly. A woman explained:

There are a lot of prejudices against Somalis. People have heard that Somalis are difficult, complicated and strange. If I am mentally ill and behave completely crazy, they will say it’s a ‘Somali thing’ or a ‘Somali woman.’ ... [Somali mothers] never reveal how many children they have so that the doctor won’t think they are sick because of their children. They are told to do gymnastics, drink water, meet people and that they have too many children. (Wedel 2011: 75)

Another woman discussed a case with a boy who was sent to Somalia for Qur’anic reading after being diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) in Sweden: “He was medicated. He became calm. He became different. But he wasn’t crazy. He was over-active and rowdy and just needed to grow up” (Wedel 2014b: 2350).

In particular, Somali-Swedes felt that Swedish healthcare workers had little understanding for Somali views, perceptions, illness explanations and treatments, such as Qur’anic reading and *jinn* exorcism, when facing mental distress. For example, Qur’anic readings were sometimes interrupted when the hospital’s visiting time was over, and the reader had to leave. In one case, a man had let his wife suffering from a psychosis, to listen to recordings of Qur’anic verses in the hospital where she was treated. The man related: “When she listened, she cried. The doctor said ‘no, no, no, she’s crying. You should let her listen to classical music’. The psychiatrist did not understand what was happening to my wife” (Wedel 2014b: 2355).

Many Somalis whom I met during fieldwork were also of the opinion that psychological or psychiatric treatments were ineffective or even harmful. A woman explained “...we Somalis don’t believe in psychologists. That is especially true when one, for example, hears voices [which may be a sign of *jinn* possession]” (Wedel 2011: 76). In a similar vein, a man said that he did not expect a Swedish psychologist “to understand him or his culture”. He expressed concerns that the psychologist’s questions “could make it worse”, that antidepressants had worrisome and unwanted side effects and that psychiatric treatment could lead to being locked up in a psychiatric institution for years (ibid.).

Swedish healthcare personnel, on the other hand, were struggling to understand their Somali patients and give a correct diagnosis. They described how Somali patients exaggerated their physical symptoms in order to get the physician’s attention. Physicians and nurses often understood these symptoms as related to a general stressful life situation. They also complained that Somali-Swedes were stoic and seldom showed any sign of pain when they were examined, and that this made it difficult to make a diagnosis and find a solution to the patient’s problem. Overall, it was a common opinion among Swedish healthcare personnel that Somali-Swedes were culturally different and difficult to deal with, that they often denied their psychological problems, and that they tended to avoid Swedish mental healthcare services (Wedel 2011, 2014b).

Mental health among the Sami people in Swedish Sápmi

The indigenous Sami population in Sweden consists of 20-30,000 people, and about 10 per cent of them are reindeer herders (Daerga 2017; Stoor 2015). Overall, the Swedish Sami experience high rates of mental health problems. Every other young woman has had suicidal thoughts. About half of the male reindeer herders suffer from anxiety disorder. No less than one in three of the young Sami reindeer herders and one in five of the adults have considered taking their lives (Omma 2013; Sametinget 2016; Kaiser et al. 2010; Omma et al. 2013). Factors such as high predator pressure on reindeer pasture land, climate change, land conflicts, and powerlessness in connection with exploitations all create feelings of stress, hopelessness, and worries about the future. Young adults particularly are concerned about the conditions for continuing with reindeer herding and about losing their Sami identity (Daerga 2017; Kowalczewskia and Klein 2018; SANKS 2017; Omma 2013).

Many young Sami experience ethnic discrimination in Sweden, which may result in increased stress and mental distress. There is a lack of understanding concerning Sami mental health issues in healthcare institutions and people may feel that they have to defend their Sami identity when seeking healthcare, or hide their needs. There is also a lack of confidence in governmental institutions in general, mainly because of historical abuses and limited self-determination (Omma 2013; Sametinget 2016). Religious repression, displacements, nomadic schools, racist ideologies, environmental degradation, and the gradual loss of the Sami language has contributed to what has been defined as historical trauma (Sametinget 2016; SANKS 2017; Lindmark and Sundström 2016; Labba 2020).

