Dankertsen, A. & Lo, C. (Eds.) (2023).
*The End of Norwegian Egalitarianism?*
Universitetsforlaget.
DOI: https://doi.org/10.18261/9788215059839-23-03

# 3. Seeing sameness and difference: Meetings between mental health care workers and Sámi patients in the Norwegian universal health care system

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**Abstract** This chapter explores the negotiation of egalitarianism and decolonization in Norwegian mental health care for Sámi patients. While there is an ideal of universalism in Norwegian health care, there is also a growing need for a focus on Sámi perspectives. I argue that through concrete clinical meetings, informed by knowledge about and awareness of the complexity of Sámi lives today, one can enable a new and more inclusive "sameness" and make amends for past injustice.

**Keywords** Sámi | indigenous | health | decolonization | sameness

## INTRODUCTION

The Sámi people are an indigenous group who inhabit Norway, Sweden, Finland, and the Kola Peninsula in Russia. I base the analysis on qualitative material gathered through interviews with mental health care workers who work with Sámi patients in Norway. I argue that while egalitarianism and the expansive welfare state has been positive for inhabitants of Norway, the specific way the welfare state has been constructed has at the same time excluded certain individuals, such as the indigenous Sámi, who do not fit into the conformity that can be seen as an implicit part of Norwegian society.

This chapter explores how sameness and difference are crucial elements for those involved in theorizing, practicing, participating in, and consuming knowledge about mental health in Sámi areas and how a decolonial perspective destabilizes the silencing of Sámi individuals that is taken for granted in the Norwegian mental health system. As we argue in the introductory chapter, the idea of

homogeneity in Norwegian society is taken for granted, and it affects the way Norwegian egalitarianism is practiced through the welfare state and its institutions. Universalism is also a central aspect of the Norwegian health care system today, through its systems, knowledge production, and practice. This universalism is based on the notion that this system is important for securing the egalitarian values of Norwegian society. As discussed in several chapters in this book, especially the chapter by Halvard Vike and Christian Lo, following the work of Henrik Stenius (2010), the universalistic principles of the Norwegian welfare state can be understood as a reconceptualization of conformity translated into welfare policies.

Through the lenses of Marianne Gullestad's (2002) perspective on egalitarianism and sameness and decolonial perspectives, I analyze how mental health care workers talk about their meetings with Sámi patients. Decolonization is not an easy process but can be analyzed as a part of a spectrum that might involve indigenous exclusion or inclusion at one end and decolonial indigenization at the other, which involves a total reorientation of the production of knowledge based on balanced power relationships between indigenous people and Norwegian society (Gaudry and Lorenz 2018). Rather than analyzing this as a linear process, I argue that elements might occur in concrete meetings between different cultures and knowledge regimes. On the contrary, these meetings might, if they are successful, be a part of a process that may lead to making amends for past injustice.

To understand how egalitarianism and decolonization are relevant when analyzing welfare-related issues in relation to Sámi individuals, it is important to understand the history of the colonization of the Sámi people in Norway, as well as the link between the development of the Norwegian welfare state and its consequences for the Sámi people. A relevant starting point is the "Norwegianization period," which stretched from about 1850 to 1980, with the Alta controversy[1] as a turning point. The Norwegianization period is characterized by the harsh forced assimilation of the Sámi people and other national minorities such as the Kvens.[2] The policy had both educational and nation-building purposes, where the aim was to turn people into "good Norwegians" (Minde 2010). The establishment of Finnefondet [The Lapp Fund] by the Norwegian Parliament in 1851 can be said to

1 The Alta controversy involved demonstrations against the plans for the construction of a hydroelectric power plant in the Alta river in Finnmark, Northern Norway, in the heart of the North Sámi area. It became a symbol for the Sámi fight against colonization, discrimination, and marginalization and for political autonomy.

2 The Kvens are a Finnic ethnic minority in Norway. They descend from Finnish peasants and fishermen who emigrated from the northern parts of Finland and Sweden from as early as the sixteenth century until the nineteenth century.

represent the formal beginning of the Norwegianization policy, a specific type of forced assimilation policy aimed especially at the Sámis and Kvens.

