

ORIGINAL ARTICLE

USE OF TRADITIONAL HEALING AMONG SÁMI PSYCHIATRIC PATIENTS IN THE NORTH OF NORWAY

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ABSTRACT

Objectives. The purpose of this study was to learn more about the extent of, and factors related to, the use of traditional and complementary healing modalities among Sámi psychiatric patients.

Study Design. A quantitative survey among psychiatric patients in Finnmark and Nord-Troms, Norway.

Results. A total of 186 Sámi and Norwegian patients responded to the survey, a response rate of 48%. Of these, 43 had a strong Sámi cultural affiliation. Use of traditional and complementary treatment modalities was significantly higher within the Sámi group. Factors related to use differed between Sámi and Norwegian groups. Sámi users were found to give greater importance to religion and spirituality in dealing with illness than Sámi patients who had not used these treatments. They were also found to be less satisfied with central aspects of their psychiatric treatment.

Conclusions. In this study, we found several differences in factors related to the use of traditional and complementary treatments between Sámi and Norwegian psychiatric patient groups. Sámi users were found to give greater importance to religion and spirituality and were less satisfied with the public psychiatric services than Sámi patients who had not used traditional or complementary treatments. The study implies that finding ways to include different aspects of traditional healing within the health services to the Sámi community should be given consideration.

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Keywords: Sámi, traditional healing, complementary medicine, spirituality, psychiatry, treatment satisfaction

INTRODUCTION

The history of the Sámi people and the history of their traditional forms of healing are closely interwoven. We know that the culture of the Sámi people, who lived throughout what are now the northern areas of Norway, Sweden, Finland and Russia, was originally based on Shamanism and a nature-oriented religion. Although important details of this tradition are now mostly lost, it is believed that certain aspects of the Shamanic healing practices were preserved, although in a form more acceptable to the Christian church, and might have found a special place within the Laetadian movement that arose in the latter part of the 1800s (1). Today, many aspects of traditional medicine and healing are still being used, and the narratives and belief systems, which provide a strong cultural foundation for this tradition, are kept alive within the community (1).

Although some knowledge of traditional Sámi healing exists from research done within the humanities, little has been studied about this tradition and its use by Sámi patients from the perspective of those working in the health care field. Two studies, however, indicate that traditional Sámi healing is still used by Sámi patients.

In a Sámi-Norwegian health survey among nearly 16,000 individuals in northern Norway, between 12% and 32% of the population reported to have used healers at some point in their lives. Those with a higher Sámi affiliation had more often made use of healers (2). The frequency of using other complementary treatments, which are readily available in the region today, has not been published.

In a recent study among 68 patients admitted to a general psychiatric hospital in northern

Norway, 37% of the Sámi patients and 14% of the Norwegian patients reported using traditional helpers during their current crisis (3). The therapists at the hospital were generally unaware of which patients had been in contact with traditional helpers, seeming to indicate that there may be little dialogue between psychiatric therapists and their patients on the subject of traditional healing (at least in the hospital setting).

Knowledge that we have gathered both from the literature (1,4,5) and through speaking with patients and their helpers indicates that traditional healing can include herbal remedies, but most often it is based on the laying on of hands or the reciting of special verses believed to have a strong healing power. The use of these verses, which have their origin in the Christian tradition, is a local practice called "laesing," which means "reading" when directly translated. Healing abilities are understood to be carried within certain family lines, and the verses are only disclosed to a family member or chosen successor when a healer grows old (4). Treatments are customarily given in a home atmosphere, although today, healers are often contacted by phone, and a form of distance healing is practised where the healer later recites the verses for the patient. Although this is the general picture of traditional healing that we have found, there most probably are many aspects of the local healing practices that we know little about.

Today, traditional healing is under the influence of a large range of other traditional and complementary practices, such as Traditional Chinese medicine. Complementary and traditional healing practices are closely related, as can be seen by definitions given by the World Health Organization. It has defined traditional

medicine and healing as health practices and beliefs with a history or tradition in a local culture, and complementary medicine as adaptations of traditional medicine in industrialized countries (6). Some Sámi helpers, mostly from the younger generation, now include more newly arrived complementary approaches in their practice (5). This makes it more difficult to consider traditional and complementary practices separately. A key question is whether traditional healing still plays an important role in Sámi culture today, since the community has undergone major changes and most live a modern Western life-style.