Having particularly low trust in healthcare institutions, some reindeer herders use their own remedies before turning to medical healthcare institutions. They “have confidence in traditional medicine and household remedies, which might conflict with the evidence-based medical approach of the Swedish health care system” (Daerga et al. 2012: 521). Many Sami also feel that healthcare personnel lack knowledge about Sami culture and lifestyle (Daerga

2017; Stoor et al. 2015). In addition, mental ill-health can be stigmatising from a Sami perspective and to talk openly about one's own illness is considered inappropriate and can be experienced as exposing oneself to others. People may therefore instead use an indirect and coded language, as if speaking in riddles (Daerga 2017; Miller 2015; Sametinget 2016). Discussing these issues with a female nurse of Sami origin who worked in a primary healthcare centre in a small town in Sápmi, she claimed that expressions of mental health problems are today changing among the Sami:

Reindeer herders really have the toughest job in the world. A family needs to have two incomes, one from reindeer herding and one from another job, to make ends meet. When it comes to mental ill-health, there is a culture of silence and you should never complain. It's the same for both men and women. On the other hand, this is changing now among the youth. They have begun to say, "we don't feel well". Now they are talking about [the problems with] suicide. That was not the case a few years ago.

The traditional Sami health concept has a broad meaning and is related to other family members, fellow members of the Sami village, domestic animals, reindeer, and nature in general. The extended family generally plays an important role for wellbeing, as well as Sami cultural identity. The nurse quoted above explained:

Sami culture is important. It keeps us together. It's the language and all the stories we have heard from family members, and handicraft, especially the making and the wearing of the *kolt* [traditional dress]. *Yoiking* [singing/chanting] is also important. Through *yoiking* you can also express how you really feel. It can be sorrow. It can be happiness.

She also claimed that among some reindeer herders, well-being was dependent on good relations with spirits in nature known as "the little people," who were also the protectors of places:

To have reindeer luck, to be sure that the reindeers will thrive and grove, you have to respect *småfolket* ["the little people"]. You cannot just throw away things in nature. It's bad luck. Bones and offal should carefully be placed in the forest. In the old days, you had to ask *småfolket* before you built a house in a certain place.

Especially among Sami reindeer herders, a healer, known as *reader*, *gunsttar*, *guvvlar* or *noaidil nåejtie*, who may use telephone conversations, prayers and various physical techniques and objects, including neo-shamanic practices, may well be the first choice when facing mental or bodily afflictions. People are generally reluctant to talk about these healers and their healing methods with outsiders and biomedical personnel (Daerga 2017; Eriksson 2018; Langås-Larsen et al. 2018; Miller 2015; Helander-Renvall 2010; Skott 1997). A female physician who worked in a healthcare centre in Sápmi, and who was of Sami origin and spoke the Sami language, said that it was common to use alternative, non-biomedical treatments:

This is *Norrland* [Northern Sweden]. People go here and there, but it's nothing they talk about. I grow up here. I know what's going on and I know that some look for alternative treatments. Sometimes people tell me. I don't decide over anyone and I reject nothing. But it's not anything I record and register. I just say, "it's your choice, do as you please". The reason that people don't want to talk is also because of all the bad [historical] things that have happened here. Some researchers talk about a cultural trauma.

Among the Sami, there are various non-scientific explanations for illness, particularly among some reindeer herders. A person for example, may lose his/her soul and may die if a “death bird” (*guottalvis*) picks up one of his/hers personal belongings, such as hair, a piece of clothing or shoe bands, and carries it to the graveyard (Beach 2001: 113). A force known as the evil ear, *onda örat*, which is said to exist everywhere, hears if someone jokes about illness and may cause illness or other affliction if a person says something disrespectful about someone else (Skott 1997: 210f). Illness may also be the result if a person has “provoked an affliction on someone” or “*satt ont på en*”. In addition, people sometimes have experiences that can be seen as indications of mental ill-health from a non-Sami perspective. Some may experience foreboding, see and hear deceased persons (Stoor 2015: 32), and develop relations with spiritual beings known as *katniha* or *gufihtar* (Skott 1997; Helander-Renvall 2010). The Sami nurse quoted above said that foreboding in particular was common:

Many Sami experience foreboding. My mother had it. She was warned when something was going to happen. She could hear a tree falling, but it did not fall. She could see black shadows running. The spirits warn you that something is going to happen. It's not strange or scary. If a Sami patient who suffers from mental ill-health tells me this, I will understand. I could ask “did you invite them [the spirits]”. A [non-Sami] psychiatrist would just say that the patient is mentally ill.