The aftermath and the horrible impact of the crimes based on Nazi ideology during World War II made the concept of race more and more problematic in western Europe (Chin, Fehrenbach, and Eley 2010). However, race continued to have an impact on European societies in the decades to come, through the states' colonial relations, as citizens of the former colonies came en masse to the European countries as labor migrants, in addition to refugees and asylum seekers from the early 1990s onward. This resulted in the growth of a racialized consciousness especially in right-wing politics in European countries (Chin, Fehrenbach, and Eley 2010). However, the link between racialized ideas and the Sámi was gradually blurred, probably because the Sámi, due to both assimilation and the rise in living standards and education, have become "more similar" to the majority population and thus seen as "more civilized" and therefore less explicitly racialized.

While early state intervention focused especially on schools as the main institution for assimilation (Minde 2010), as an explicit attempt to replace indigenous language and culture with its Norwegian counterpart, the expanding welfare state after World War II (Hilson 2008) involved a continuation of the old racist attitudes through institutions (Minde 2010) and everyday life discrimination and stigmatization (Eidheim 1969; Høgmo 1986). The well-meaning welfare policies after World War II, which also sought to help the Sámi out of poverty, involved an indirect continuation of the Norwegianization policy. The Sámi Act, which formally stipulated the establishment, responsibilities, and powers of the Norwegian Sámi Parliament, was passed by the Norwegian Parliament in 1987. In 1989 the first session of the Norwegian Sámi Parliament was opened by King Olav.

During the last few decades, there has been a positive development regarding Sámi rights, including in the mental health sector. The Sámi Psychiatric Youth Team (PUT-SANKS) was established in Karasjok in 1990 as a project directly funded by the Norwegian government. The team was established as a response to a suicide cluster among young Sámi men. This team represented the beginning of a process that later came to be the Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS), established in 2001 (Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse 2017, 13). SANKS is now a part of the Finnmark Hospital and aims to give the Sámi population an equal service to treat mental health and substance abuse. Its head office is in Karasjok in Finnmark, with several departments and offices all around Norway. Their functions are district psychiatric services in the Mid Finnmark administrative area and mental health services for adults, youth, and children all around the country. They have offices in Karasjok and Lakselv. They also have a national team

with offices in Oslo, Røros, Snåsa, and Hamarøy, which serve patients all around the country. They also collaborate with health care in regions with Sámi populations in Finland and Sweden. They also have a research and development unit and have a mission to further develop services and offer education, guidance, and specialist training for health workers in Norway in general. As I will show, the legacy of the Norwegianization policy and the development of the universalism of the Norwegian welfare state reproduce the still existing but often taken-for-granted marginalization of Sámi individuals in the Norwegian state.

This can be said to be in line with the idea about culturally sensitive mental health care (Stordahl 1998). However, I argue that there is a need to move beyond cultural sensitivity and discuss how people who work with Sámi patients articulate an understanding of what Sámi culture is and its relevance for their practice of mental health care when they meet Sámi patients. I argue that through concrete meetings with mental health care workers and Sámi patients, and a growing knowledge and awareness about the complexity of Sámi lives today, one can open up a new "sameness" that does not involve a majority-dominated universalization.

## EGALITARIANISM AND POSTCOLONIAL MOMENTS

Marianne Gullestad (2002) argues that while egalitarian individualism is a characteristic feature of the Western world (referring to Dumont1986; Kapferer 1988), the specific tendency in Norway is that the idea of equality leads to a discussion about identity, where there is an assumption that is taken for granted that one needs to be the same in order to be of equal value. This tension between individualism and pressure to conform involves, according to Gullestad (2002), an interaction style that emphasizes commonalities, while playing down differences, since "too much" difference becomes a problem. Since open conflicts are also a threat to basic values for interaction, and being too different is potentially interpreted as conflict, it is important to establish an imagined sameness where fundamental differences are avoided (Gullestad 2002, 47).

While Gullestad (2002) focuses on the cultural roots of Norwegian egalitarianism, Halvard Vike (2017) criticizes the assumption that equality is a cultural premise in itself. He argues that egalitarianism in Scandinavia is rather a result of social organization characterized by political tension, political mobilization, and conflict resolution between different groups in society. Vike (2017) reminds us of the fact that egalitarian values cannot be taken for granted as cultural values but must be understood as a result of concrete and intentional institutional, political, ideological, and relational work.

Another way of discussing sameness and difference is the way Helen Verran (2002) uses it through the concept of postcolonial moments. Verran defines these as moments of possibilities for cooperation, while respecting differences in the production of knowledge. These are moments where different knowledge traditions meet and where they create a space for interrupting the colonial power relationships embedded in science. Postcolonial moments are moments where it is possible to establish a common ground or sameness, which at the same time enables difference to be collectively enacted. Through these moments, it is possible to make amends for past injustice, while at the same time creating space for development and change (Verran 2002, 730).