In Europe and North America, around 50% of the population have used complementary medicine at least once (6), but this percentage varies from study to study depending on how complementary medicine is defined and where the study is carried out. A recent study from Germany among psychiatric inpatients showed that half had used traditional or complementary medicine parallel to psychiatric treatment, and that those patients from a migrant background had predominantly used traditional forms of healing in comparison with the German patients who had used complementary treatment forms (7). A study from the U.S. showed that the total number of visits to complementary therapists exceeds that of visits to all primary physicians throughout the country (8). The exact reasons for the popularity of complementary medicine are not well understood (9). Reasons that have been identified involve dissatisfaction with conventional treatments, the need for more personal choice over health care decisions and congruence of complementary therapies with personal values and beliefs about health and illness (9). Some studies have found a higher use of complementary medicine among better-

educated people, women and those with poorer health (8,10,11). Higher rates of use have also been found among people with psychiatric problems (12). A large longitudinal study from Switzerland showed that the vast majority of use was in addition to Western treatments and that use was a complex phenomenon which could not be adequately explained by simple theoretical models (13).

Some of the reasons for the use of traditional healing will naturally differ from that of complementary medicine. One large study from two American Indian reservations showed that close to half of those seeking help for substance abuse problems sought it from outside the biomedical health services (14). Indigenous patients also used traditional healers for psychological problems relatively more than they did for physical problems when compared with use of biomedical services, and use was generally correlated with identification with American Indian culture (15). A spiritual world view and intuitive forms of knowledge have been identified as central to the healing traditions of indigenous cultures throughout the world (16,17).

The international literature from other areas suggests that the success of traditional healing in treating mentally ill patients rests on the fact that the techniques are related to the relevant cultural premises of the patient (18) and that traditional healing can provide an understandable and integrated system of meaning for some psychiatric disorders (19). In addition, positive expectations of the treatment may be greater for traditional healing (20), or it may be based on a stronger therapeutic alliance and therefore be more clinically beneficial (21).

American Indians and Alaska Natives have preserved and revitalized a number of traditional healing practices and applied these to

the treatment of alcohol-related problems. These healing practices include sacred dances, sweat lodges, talking circles, four direction circles and cultural enhancement programs (22). However, with regards to traditional Sámi healing, there has been no organized renewal of healing traditions or rituals, or use of these in health programs. Nevertheless, the general revitalization of Sámi culture may include an increase in traditional healing practices among Sámi people today.

For several years there has been a national initiative in Norway to develop culturally appropriate health services for the Sámi population. Within the psychiatric health services there has been a specific emphasis on increasing cultural awareness about and the knowledge of the Sámi language among health professionals (23). A national plan for Sámi health services encouraged co-operation between traditional Sámi healers and health professionals (24), and although a centre for such co-operation was proposed (25), to this date, more than 10 years after the national plan was launched, there has been no formal co-operation between these traditions. Today, the mainstay of treatment at the district psychiatric centres throughout Finnmark and Nord-Troms is Western psychotherapy, often in combination with psychopharmacological treatment. Although a few clinics offer, to a limited degree, less verbal forms of therapy, such as thought field therapy and the Rosen method, modalities such as music therapy or body-mind therapies are, like the traditional forms of healing, poorly represented at the clinics.

We know little about how extensively traditional and complementary healing modalities are used among the wider population of Sámi patients using the psychiatric services,

and what factors this use might be related to. Based on the literature from other areas, and the importance of traditional healing in Sámi culture, we hypothesized that Sámi patients would use these methods more widely than Norwegian patients, and that these practices might be more widely used among Sámi patients who had a greater spiritual orientation, a more distressing or serious condition or less satisfaction with Western psychiatric treatments. Other potential factors we chose to look at specifically were personality and beliefs related to health (health locus of control). With respect to personality, the study was more exploratory, and the measures we chose to use were extraversion, emotional stability and conscientiousness from the Big 5 personality inventory.