Possible Interventions: The anthropologist as mediator

The two case studies discussed here highlight the complexity of mental ill-health and how meanings, perceptions, and ideas concerning illness causation and health are interrelated with, and affected by, larger societal forces and conditions. The cases also point to the multifaceted, holistic, and interrelated approach needed to face mental health issues relative to interacting with social, historical, political, and economic processes.

In the case of the Sami people in Norway, researchers have identified social and extended family networks, Sami language competence, *yoiking*, knowledge of reindeer herding, ecological knowledge, and involvement with nature as protective factors and as contributions to wellbeing and resilience among Sami youth (Nystad et al. 2014), and there have been attempts in the direction of more holistic healthcare methods. The Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse, SANKS, has developed *miljöterapi* or environmental therapy, which takes place in people's home or at the workplace such as in the reindeer corral, with an emphasize on physical activities, seasons changes, and Sami values and identities. These activities may also be part of more targeted efforts on suicide prevention and programmes to limit the exposure to violence and discrimination, and to strengthen identity, self-determination and diversity (SANKS 2017; Mikkola 2019; Finnmarkssykehuset 2019).

Generally speaking, the two cases discussed above show the need for an anthropologically informed, holistic, non-essentialist, and inclusive approach to cultural competence that takes into account the effects of existential, religious, social, physical, historical, political, and economic processes and their effect on individual mental health. This also includes how these processes are interrelated. Healthcare units wanting to work with this kind of holistic approach will benefit from having stipulated, feasible, and inclusive institutional policies of diversity, equity, social justice, anti-discrimination, anti-marginalisation, and anti-racism. To

build trust and reduce stigma attached to psychiatric institutions particularly, the healthcare infrastructure should be flexible and adapted to meet the needs of individuals.

In both psychiatric institutions and primary healthcare, this would imply an anthropologically informed, explicit power-sharing policy where minorities, indigenous people, ethnic communities, religious, and secular organisations and congregations are involved in policy making, decision-making, planning and the delivery of mental health services (Garneau and Pepin 2015; Kirmayer 2012a). Moreover, adapting mental healthcare to the needs of patients would include practical efforts. This could be for example, to allow flexible visiting hours in psychiatric clinics/wards to facilitate group praying, or making space for prayer or healing, as well as creating flexible opening hours at primary healthcare clinics.

The Swedish Psychiatric Association in Sweden has published guidelines in transcultural psychiatry, including information about training resources and courses (Svenska psykiatriska föreningen 2018). Some caregivers in transcultural psychiatry also use the Cultural Formulation Interview, CFI, which is included in the DSM-5 (*Diagnostic and statistical manual of mental disorders, 5th Edition*, American Psychiatric Association 2013). This patient-centered, transcultural interview guide consists of a number of open-ended questions focusing on the patient's experiences, perceptions, expectations, and networks. The CFI is recommended by the Transcultural Center, Stockholm County Council (Transkulturellt centrum 2020; see also Bäärnhielm and Mösko 2012). However, according to Bäärnhielm and Sundvall (2018: S11), in actual practice, there is seldom time to work with the CFI in a proper way and clinicians cannot fully "grasp the meanings patients give to illness and life situations and their expectations of care. ... time is often considered too short for a proper assessment, especially an assessment involving the patient's perspectives".

To take advantage of the CFI, primary healthcare clinics and mental healthcare institutions may use cultural mediators. They have been known to play an important role in therapeutic encounters (Schouler-Ocak et al. 2015; Kirmayer 2012a; Kirmayer et al. 2014). These mediators may advantageously be anthropologists as they are "guided by multiperspectivity, which allows them to make sense of the world from the point of view of various actors" (Podjed et al. 2016: 61). Moreover, in clinical settings the anthropological focus on context and lived experience have shown to be important for understanding the patient's health behaviour and the patient's ability to understand health information (Lane et al. 2017). Anthropologists working with clinicians may also improve healthcare in general by creating knowledge of, and an understanding for, multiple perspectives and mixed research methods (Deitrick et al. 2010).

Given sufficient time and resources, an anthropologist who takes the role of a cultural mediator may create the conditions for effective, trustworthy, responsive, inclusive, and individualised culturally competent mental healthcare that does not stereotype patients. He/she may also timely organize culturally competent techniques and therapies and an open safe space for encounters, dialogue, critical thinking, mutual understanding, and reciprocity. In this role in a primary healthcare clinic or psychiatric ward, the anthropologist may cooperate with clinicians and patients to promote healing, resilience and hope, create patient-centred and power-sharing healthcare encounters, mediate between different perspectives and treatment options, and take advice from religious/spiritual practitioners and healers when needed.