To analyze what Sámi perspectives mean, I am inspired by the work of Adam Gaudry and Danielle Lorenz on what indigenization of academia means (2018). They argue that indigenization is a three-part spectrum, where one end is indigenous inclusion, the middle is reconciliation indigenization, and the other end is decolonial indigenization (Gaudry and Lorenz 2018, 218). Indigenous inclusion might involve the mere inclusion of indigenous individuals. However, this does not imply that indigenous perspectives are included and the power structures and content of the knowledge production might be the same. What separates mere indigenous inclusion from reconciliation indigenization is the attempt to alter the structures of knowledge production, center dialogue and collaboration, and "change how they think about, and act toward, indigenous people" (Gaudry and Lorenz 2018, 222). It is therefore a way of creating space for indigenous knowledge traditions. Decolonization, however, involves a total transformation of existing institutions that focuses on rebuilding and strengthening indigenous culture, knowledge, and political order. This involves a knowledge system that is governed by indigenous peoples and indigenous community leadership (Gaudry and Lorenz 2018, 222–24).

## INTERVIEWING HEALTH CARE WORKERS

The article is based on qualitative interviews with health care workers working with mental health related issues in areas with Sámi inhabitants. I have interviewed twelve workers, in addition to five leaders in mental health institutions. The interviews were conducted in 2016 and 2020. I have primarily interviewed people working with youth and young adults and have excluded issues related primarily to elderly Sámi. In addition to the interviews, I have participated in four seminars on mental health in Sámi areas, where I also had informal conversations with other professionals in this sector.

I recruited the participants through leaders in mental health institutions, who distributed an invitation letter to their employees. I have also contacted some

people directly through the seminars on Sámi mental health care that I participated in. I have only interviewed people working at Norwegian mental health institutions. However, some of the participants have also worked with Sámi patients from Sámi areas in Sweden and Finland. I have interviewed professionals who have been working with patients in all Sámi areas in Norway. However, a majority of them are working in the North Sámi area, which is the largest Sámi area in Norway. I have recruited people who have a lot of mental health care expertise in Sámi areas, as well as people who do not have so much knowledge about Sámi language and culture. Some of the professionals are Sámi themselves, while others are not. While I have tried to recruit both men and women for the interviews, only two of them are men, something that probably also reflects the gender imbalance in the sector in general.

The interviews were conducted with the help of a semi-structured interview guide, where I focused on their professional work, culture, gender, and Sámi perspectives. All interviews were audio-recorded and professionally transcribed. The project was approved by the Norwegian Center for Research Data (NSD). All participants were briefed about the projects in meetings open for all employees at some of the institutions. The participants also received a written information letter about the project and have signed a written consent.

I focus in my analysis on the concrete meetings between me and the mental health care workers and between the mental health care workers and the Sámi patients. However, as I will show in the analysis, these meetings also reflect a complexity in what counts as science, the background of the researchers and the mental health care workers and the cultural, linguistic, and social complexity of Sámi society. For these meetings to be successful, I argue that it is important to acknowledge the difference between various disciplines and professions within mental health care as a health care system, the difference between different health care workers, and the difference between Sámi patients. These meetings therefore involve meetings between many different knowledge systems at the same time.

In the analyzing process, I have used nVivo as a tool for coding the interviews. I analyze the meetings between mental health care workers and their patients and what happens in these meetings. The complexity of these meetings also involves both Sámi and non-Sámi health care workers and people with different professional backgrounds and theoretical and therapeutical perspectives. The patients also reflect the complexity of Sámi society today, regionally, culturally, linguistic, socially, and culturally, in addition to different experiences regarding colonialism and the effects of assimilation policies in the past and present. The meetings between the professionals and the Sámi patients therefore involve a web of

complexity that needs to be handled. I argue that it is important to analyze how this is done in the concrete work of mental health care workers. By analyzing meetings between people and knowledge systems, I analyze how health care workers articulate their experiences of managing these meetings in a Norwegian health care system where universal health care and standardization are the norm. I explore how the taken-for-granted ideal of homogeneity in the Norwegian welfare state is both challenged and carried on in the everyday working lives of the health care workers, both through the individuals and their stereotypes and lack of knowledge and through the health care system.