MATERIAL AND METHODS

This was a cross-sectional study over a 3-month period between February and April 2006. Patients received information about the study through brochures and a poster left at each clinic and in the survey packet their therapist or the secretary at the reception gave them. The survey was anonymous, and all patients in a stable phase who were evaluated as being able to understand the implications of informed consent were invited to participate.

The questionnaire, which was available in both Sámi and Norwegian, was developed in co-operation with 4 of the study centres and the National Research Centre in Complementary and Alternative Medicine (NAFKAM). It was accepted by the regional ethical committee. The following measures were assessed through the questionnaire.

Cultural affiliation

Fourteen items were selected from a 20-item questionnaire (26) assessing self-defined cultural affiliation, how ethnicity was perceived by others, languages learned at home, and languages spoken by grandparents. In this study, we used self-defined cultural affiliation as a measure of ethnicity. This was shown to be a valid measure of ethnicity in an earlier study among psychiatric patients (3). The series of questions used in scoring self-defined cultural affiliation rated this on a 5-point scale, ranging from “not at all” to “very much” with respect to Norwegian, Sámi, Finn, Kven or other cultural affiliation.

Extent of use of traditional or complementary treatments

Patients were asked if they ever had contacted therapists or helpers outside the public health services, either in person or by phone, if this treatment was for physical or psychological health problems, and what form of treatment they had received. They were also asked when the last contact had been.

Factors associated with use

All items in the following measures were on a 5-point scale, ranging from 1 (not at all) to 5 (very much). The Chronbach alpha coefficients refer to the present study.

Quality of the patient–therapist relationship and global satisfaction with treatment

We selected 6 items from the patient version of the 12-item Working Alliance Inventory (WAI) (27) and 3 items from “the quality of contact with the therapist” factor from a patient satisfaction questionnaire (28). A factor-analytic approach showed that all 9

items were included in a 1-dimensional relationship factor ($\alpha=0.92$, scoring range 9–45).

Global satisfaction with treatment was assessed through a single Likert scaled question in which patients were asked how satisfied they were with the treatment they had received within the psychiatric services.

Spirituality and religious mindedness

A 3-item scale addressed the degree to which the patients’ religious or spiritual beliefs had supported them and whether they had been searching for spiritual help or had used prayer during their illness (28) ($\alpha=0.68$, scoring range 3–15).

Emotional symptoms, daily level of function and social support

The SCL-5 version of the Hopkins Symptom Checklist (29) was used in evaluating emotional symptoms (5 items; $\alpha=0.87$, scoring range 5–25).

Daily level of functioning was assessed through 2 intercorrelated items assessing the degree to which patients’ needed practical help and support in their daily lives ($\alpha=0.64$, scoring range 2–10).

In assessing social support, we used a 4-item scale measuring how likely the patients believed they would receive necessary help from family, friends neighbours and colleagues if they were bedridden due to illness (30) ($\alpha=0.73$, scoring range 4–20).

Personality and multidimensional health locus of control (MHLC, form A)

A 10-item version of the Big 5 personality inventory was used (31). We used the emotional stability (2 items; $\alpha=0.49$), extraversion

(2 items; $\alpha=0.50$) and conscientiousness (2 items; $\alpha=0.56$) dimensions.

The MHLC (32) is an 18-item measure evaluating the expected relationship between one's own behaviour and its consequences on personal health. It includes questions that rate an individual's belief in the importance of personal factors such as life-style or outer factors such as the importance of family or therapists in preventing illness. The instrument has been shown to have 3 subscales corresponding to internal, powerful others and chance control. For the present study we used the internality and powerful others subscales. The alpha coefficients were 0.76 for the internal control scale and 0.63 for the powerful others control scale.

Statistical analysis

Missing values ranged from 0–10%, and percentages given in the text are valid percentages based on the number of patients answering. Missing values in the variables used in the analysis were replaced by the mean of the user or non-user group to which the patient belonged. The most frequent answer in this group was also used for missing dichotomous values.