By working together with the anthropologist as cultural mediator, clinicians would also be supported to develop open, humble, and respectful ways to tailor mental healthcare to individual needs. The caregiver, patient, and anthropologist may thereby personally and jointly participate in a sensitive therapeutic relationship, learn from each other, and discuss religious, spiritual, existential, social, political and economic issues. With this engagement in the patient's life-worlds, clinicians may also broaden their horizon concerning their own values and perceptions. In so doing, they can develop self-reflexivity, empathy, and an awareness of differences and similarities concerning notions, expressions, and explanations for mental distress (Kirmayer 2012a; Garneau and Pepin 2015; Schouler-Ocak et al. 2015).

In this model, the anthropologist as cultural mediator works together with the patient and the caregiver to understand and make sense of afflictions from an emic, insider's, perspective, with a particular focus on illness perceptions, family, work and social networks, and in relation to larger socioeconomic and socio-political forces and processes. Furthermore, with this holistic and eclectic approach, there is an emphasis on engagement in the patient's life-world and an aspiration to inquire into what is at stake for the patient and what matters most, with an awareness that cultural processes are diverse, ongoing, flexible and inseparable from religious, political, social and economic conditions (Kleinman and Benson 2006).

Working together with the CFI, cultural mediators/anthropologists, clinicians and patients can also jointly develop the patient's narrative/life-story. With a focus on ideas, perceptions, and meaning, they may discuss, together and on equal terms, individual or group health-promoting resources involving for example, community and diasporic networks. This dialogue may also include illness explanations, symptom presentations, non-biomedical alternative treatments and healing, psychosocial stresses, the effects of migration, discrimination and racism, and the importance of family and social networks. In cases where religion or spirituality seems particularly important in the patient's life, the clinician, patient, and mediator could also together find out ways to integrate religiosity and spirituality into the treatment plan to enhance recovery, healing, and resilience.

Possible interventions: The anthropologist as educator

Anthropological education, with its focus on anthropological theory and ethnographic methods, may be a valid and useful complement to existing Swedish transcultural psychiatric educational efforts (Svenska psykiatriska föreningen 2018; Bäärnhielm and Mösko 2012). This is especially true for primary healthcare clinics and psychiatric wards that want to promote a holistic, self-reflexive, and non-essential view of cultural competence. Such initiatives could include a series of occasional lectures at the workplace, or possibilities to take part in more extended university courses in anthropology (ideally through workplace authorized paid leave).

As such lectures and courses emphasise openness, flexibility, and self-awareness, they will also encourage the caregiver to reflect upon his/her own identity, attitudes, and perceptions. Consequently, as the clinician gradually occupies an open-minded, reflective, and curious position, an awareness of his/her own prejudices, biases, and stereotypes is acquired. Teaching that includes role-playing, drama, ethnography, and fictive patient encounters can be particularly useful in this context (Skott et al. 2013).

Mental healthcare policymakers may also benefit from the suggested lectures and courses. They would acquire a more holistic understanding for policymaking which in turn

will make them better equipped to understand policies in relation to issues such as mental health inequalities, racism and intolerance. Consequently, they would also be better prepared for unexpected and unintended consequences of policies and interventions (Bernstein and Razon 2019; Farmer et al. 2013).

Mental healthcare practitioners and policy-makers would particularly benefit from lectures and courses in medical anthropology as they commonly focus on a broad understanding of illness, health and healing, as well as both emic (insider's) and etic (outsider's or comparative) perspectives. Over the years, I have myself been teaching medical anthropology at healthcare units, workplaces, and universities in Sweden and abroad, focusing on illness and health in a comparative perspective as well as on how illness perceptions influence and shape the experience of health and illness in relation to social, economic, religious, and historical processes. Teaching has also included how historical injustices and structural discriminations may generate social, political, and economic inequalities in relation to inequalities in health. This has also included factors that contribute to good mental health (Kirmayer 2012a, 2012b; Garneau and Pepin 2015).