## LEARNING HOW TO SEE SAMENESS AND DIFFERENCE

In this section I will focus on how mental health care workers see sameness and difference in meetings with Sámi patients and what constitutes this sameness and difference. I will combine the concept of egalitarianism as it is used by Marianne Gullestad (2002), as an imagined sameness where fundamental differences are avoided, in combination with Helen Verran's (2002) concept of postcolonial moments, to analyze the quotes of the mental health care workers interviewed. A central premise here is that I argue that to create a successful meeting between the health care workers and their patients, they need to actually be able to see the difference. If they are not able to see this, the situation cannot be a postcolonial moment, since they are not able to identify the colonial relations and its impact on concrete situations in their everyday working lives. This is a competence that can be acquired through one's own experience with Sámi culture, but also professionally through training and theoretical and therapeutical reflections among colleagues. One of the participants in the project says:

> A: I have only had two patients that have brought up the Sámi [perspective] in conversations. I have only worked here for half a year. But I think that when it is two people in half a year, it may not be that urgent.

In this quote, we see how A finds it difficult to see the relevance of Sámi perspectives in therapy. The quote also shows how the taken-for-granted ideal of homogeneity in the Norwegian welfare state shapes what is seen as "necessary" and "good practice" in the institutions. In a day-to-day working life where time and resources are always in short supply, issues that are seen as not "urgent" or "necessary" will not be prioritized. This shows the importance of strengthening and the institutionalization of competence about Sámi issues in mental health care.

Sámi culture is almost invisible for A, even though A works in a community where a lot of Sámi people live. A is working in a Sámi community where the assimilation policy was especially hard and where a lot of people learned to hide their Sámi background. While A clearly is able to see the relevance when they meet a patient who resembles the stereotypical notion of what a Sámi is, the relevance of a Sámi perspective in the local coastal Sámi context is more unclear. Sámi culture is often stereotypically associated with a Sámi-speaking reindeer herder in traditional Sámi clothes who does not speak Norwegian fluently. When A meets a Sámi that does not meet the stereotypical criteria of what it is to be Sámi, in a local community where people might have lost the Sámi language and do not use visible Sámi symbols in everyday life, it is not that easy to see the difference. In addition, the patient might be ashamed of being Sámi or maybe even ashamed of not being Sámi enough. Like the Sámi people in Eidheim's (1969) article, the Sámi language and traditions were for a long time stigmatized, and they learned to hide it. While a lot of young people are now proud of their Sámi heritage (see Hovland 1996), some are not, and they might not discuss it with outsiders, especially if they are in a vulnerable position, which people who go to a psychologist often are.

The fact that A does not "see" the Sámi culture and its relevance can be a result of A's lack of competence in Sámi culture in general, something that A clearly states in the interview. It can also be a result of working in a community where individuals have learned to hide their Sámi background to be accepted as equals in the majority-dominated society. At the same time, it is also important to remember that Sámi people today live in a society where it is important to have dual cultural and linguistic competence, where many individuals, especially the youngest generations, master the culture and language of the majority-dominated society very well. This means that some of the patients themselves might not see that experienced otherness and non-Norwegianness as problematic. Since I only have A's version of this, and not the patients' and their needs, it is impossible to know the right answer to this in each individual situation. However, A's relative inexperience in working with Sámi individuals in this community strengthens the invisibility interpretation of the quote. It clearly shows that while I and the more experienced health care workers are able to identify the Sámi presence in the community, A is not able to do so that easily. While it is impossible to know why A's patients do not mention anything about them being Sámi, it is also impossible to know if it is something "urgent" or not. Their silence can be interpreted in many different ways, especially in a coastal community like this where people have learned for generations not to talk about the Sámi language and culture. B, another mental health worker, says something similar:

B: It is not that often we have Sámi patients here. But the few times that we have, it is this understanding of who they are in relation to … Now I am thinking about reindeer herders … Where they are in the moving [of the reindeer], and if they are leaving.