Cross-tabs and chi-square analysis were used to determine relationships between the different variables and use of traditional and complementary treatments for psychological problems. The comparison groups were those patients who had not used traditional and complementary treatments for psychological problems, this group included some patients who had used these treatments for physical problems. Those variables that were significant or trended to significance ($p<0.1$) in the univariate analysis were included in a multiple logistic regression analysis. The strength of

the associations was expressed as odds ratios (ORs) with 95% confidence intervals (95% CI). All statistical tests were done as 2-tailed tests, and the significance level was set at $p=0.05$. We used SPSS for Macintosh 13.0 for all statistical analyses.

RESULTS

Of the 389 patients invited to participate, 186 responded to the survey, a response rate of 48%. The mean age was 39 (SD=12.7); 140 (77%) of the patients were women and 98 (53%) were married or living in common law; and 156 (84%) of the patients were being treated as outpatients.

Cultural affiliation

Seventy-two (39%) of the patients considered themselves as being "a little" Sámi or "more than a little," while 43 (23%) considered themselves as being "quite a lot" or "very much" Sámi. We have chosen to define this last group ("quite a lot" or "very much") as the Sámi group, and will use this group in comparison with the non-Sámi group ($n=114$), which we will call the Norwegian group since it primarily consisted of Norwegians. There was no significant difference between the Sámi and Norwegian groups with respect to age, gender, years of schooling, marital status, hospital admissions, length of psychiatric problems or satisfaction with psychiatric treatment. However, the Norwegian group had a significantly higher symptom level ($p=0.02$), scored lower on daily functioning ($p=0.04$) and emotional stability ($p=0.01$), and had used significantly more psychopharmacological treatment ($\chi^2(1)=10$, $p=0.002$). In addition, the Sámi patient group also scored higher

on the scale of spirituality and religious mindedness ($p=0.001$)

Within the Sámi group, 30 (70%) had learned Sámi at home and 39 (91%) had 1 or more Sámi-speaking grandparents. Thirty-three (77%) had 1 or more Sámi-speaking grandparents on both their mothers' and fathers' sides of the family.

Extent of use

Within the Sámi group, 29 (67%) had used traditional and complementary healing modalities for all problems, and 19 (50%) for psychological problems.

Within the Norwegian group, 49 (45%) had used traditional and complementary healing modalities for all problems, and 32 (31%) for psychological problems.

In comparing the Norwegian group to the Sámi group, Sámi patients had used significantly more traditional and complementary healing modalities than Norwegian patients for all problems ($p<0.01$) as well as for psychological problems ($p<0.05$).

Extent of use of "healing"

In defining "healing," we have chosen the laying on of hands, distance healing and "reading" or prayer. This likely includes the help given by traditional helpers. Eighteen (42%) of the Sámi group, and 36 (33%) of the Norwegian group had used some form of healing; however, this

was not a statistically significant difference at the .05 level. Besides healing, the other forms of treatment used were complementary treatments such as acupuncture, massage and herbal remedies.

Factors associated with use for psychological problems found in the univariate analysis

Sámi patients who had used traditional or complementary healing modalities rated both their global satisfaction with the psychiatric services and the quality of their relationship with the psychiatric therapist, as lower than those Sámi patients who had not used traditional and complementary treatment for psychological problems ($p<0.05$ for both). They also scored significantly higher on the scale of spirituality and religious mindedness ($p<0.001$) and were found to have used psychopharmacological treatment more often ($p<0.05$). One other result that was close to significant and that was included in the multivariate analysis was the lower scores on the scale of conscientiousness ($p=0.06$). There were no other significant differences with respect to duration of psychiatric problems, hospitalizations, symptoms, level of functioning, social network, gender, age, marital status or personality factors.

Norwegian patients using traditional healing modalities for psychological prob-

Table I. Frequency of use of traditional and complementary treatment modalities among Sámi and Norwegian patients.

	Sámi patients (n=43)	Norwegian patients (n=109)	Pearson chi-square	p
Use of traditional and complementary medicine for all problems	29 (67%)	49 (45%)	6.2	0.01
Use of traditional and complementary medicine for psychological problems	19 (50%)	32 (31%)	5.2	0.02

lems also rated their global satisfaction with the psychiatric services as lower than those Norwegian patients who had not used traditional or complementary healing modalities ($p < 0.05$). However, in contrast to the Sámi group, a significantly poorer relationship with the psychiatric therapist was not found, and use within the Norwegian group was found to be significantly associated with earlier or current hospital admission.