In the educational efforts for mental healthcare practitioners outlined here, participants would acquire an insight into indigenous worldviews, which in turn could help them to question taken-for-granted biomedical and Western concepts, including models of the body, self, soul, and social relations. Students may thereby begin to critically reflect on how mental health is understood and how mental health problems are treated in biomedicine and psychiatry, and acquire an understanding for healing in a broader perspective and “universal logics of causation (jealousy, magic, sorcery, contagion, possession, etc.)” (Miklavcic and LeBlanc 2014: 123; cf. Kapferer 2003).

By using patient/client-centred teaching material and case studies that encourage empathy, sensitivity, respect, curiosity, and wonder, a non-essentialist and non-stereotyping view of cultural competence is promoted. This may contribute to a more holistic understanding for issues such as religion/spirituality and non-western medicine/healing, and encourage the empowerment of patients. Accordingly, this may also help to develop an understanding for healing, religion, and spirituality as resources to promote resilience, hope, perseverance, and agency (Whitley 2012; Schouler-Ocak et al. 2015; Kirmayer 2012a, Kirmayer et al. 2011; Wedel 2004). Using a theoretical framework based in medical anthropology, this also contributes to an ongoing two-way learning where biomedical and psychiatric notions and practices may be discussed, problematized, and challenged. Critical concepts and ideas in this educational process may include the individualisation of mental ill-health, morality in caregiving, mind-body dichotomies, caring vs curing, healing of illness vs curing of disease, placebo/nocebo effects, medicalisation, ethnocentrism, and the universal validity of psychiatric categories (Good 1994; Kleinman 2012; Moerman 2002; Gadamer 1996).

Concluding remarks

In this article, I have discussed how an anthropologically informed view of cultural competence may contribute to addressing mental distress and offer appropriate mental healthcare in diverse settings using two case studies on mental health from Sweden as examples. Acknowledging the differences and variations in people's values, attitudes, and behaviours, as well as in relation to the larger social order, I have argued against an oversimplified, undifferentiated, and essentialist view of cultural competence in mental

healthcare. Moreover, by giving suggestions on how an anthropologically informed, holistic, inclusive, non-essentialist, non-stereotyping, contextual, flexible, and multifaceted approach to cultural competence in mental healthcare may deal effectively with patients from various backgrounds, I have envisioned how an anthropologist may help to mediate between perspectives and contribute to reflective teaching and education in mental healthcare.

The two ethnographic cases discussed here which are based on the experiences of the Somali-Swedes and the Sami people, not only show the need for a culturally competent, sensitive, and holistic approach to understand and deal with diverse mental health problems; they also indicate the importance of bridging the gap between biomedical and non-Western perceptions, explanatory models, and notions of illness causation (Wedel 2009; Kleinman and Benson 2006).

The concept cultural competency has been criticised and sometimes understood in an essentialist and simplistic way in mental healthcare. If the term is to be used in the future, it should be understood and applied from an anthropological standpoint and based on a holistic, non-essentialist perspective, and a critical self-reflective position. Used in this way, it also encompasses the term cultural safety and related concepts as it emphasizes self-reflection and listening to patients, as well as the complex social, historical, political, and economic circumstances creating and contributing to power imbalances and indigenous and ethnic inequalities (Curtis et al. 2019; Kirmayer 2012a).

Acknowledgements

Research was funded by Ekshagastiftelsen, Åke Wibergs stiftelse, and the Swedish Research Council for Health, Working Life and Welfare.