Compared to A, B is able to see the "urgency" of knowledge about Sámi culture in the sense that it is relevant to know if a patient is a reindeer herder and if this has any practical importance for the treatment. For a reindeer herder, living a life that is based on the needs of the reindeer and the day-to-day changes in the natural environment and weather, the rigid health care system when it comes to time can often be a challenge. When B says that it is important to have an "understanding of who they are in relation to", it is probably this conflict between the rigid time cycle of health care institutions and the dynamic life of the reindeer herders B refers to. This shows how the Norwegian egalitarianism that the Norwegian welfare state is based on often reproduces a certain ideal of homogeneity that excludes individuals who fail to fit into the rigid systems of the welfare states and its institutions. While the lack of otherness for some patients, like the patients that A had met, might be an obstacle for culturally sensitive health care, the opposite situation, namely, the more explicit otherness of the reindeer herders, can also be a challenge.

As I will continue to argue in this article, it is important for the health care workers to have knowledge about this complexity of Sámi society and the different needs of individuals in Sámi communities. B bases their understanding of Sámi culture on stereotypical notions of what a Sámi patient is, ignoring the fact that B is working in a community where a large number of the inhabitants may have some connection to the Sámi language and culture in the past and the present. The patients that B meets might be Sámi, but they do not articulate this in a way that is recognizable to B. Rather than taking this into account, B apparently assumes that the patients are Norwegian and that a Sámi perspective might not be relevant. C, another mental health worker, has a Sámi family background from a coastal Sámi community. C talks about the relevance of a Sámi perspective in a quite different way, which at the same time resembles the challenges of A and B regarding seeing the relevance of a Sámi perspective:

C: I don't know if it is different in Sámi areas than in other areas. I am used to this culture. It isn't everything that is put into words. And what I have learned in relation to the Sámi [culture] is that you just should accept, not say that much, not put that many words on things, but just accept things like they are. And have difficulties talking about feelings and things that happen.

In this quote, C describes in a similar way how people do not mention things or put things into words. C describes this as a central aspect of the Sámi culture in this area. This quote says a lot about the presence of Sámi culture in areas that have experienced the forced assimilation policy and the marginalization of the Sámi people. On the one hand, C shows how people have learned to be subjugated by the Norwegian state and the Norwegian majority. On the other, we also see elements of Sámi culture in the way they handle conflicts. Rather than opposing explicitly, opposition is often made through silence. It is also a strong tendency in Sámi culture to manage the situation as it is, or as C formulates it, to "just accept things like they are". The quote shows some of the hindrances for traditional "talking therapy" when dealing with Sámi patients, since the importance of the unspoken in the Sámi culture might be in conflict with the ideals of this type of therapy.

This resembles the Sámi concept of *birget*, which describes how people should manage or handle all aspects of life, from your household to difficulties, in a way that emphasizes togetherness. It is not about competing or being successful, but about independence and relational competence (Saus and Boine 2019). The silence from the patients can therefore also be analyzed paradoxically as a form of empowerment, through the competence of being able to handle and accept one's own situation. This is something that is similar to what D talks about in the interview. D comes from a reindeer herding community and has the Sámi language as a first language, and they share how they communicate with Sámi patients about their problems:

> D: I think, if I should be concrete, for example those from reindeer herding. I think … My experience is that it isn't always that smart or easy to talk about feelings right away. My approach is that I talk a little bit about what they are doing, what they manage to do, how they experience doing those things. And I also use metaphors. I use those (…) when I experience that it maybe is difficult to talk directly about the emotional aspects.

While D's knowledge is also the result of coming from a Sámi community themselves, D also has formal competence in Sámi perspectives on mental health care. D is able to formulate both the norms and the values in Sámi culture and how this can be used concretely in contact with patients. This shows that while there are certain hindrances in Sámi culture for traditional "talking therapy", where the value of the unspoken might be in conflict with the ideal of talking in traditional therapy, D is able to make space in the meeting with patients to talk about issues in a way that both respect and challenge the modes of communication in Sámi culture. Through D's knowledge about typical Sámi communication patterns,

D is able to both see the problem and help the patient to talk about the problem in a way that is easier for the patient. D connects this strategy to the concept of *birget*:

> D: Especially in the Sámi [culture], you have this *ieš birget*—manage oneself. This can be really good sometimes, but sometimes not that good, and it tells us that these patients that also are in treatment, or have been in treatment, have managed themselves for many years. Had a lot of strategies to solve these mental … or all the painful thoughts and feelings. And then the cup is full, and it spills out.