Other factors that were close to significant with respect to use among Norwegian patients were higher scores on religious mindedness ($p = 0.07$), extraversion ($p = 0.06$) and locus of control other ($p = 0.07$), higher age ($p = 0.9$), and lower scores on emotional stability ($p = 0.09$).

Regression analysis

All variables that leaned towards significance in the univariate analysis were entered into the regression analysis. For Sámi patients this

was spirituality and religious mindedness, global satisfaction with psychiatry, quality of relationship with the therapist, psychopharmacological treatment and conscientiousness. In this analysis, only spirituality and religious mindedness ($p = 0.008$) was found to be an independent predictor of use among Sámi patients. However, lower scores on the scale of conscientiousness was close to significant ($p = 0.07$).

For the Norwegian group, spirituality and religious mindedness, global treatment satisfaction, emotional stability, extraversion, age and earlier or current hospital admission were entered into the analysis. Lower scores on emotional stability ($p = 0.02$), higher scores on extraversion ($p = 0.03$), higher age ($p = 0.03$) and earlier or current hospital admission ($p = 0.04$) were all found to be independently related to use for psychological problems in this group.

Table II. Factors from the univariate analysis found to be related to use for psychological problems among Sámi (above) and Norwegian patients (below).

Sámi group				
	Sámi users M(SD)	Sámi non-users M(SD)	t(df)	p
Spirituality and religious mindedness	10.4 (4.0)	5.7 (3.3)	3.9 (36)	<0.001
Global satisfaction with psychiatry	3.6 (1.1)	4.3 (0.7)	-2.2 (36)	0.04
Quality of contact with psychiatric therapist	34.4 (7.8)	39.1 (6.0)	-2.1 (36)	0.05
Use of psychopharmacological treatments	11 of 18 patients	5 of 19 patients	Cross-tab analysis $\chi^2(1)$ 4.6	p 0.03
Norwegian group				
	Norwegian users M(SD)	Norwegian non-users M(SD)	t(df)	p
Global satisfaction with psychiatry	3.5 (1.2)	3.9 (0.9)	-2.1 (103)	0.03
Earlier or current hospital admission	16 of 32 patients	18 of 71 patients	Cross-tab analysis $\chi^2(1)$ 6.0	p 0.01

Table III. Factors from the multivariate logistic regression found to be independently associated with use of traditional and complementary healing for psychological problems.

Sámi group				
	Odds ratio	95% CI		p
		lower	upper	
Spirituality and religious mindedness	1.5	1.1	2.1	0.007
Norwegian group				
	Odds ratio	95% CI		p
		lower	upper	
Emotional stability	0.64	0.44	0.93	0.02
Extraversion	1.45	1.03	2.04	0.03
Age	1.05	1.01	1.20	0.03
Earlier or current hospital admission	3.30	1.08	10.06	0.04

DISCUSSION

It is important to note that this is a multicultural region, and that this study was done in both the inland regions, where Sámi culture and language are well preserved, and the coastal regions. Particularly in these coastal regions, Sámi and Norwegians have lived side by side and have intermarried for generations, and the assimilation policy has served to erode more open cultural differences. Therefore, assigning patients to cultural or ethnic groups is to some degree arbitrary. Most Sámi patients identified themselves with both the Norwegian and Sámi cultures, and Norwegian patients are also influenced by the Sámi cultural heritage of the region.

Although similar with respect to demographics, patients within the Norwegian group may have had more serious conditions, judging by the higher symptoms, lower emotional stability, lower functioning and greater use of psychopharmacological treatments. However, they did not have more hospital admissions or longer durations of illness, implying that any such difference was probably not large. The differences here would also only serve to

underestimate any difference in frequency of using traditional and complementary healing modalities, as both lower emotional stability and use of psychopharmacology is linked to a greater frequency of these treatments in this study. With respect to comparing the Norwegian and Sámi groups in general, it is also important to keep in mind that there may be some cultural differences in the way in which Sámi and Norwegian patients respond to questions relating to health, personality and beliefs in a questionnaire.