References

- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. Arlington (VA): American Psychiatric Association.
- Abrams, L. S. and J. A. Moio. 2009. Critical Race Theory and the Cultural Competence Dilemma in Social Work Education. *Journal of Social Work Education* 45(2): 245-261.
- Beach, H. 2001. *A Year in Lapland: Guest of the Reindeer Herders*. Seattle and London: University of Washington Press.
- Bernstein, A. and N. Razon. 2019. Anthropological Approaches to the Study of Health Policy. *Human Organization* 78(1): 75-84.
- Bäärnhielm, S. and M. Sundvall. 2018. Clinical Challenges in Cultural Psychiatry – Searching for Meanings, Searching for Methods. *Nordic Journal of Psychiatry* 72(suppl.1): S9-S12.
- Bäärnhielm, S. and M. Mösko. 2012. Cross-Cultural Training in Mental Health Care – Challenges and Experiences from Sweden and Germany. *European Psychiatry* 27(suppl. 2): 70-75.
- Carpenter-Song, E. A., M. Nordquest Schwallie and J. Longhofer. 2007. Cultural Competence Reexamined: Critique and Directions for the Future. *Psychiatric Services* 58(10): 1362-1365.
- Curtis, E., R. Jones, D. Tipene-Leach, C. Walker, B. Loring, S-J. Paine and P. Reid. 2019. Why Cultural Safety Rather Than Cultural Competency is Required to Achieve Health Equity. *International Journal of Equity in Health* 18: 174.
- Daerga, L. 2017. *Att leva i två världar: Hälsoaspekter bland renskötande samer*. PhD Diss. Umeå: Umeå Universitet, Institutionen för folkhälsa och klinisk medicin.
- Daerga, L., P. Sjölander, L. Jacobsson and A. Edin-Liljegren. 2012. The Confidence in Health Care and Social Services in Northern Sweden – A Comparison Between Reindeer-Herding Sami and the non-Sami Majority Population. *Scandinavian Journal of Public Health* 40(6): 516-522.

- Deitrick, L. M., T. Capuano and D. Salas-Lopez. 2010. Practicing Anthropology in an Academic Community Hospital: Lessons from the Field. *Practicing Anthropology* 32(4): 19-23.
- Eriksson, J. I. 2018. *Samisk Shamanism: Var tids noaidi*. Umeå: Bokförlaget h:ström – Text & Kultur.
- Farmer, P., A. Kleinman, J. Kim and M. Basilio (eds). 2013. *Reimagining Global Health: An Introduction*. Berkeley: University of California Press.
- Finnmarkssykehuset. 2019. Kognitiv miljöterapi ved SANKS Karasjok. Retrieved from <https://finnmarkssykehuset.no/behandlinger/kognitiv-miljoterapi> . (Accessed: 20 August 2019).
- Gadamer, H.-G. 1996. *The Enigma of Health*. Stanford, CA: Stanford University Press.
- Garneau, A. B. and J. Pepin. 2015. Cultural Competence: A Constructivist Definition. *Journal of Transcultural Nursing* 26(1): 9-15.
- Good, B. J. 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.
- Helander-Renvall, E. 2010. Animism, Personhood and the Nature of Reality: Sami Perspectives. *Polar Record* 46(1): 44-56.
- Johnsdotter, S., K. Ingvarsdotter, M. Östman and A. Carlbom. 2011. Koran Reading and Negotiation with Jinn: Strategies to deal with Mental Ill Health among Swedish Somalis. *Mental Health, Religion & Culture* 14(8): 741-755.
- Josewski, V. 2011. Analysing 'Cultural Safety' in Mental Health Policy Reform: Lessons from British Columbia, Canada. *Critical Public Health* 22(2): 223-234.
- Kaiser, N., P. Sjölander, A. E. Liljegren, L. Jacobsson and E. S. Renberg. 2010. Depression and Anxiety in the Reindeer-Herding Sami population of Sweden. *International Journal of Circumpolar Health* 69(4): 383-393.
- Kapferer, B. 2003. Introduction. Outside All Reason. Magic, Sorcery, and Epistemology in Anthropology. In *Beyond Rationalism: Rethinking Magic, Witchcraft, and Sorcery*, Kapferer, B. (ed.), New York: Berghahn Books.
- Kirmayer, L. J., J. Guzder and C. Rousseau (eds). 2014. *Cultural Consultation: Encountering the Other in Mental Health Care*. New York: Springer.
- Kirmayer, L. J., S. Dandeneau, E. Marshall, M. K. Philips and K. J. Williamson. 2011. Rethinking Resilience from Indigenous Perspectives. *Canadian Journal of Psychiatry* 56(2): 84-91.
- Kirmayer, L. J. 2012a. Rethinking Cultural Competence. *Transcultural Psychiatry* 49(2): 149-164.
- Kirmayer, L. J. 2012b. Cultural Competence and Evidence-Based Practice in Mental Health: Epistemic Communities and the Politics of Pluralism. *Social Science & Medicine* 75: 249-256.
- Kleinman, A. 2012. Caregiving as Moral Experience. *The Lancet* 380(9853): 1550-1551.
- Kleinman, A. 2009. Global Mental Health: A Failure of Humanity. *The Lancet* 374(9690): 603-604
- Kleinman, A. and P. Benson. 2006. Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix it. *PLoS Medicine* 3(10): 1673-1676.
- Kohn-Wood, L. P. and L. M. Hooper. 2014. Cultural Competency, Culturally Tailored Care, and the Primary Care Setting: Possible Solutions to Reduce Racial/Ethnic Disparities in Mental Health Care. *Journal of Mental Health Counseling* 36(2): 173-188.
- Kowalczewskia, E. and J. Klein. 2018. Sámi Youth Health, the Role of Climate Change, and Unique Health-Seeking Behaviour. *International Journal of Circumpolar Health* 77(1): 1454785.
- Labba, E. A. 2020. *Herrarna satte oss bit: om tvångsflyttningarna i Sverige*. Stockholm: Nordstedts.
- Lane, S. D., R. A. Rubinstein, R. H. Keefe, L. B. Satterly, T. Ramachandran, S. Huntington, et al. 2017. Action Anthropology in a Free Clinic. *Human Organization* 76(4): 336-347.
- Langås-Larsen, A., A. Salamonsen, A. E. Kristoffersen, T. Hamran, B. Evjen and T. Stub. 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.
- Lindmark, D. and O. Sundström. (eds). 2016. *De historiska relationerna mellan Svenska kyrkan och samerna. En vetenskaplig antologi*. Skellefteå: Artos & Norma bokförlag.
- McMichael, C. 2002. 'Everywhere is Allah's Place': Islam and the Everyday Life of Somali Women in Melbourne, Australia. *Journal of Refugee Studies* 15(2): 171-188.