Through this approach, D manages to identify how the patient struggles, acknowledges the strength of the patient, even if the patient should have sought help, and through this approach, manages to empower the patient. D is also able to help the patient find alternative strategies and, through this, help the patient, who may have been silent about their problems for too long. We see here how D manages to integrate their competence in the Sámi language and culture into the practice in a way that does not challenge the general system but that challenges the taken-for-granted homogeneity of the Norwegian egalitarian ideals in the Norwegian welfare system. Through the use of the concept of *birget* as a tool in treatment, they help the patients to develop strategies to cope with their mental issues. This situation can be analyzed as a postcolonial moment (Verran 2002), where D manages to combine Sámi traditional knowledge with Western medical knowledge and uses this combination actively in their treatment of the Sámi patients.

## INTERRUPTING EGALITARIAN SAMENESS: NEGOTIATING DIFFERENCE IN THE MEETINGS

I will now continue with an analysis of how the mental health care workers negotiate difference as a way of interrupting the taken-for-granted sameness in the Norwegian egalitarian value of sameness. E, a Sámi therapist, talks about the experiences of being an indigenous individual in an academic milieu where indigenous perspectives are not necessarily acknowledged or taken into account:

> E: But when you are in the academic milieu and experience stings every day, then I ended up thinking that I wasn't worth that much [as the others]. I almost said it yesterday when you had the lecture, but then I thought that I could tell about it today. Because it is almost a feeling of being invisible as a person.

E describes in this quote how the mere inclusion of indigenous individuals does not automatically involve a change in the concept of knowledge or what counts as knowledge. While the indigenous individual might be included on an individual level, they are nevertheless expected to be socialized into the dominant knowledge regime. In E's situation, we see how this involves a process of alienation and feeling of being invisible as a person, to use E's own words. This shows how inclusion of Sámi health care workers might not lead to a decolonization of knowledge in itself, since the system might still involve the need to subordinate and accept the given knowledge regime. In contrast to Helen Verran's (2002) postcolonial moments, this can be described as a colonial moment, where E experienced a moment where two different knowledge system meet, but where their Sámi background does not count as knowledge or is equally respected. We see here how the taken-for-granted homogeneity of the Norwegian welfare system alienizes individuals with a different background. While including indigenous individuals in mental health care might be useful in meetings with patients, it is important to remember that this is not something that automatically happens. The system needs to be changed in a way that makes it easier to integrate individuals and ideas as well as practices that break with the homogeneity ideal of the Norwegian egalitarian welfare system.

While there is a growing awareness of the need to include Sámi therapists and to have sensitivity towards Sámi patients, something that can be defined as indigenous inclusion in Gaudry and Lorenz's terms (2018), this does not necessarily mean that the system or knowledge regime changes drastically. F has both a Sámi background and training in the use of Sámi perspectives in therapy. In the interview, we discuss how F understands colonization and decolonization and if and how this has relevance for mental health care in Sámi societies.

> F: It is important to have this … [it] is this the commission [the Truth and Reconciliation Commission] will work in regarding seeing the effects of the Norwegianization, the health effects. Because I think that this is an unplowed [unknown] field that isn't … one does not know what … when one starts to plow it [explore it], what will come through. One can have a sense. There is done [some] research and things in relation to that.

In this quote, F connects this more to the effects of the forced assimilation policy than something that directly involves a reflection of how mental health care is done. Colonization is here understood as directly linked to forced assimilation and its effects on mental health among Sámi people. Helping Sámi patients with managing this is therefore something which is central for mental health care workers. This can be analyzed as a form of reconciliation indigenization. However, this does

not necessarily involve a different knowledge regime. Theoretically and therapeutically, helping the Sámi patients is thus something that can be done within the mainstream Norwegian mental health care system. In the beginning of the interview, F clearly relates to a mainstream Norwegian mental health care knowledge regime. However, when I ask more directly about the challenges, F has more to say:

> F: So of course, in our [electronic] medical record system there are no places where we can write that the [patient] is Sámi speaking. Now Finnmark hospital is working to create a comment field. But I think that is just stupid. Because how often do I go into the comment field (…) [in the medical records] to see what language it is [the patient has]? Never.

In this quote, we see how the Norwegian mental health care system forces a knowledge system on Sámi patients through a computer system that does not recognize technologically that some of the patients might need to get help in their own language. We see here how the taken-for-granted homogeneity of the Norwegian egalitarian welfare system even creates barriers on a technological level, which makes it impossible to include certain Sámi words and names. In contrast to Helen Verran's (2002) postcolonial moments, moments of possibilities for cooperation, while respecting differences in the production of knowledge, this is the opposite, where the invisible colonial structures even shape how the technology of the health care system works as an effective tool for erasing the Sámi presence.