The Sámi patients had used significantly more traditional and complementary treatments than Norwegian patients, and also differed from the Norwegians with respect to central factors associated with this use. "Healing" constituted a major portion of their practise, and based on our qualitative interviews and the literature (1,3–5,33,34), we can assume that the healing used by Sámi patients is predominantly from the Sámi tradition.

Use of traditional healing among Sámi patients was highly related to spirituality, the only factor found significant in the multivariate analysis, and possibly the most central finding in this study. Traditional healing in other

indigenous cultures is known to be grounded in a broad spiritually oriented world view (16,17), and although often not explored in studies on the use of complementary medicine in Western populations, spirituality is generally not considered equally central to its use. Among Norwegians, healing practices were not found to be independently associated with spirituality but rather with higher scores on extraversion, higher age and hospital admissions and lower scores on emotional stability, all of which have been earlier linked to the use of complementary treatments (13). These findings together seem to reflect that Sámi patients continue to use a healing practice that is more of a traditional nature, while among the Norwegian patients the practice follows patterns seen in studies of complementary medicine from other Western countries.

Although the factors of lower satisfaction, poorer quality of relationship with the therapist and use of psychopharmacological treatments found to be associated with healing among Sámi patients in the initial univariate analysis were eclipsed by the importance of spirituality in the multivariate analysis, these findings are worth noting. As Sámi users had more often been treated with psychopharmacological medicines, it might be thought that these patients generally had a more serious condition, possibly explaining their poorer satisfaction with psychiatric treatments. However, there were no other findings from this study implying that these patients had more serious conditions. Though we did not have information on their diagnosis, Sámi users were no worse with respect to symptoms, illness duration, hospitalization or daily functioning than Sámi non-users.

Medical treatment is frequently used for less serious psychiatric conditions in Norway today, often before patients are referred to a psychiatric clinic. Many patients are not satisfied with this treatment option and might naturally turn to local healing traditions or try other treatment alternatives. Psychopharmacological treatment was moderately correlated with lower treatment satisfaction ($r=-0.41$, $p<0.01$) and poorer patient–therapist relationship ($r=-0.49$, $p<0.001$), but not significantly correlated with length of illness, hospital admissions, symptoms or daily functioning. These associations correspond with findings from other studies where poor satisfaction with conventional treatment options such as psychopharmacological treatment or a sense of being misunderstood by Western-trained therapists has been shown to be an important reason for turning to traditional and complementary treatments (9,35).

The associations between traditional healing, spirituality and lower satisfaction with the psychiatric services among Sámi patients are important and outline a special challenge in the encounters between psychiatric services and Sámi patients. The practical and ideological separation of the physical, mental and spiritual within Western medicine and psychiatry both contrasts and potentially complements the more intuitive and integrated approach towards healing in Sámi culture. For patients, both systems must be valuable as they are clearly used by many, as seen in this study as well as in earlier studies from this area. However, the practical separation of Western and local healing traditions may give rise to frustration in some Sámi patients, as the lower satisfaction and poorer quality of patient–therapist rela-

tionship among users might indicate. Some form of integrating the perspectives of both traditions may help remedy this situation.

The issues of ethnicity and the use of traditional healing by patients using the public health services are particularly sensitive for many in this area, and it was challenging to prepare a questionnaire that adequately addressed these issues in a sensitive manner. Questionnaire studies have a negative reputation in this area, and though Sámi consultants helped develop the questionnaire, it too may have had its shortcomings with respect to fully and sensitively addressing the use of traditional and complementary healing by Sámi patients. Some patients may not have wished to participate in this study due to these issues, which could be reflected in the somewhat low response rate. Others may have under-reported their use of traditional practices as we found some had unintentionally done when interviewing a small group of the patients after they had completed the questionnaire.

Beyond these reservations, the central findings of this study are clear. These findings highlight the broad use of traditional and complementary healing modalities among Sámi patients and the key factors associated with their use, such as spirituality and lower satisfaction with psychiatric treatments. These factors should be given serious consideration when applying Western psychiatric treatments in this area as well as in further adapting the psychiatric health services to the Sámi population.

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