- Mikkola, P. 2019. Samiskt center för psykisk hälsovård. Nordkalotträdet. March 11. Retrieved from <https://nordkalottradet.org/uutinen/samiskt-center-for-psykisk-halsovard/> . (Accessed: 1 September 2019).
- Miklavcic, A. and M. N. LeBlanc. 2014. Culture Brokers, Clinically Applied Ethnography, and Cultural Mediation. In *Cultural Consultation: Encountering the Other in Mental Health Care* (eds) L. J. Kirmayer, J. Guzder and C. Rousseau. New York: Springer.
- Miller, B. H. (ed.) 2015. *Idioms of Sámi Health and Healing*. Edmonton: University of Alberta Press.
- Moerman, D. 2002. *Meaning, Medicine and the "Placebo Effect"*. Cambridge: Cambridge University Press.
- Mölsä, M., M. Tiilikainen, and R.-L. Punamäki. 2019. Usage of Healthcare Services and Preference for Mental Healthcare among Older Somali Immigrants in Finland. *Ethnicity and Health* 24(6): 607-622.
- Mölsä, M. E., K. H. Hjelde and M. Tiilikainen. 2010. Changing Conceptions of Mental Distress among Somalis in Finland. *Transcultural Psychiatry* 47(2): 276-300.
- Nystad, K., A. R. Spein, and B. Ingstad. 2014. Community Resilience Factors among Indigenous Sámi Adolescents: A Qualitative Study in Northern Norway. *Transcultural Psychiatry* 51(5): 651-672.
- Omnia, L., M. Sandlund and L. Jacobsson. 2013. Suicidal Expressions in Young Swedish Sami, A Cross-Section Study. *International Journal of Circumpolar Health* 72(1): 19862.
- Omnia, L. 2013. *Ungsame i Sverige: Livsvillkor, självvärdering och hälsa*. PhD Diss. Umeå: Umeå universitet.
- Podjed, D., M. Gorup and A. B. Mlakar. 2016. Applied Anthropology in Europe Historical Obstacles, Current Situation, Future Challenges. *Anthropology in Action* 23(2): 53-63.
- Sametinget. 2017. *Kunskapsnätverk för samisk hälsa inrättas*. April 19. Kiruna: Sametinget. Accessed 9 January 2019: <https://www.sametinget.se/113059> .
- Sametinget. 2016. *Kunskapsnätverk om samers psykosociala ohälsa*. Kiruna: Sametinget. Accessed 1 September 2019: <https://www.sametinget.se/rapport-psykosocial-ohalsa> .
- SANKS (Samisk nasjonalt kompetansetjeneste – Psykisk helsetjeneste og rus [Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse]). 2017. *Plan for Suicide Prevention among the Sámi People in Norway, Sweden and Finland*. Karasjok: SANKS. Accessed: 1 September 2019: <https://finnmarkssykehuset.no/Documents/SANKS/Plan%20FOR%20SUICIDE%20PREVENTION%20AMONG%20THE%20S%3%81MI%20PEOPLE%20IN%20NORWAY.pdf> .
- Schouler-Ocak, M., I. T. Graef-Calliess, I. Tarricone, A. Qureshi, M. C. Kastrup and D. Bhugra. 2015. EPA Guidance on Cultural Competence Training. *European Psychiatry* 30: 431-440.
- Skott, C., L. Dellenborg, M. Lepp and K. Nässén. 2013. *Människan i vården: Etnografi, vård och drama*. Stockholm: Carlsson Bokförlag.
- Skott, C. 1997. *Bota blod och läka hjärta: Samer berättar om bot*. Stockholm: Carlsson Bokförlag.
- Statistiska Centralbyrån. 2018. *Befolkningsstatistik*. Accessed 15 August 2019: <https://www.scb.se/hitta-statistik/statistik-efter-amne/befolkning/befolkningens-sammansattning/befolkningsstatistik/> .
- Stoor, J. P. A. 2015. Varför söker svenska samer vård i Norge? – om kultur och kontext i samisk psykiatri. *Socialmedicinsk tidskrift* 1: 26-37.
- Stoor, J. P. A., N. Kaiser, L. Jacobsson, E. S. Renberg and A. Silviken. 2015. "We are like Lemmings": Making Sense of the Cultural Meaning(s) of Suicide among the Indigenous Sami in Sweden. *International Journal of Circumpolar Health* 74: 27669.
- Svenska psykiatriska föreningen. 2018. (Swedish Psychiatric Association). *Transkulturell psykiatri. Kliniska riktlinjer och behandling* [Transcultural psychiatry. Clinical guidelines and treatment]. Stockholm: Gothia Fortbildning.
- Tervalon, M. and J. Murray-Garcia. 1998. Cultural Humility versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved* 9(2): 117-125.
- Transkulturellt centrum. 2020. Region Stockholm (Transcultural Center, Stockholm County Council). Retrieved from <https://www.transkulturelltcentrum.se/>
- Tiilikainen, M. and P. H. Koehn. 2011. Transforming the Boundaries of Health Care: Insights from Somali Migrants. *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 30(5): 518-544.