Even though Sámi patients have the right to speak and be spoken to in the Sámi language, at least through an interpreter, through several laws, such as the Patient Rights Act and the Sámi Act (Ministry of Local Government and Modernization 1990), with an extended right to use Sámi in the Sámi language administrative districts (Ministry of Local Government and Modernization 2014), research indicates that clinicians are often not aware of the patients' language needs. They therefore often have to deal with the Sámi patients' language rights ad hoc when patients arrive. Moreover, they need to be aware of the patients' first language and its significance, even though the patient might choose to or agree to speak Norwegian in therapy (Dagsvold, Møllersen, and Stordahl 2016). G, another therapist, says:

> G: I think that the young people now … it is a little bit cool to be Sámi. It was not like that in my parents' generation. My mother, who was Sámi, wanted to spare us from the Sámi influence. She did not teach us Sámi. And when she got older, it was revealed that she did not want us to have the same sadness that she had. Or … it wasn't the way she expressed herself—she didn't want us to experience the same trauma that she had experienced. It has do to with

> self-worth. It [the feeling of self-worth] is something that is passed down, I guess, that those who have experienced the Norwegianization process, they feel that we [the Sámi] are not worth anything, that the others are worth more.

We see how G uses their own personal experiences to understand the trauma of their patients. Through analyzing their own mother's lack of self-worth, and how that has affected their own life, G can gain a deeper understanding of the Sámi patients' complex and intergenerational traumas. This approach can probably be useful, especially when meeting patients from areas that have experienced a tough assimilation policy and may have lost a lot regarding language and traditional knowledge. A mental health care worker that does not have this deep understanding of the Sámi historical experience of oppression, and how this still affects people today, might not even recognize that a patient was Sámi and might not know what kind of questions to ask to reveal some of these traumas. If we compare this quote with the quote earlier in the article, where A states that they have not met that many Sámi and that a Sámi perspective might not be that urgent, G, who has a deeper understanding of the complexity of Sámi society today, might see that a lot of the patients whom A meets in their working life are Sámi too, even though it is not that visible to an outsider. H, another mental health care worker, talks about the decolonization of mental health care in this way:

> H: Well, we have developed a milieu therapy based on Sámi values (…). We have had process groups where we have talked about how to emphasize these values, and (…) how these values are relevant for our practice. It is [for example] making people independent, the use of nature, humor, the extended family, the local community. (…) The respect for nature. Use that in therapy. (…) Strengthen the linguistic competence. Strengthen the emphasis on Sámi history. Other traditions that are important, such as how to make knives, birch bark soles, duodji [Sámi handicraft], that is important. (…) And at the same time we have youth and parents that, when they come to us, start to open up about their Sámi identity and talk about that. (…) And we start some processes in families where the Sámi [language and culture] in a way has been tucked away.

H explains how they at I's institution have developed a new way of thinking about therapy, where the patients are seen in relation to their families, communities, Sámi society as a whole, and its history. This is a meeting where therapy is seen as something more than just the inclusion of Sámi mental health care workers or Sámi patients as individually included in the Norwegian mental health care

system. It is more than just dealing with the effects of colonization and assimilation through mainstream theoretical and therapeutical knowledge systems. Through their work, they are transforming what therapy means, by integrating a Sámi knowledge system and values into their professional work. They challenge the homogeneity of the Norwegian egalitarian welfare state and create space for a more heterogenous and inclusive health care system. The examples of G in the interview can be analyzed as postcolonial moments (Verran 2002), as moments of possibilities for cooperation, while respecting differences in the production of knowledge.

Something that several people whom I interviewed mentioned is the socioeconomic situation of the patients. While Sámi mental health care has focused a lot on cultural competence, there is a paradox here in the way the system deals with, or does not deal with, socioeconomic differences in Sámi society. While lowering the socioeconomic differences in society has been one of the core concerns of the Norwegian welfare state since the very beginning, including the way the state has dealt with Sámi issues historically (Aubert 1969; Minde 2010), this is not something that is a central focus in today's Sámi society. However, it is clear that there is a link between mental health care and socioeconomic status, even within the Sámi society, something that J clearly addresses in the interview:

> J: When we deal with people with higher education, people that you don't expect to have psychiatric problems. We seldom get them [in the clinic], but we get them in. And it is very interesting how the leadership [in the clinic] meet these people. And then I think, why don't we do the same with those who struggle economically. They are lower in rank. (…) But that doesn't happen. And I think those observations are interesting, but it isn't really "allowed" to talk about it. And that worries me, because we are professionals, we are supposed to help them, but we take part in reproducing [the differences]. We are a part of the system.

We see here how J challenges the silencing of socioeconomic differences in Sámi society and in their workplace. The lack of research and political debate on these issues in Sámi research and politics today might be a result of the way these issues contributed to stigmatization of the Sámi people as a whole, given the history of presenting the Sámi as primitive (Kyllingstad 2012), backwards, poor, and uncivilized (Minde 2010). The socioeconomic status of the Sámi was also used explicitly as an argument for the so-called Norwegianization policy, which aimed to assimilate the Sámi into the Norwegian language and culture. This is probably one of the reasons why education was one of the most important elements of the

Norwegianization policy (Minde 2010). It might also be a result of the urgency of the fight for Sámi rights to land and language, something that might have silenced other issues in Sámi society, something that also includes gender differences (Halsaa 2013; Dankertsen 2021). Since there is a lack of research on class differences in present-day Sámi society, it is difficult to answer this question. H and some of the other mental health care workers are clearly critical of this silencing of socioeconomic differences in Sámi society, since this, as H points out, makes it difficult to actually deal with the problems related to socioeconomic differences in Sámi society. As J says, "we are supposed to help them", but she obviously feels that they are not able to deal with these issues. This is a paradox, since, as I mentioned before, and as several of the other chapters in this book point out, it is a core value and task of the Norwegian welfare state.

## CONCLUSION

The growing awareness of the need for Sámi perspectives in mental health care aimed at Sámi patients and communities challenges this taken-for-granted universalism, while at the same time it creates space for thinking in new ways about what egalitarianism means. On the one hand, the values and systems relating to Norwegian egalitarianism are reflected in the universal health care system, where sameness is treated as the basic value for interaction. On the other, there is a growing awareness of the need for Sámi perspectives in mental health care in Norway, which can also be linked to what I analyze as a process of decolonization, both of Sámi society and what counts as knowledge and professional practice in itself.

I argue based on my analysis that the principle of universalism in the Norwegian health care system involves a taken-for-granted imagined sameness (Gullestad 2002) that often makes it difficult or even impossible to include a Sámi perspective in meetings with and treatment of the patients. This means that mental health care workers who are not trained in dealing with perspectives on Sámi culture and colonialism risk reproducing the colonial power relationships in the meetings with Sámi patients in their everyday working lives. Inspired by Helen Verran's (2002) concept of postcolonial moments, I argue that decolonization of mental health care in Sámi areas can be defined as processes that consist of a multitude of postcolonial moments, which enable a redistribution of power, at least for a moment, by certain health care workers who challenge the system through the way they meet Sámi patients. Through these moments, it is possible to both make separations and identify sameness. Sameness in this respect is neither a dominating universalism nor the retrieval of a lost purity by removing an alien knowledge

tradition altogether. However, as I show in my analysis, a first stage for the health care workers must be to actually be able to identify colonialism and its impact on their everyday working lives.

As I have shown in the analysis, there is also a challenge for Sámi mental health care workers to take into account both the linguistic, cultural, and socioeconomic differences within Sámi society today and how these affect both people's mental health and their needs from the professionals in the mental health care system. As I have shown, there are also difficulties regarding how to especially deal with the socioeconomic differences within Sámi society, given the history of assimilation and how this was linked to the historic stigmatization and labeling of the Sámi as a poverty problem (Aubert 1969; Minde 2010). This also makes decolonization in relation to the Norwegian welfare state somewhat problematic, given the history of the welfare state in relation to the Sámi.

The meetings between professional health care workers and Sámi patients therefore involves meetings on many different levels, where the process of decolonization happens through moments in these meetings in different ways, inspired by Verran's (2002) concept of postcolonial moments as moments of possibilities for cooperation while respecting difference. As I mentioned in the introduction, these meetings also involve negotiating on the one hand the structures and values of the Norwegian universal health care system and its knowledge system. On the other hand, they also involve a negotiation of what indigenization means, inspired by the work of Adam Gaudry and Danielle Lorenz's (2018) three-part spectrum, where one end is indigenous inclusion, the middle is reconciliation indigenization, and the other end is decolonial indigenization.

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