- UNHCR. 2014. *UNHCR Statistical Yearbook 2013: Statistical Annexes*. Accessed 9 August 2019: <https://www.unhcr.org/statistics/country/54cf9bc29/unhcr-statistical-yearbook-2013-statistical-annexes.html?query=refugees%20by%20country>.
- Vårdhandboken. 2018. Bemötande i vård och omsorg, transkulturellt perspektiv – Översikt. Accessed 11 January 2020: <https://www.vardhandboken.se/arbetssatt-och-ansvar/bemotande-i-var-d-och-omsorg/bemotande-i-var-d-och-omsorg-transkulturellt-perspektiv/oversikt/>.
- Wedel, J. 2014a. Sjukdom och bot bland svensksomalier. In *Helig hälsa: helandemetoder i det mångreligiösa Sverige*. Moberg, J. and G. Ståhle (eds). Stockholm: Dialogos.
- Wedel, J. 2014b. Religion and Healing among Somalis in Sweden when Experiencing Illness and Suffering. Conference proceedings. The 5th European Conference on African Studies, Lisbon, Portugal, June 27-29, 2013.
- Wedel, J. 2012a. Religión, enfermedad y curación entre los Somalíes en la diáspora. Conference proceedings. CD-ROM. XII Conferencia Internacional de la Cultura Africana y Afroamericana, Santiago de Cuba, Cuba, April 12-16.
- Wedel, J. 2011. Mental Health Problems and Healing among Somalis in Sweden. *Bildhaan: An International Journal of Somali Studies* 11: 73-89.
- Wedel, J. 2009. Bridging the Gap between Western and Indigenous Medicine in Eastern Nicaragua. *Anthropological Notebooks* 15(1): 49-64.
- Wedel, J. 2004. *Santería Healing: A Journey into the Afro-Cuban World of Divinities, Spirits, and Sorcery*. Gainesville: University Press of Florida.
- Whitley, R. 2012. Religious Competence as Cultural Competence. *Transcultural Psychiatry* 49(2): 245-260.