

## **Treatment Satisfaction and Recovery in Saami and Norwegian Patients Following Psychiatric Hospital Treatment: A Comparative Study**

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**Abstract** Treatment, treatment satisfaction and recovery in Saami and Norwegian patients treated in a psychiatric hospital were compared. Although half of the Saami patients preferred to speak Saami with their therapists, only one patient did. The extensive use of traditional helpers was only partly recognized. Despite no differences in type and amount of treatment or symptom-change during the hospital stay, the Saami patients showed less satisfaction with all investigated treatment parameters including contact with staff, treatment alliance, information and global treatment satisfaction. There was less agreement between the ratings of the therapists and the Saami patients. Suggestions for improvements are made.

**Key words** indigenous mental health • Saami • therapist–patient agreement • treatment satisfaction

There are officially some 40,000 indigenous Saami people living among the 500,000 inhabitants of northern Norway. This estimate is low. Owing to the current processes of Saami revitalization, their numbers are increasing. Historically, the Saami were nomadic reindeer herders or small-scale farmers and fishermen along the coastline. Today fewer than 10% are occupied in their traditional ways of living, and most have an ordinary

western lifestyle. The Saami community is developing along two cultural tracks. Although maintaining their tradition, they are very conscious of the challenges of the modern global community. The Saami are settled in Norway, Sweden, Finland and north-west Russia. In Norway, more than half of them live in the largest and northernmost county, Finnmark.

Despite strong efforts to Norwegianize the Saami, especially from the middle of the eighteenth century, their original language, tradition and belief systems have been largely preserved. For a period of almost 100 years (1860–1959) the Saami language was prohibited in schools even where the majority of children came from Saami and Saami-speaking families. A majority of contemporary Saami have not learned the Saami language as their mother tongue, but people in so-called ‘core Saami areas’ learn it as their first language. Today all Saami children are bilingual and have either Saami or Norwegian as their first language in school.

During the suppressive policy carried out by the Nordic national states, the Saami had to hide their traditions and identity in their own cultural backyard. The current revitalization is possible thanks to the preserving effects of these hiding-away strategies, which occurred in the majority of Saami communities. Modern Saami mentality is to a large extent marked by this double identity management. Depending on the context, a Saami person may handle her Norwegian identity separate from that of the Saami. But this double identity may also, under certain circumstances, cause tension and confusion.

In 1959, the Saami obtained the legal right to be educated in their own language. This was the starting point for the modern *Sapmi*, which later was given responsibility for building its own institutions such as a college for higher education, a research institute and above all its own parliament ‘Sametinget,’ established in 1989. The Saami community wants to promote bilingual and bicultural development among the Saami people. This task is important both for self-rule and institution building. The mental health-care system is one such important area.

There are several differences between the belief-systems in western psychiatry and the Saami tradition. Modern Saami religious belief is heavily influenced by the old naturalistic religion and cosmology on which it rests. The Læstadianistic movement, in some respects a Christian transformation of traditional pre-Christian Saami religion, became a refuge for the traditional belief system (Nergård, 2000). In this system, the ‘visions’ of reality (e.g. traditional fishing, herding, harvesting and hunting) are as important as reality itself. Difficult passages in the mountains, dangerous lakes and rivers are always handled with respect on the basis of the experience of previous generations. This experience is stored in the narrative of the guardian spirit of the passage or place. The guardian spirit is part of the herder’s practical knowledge and not a mystic figure appearing

in the terrain. The logic of this spirituality somehow opposes the concept of reality management practiced in western psychiatry and people are very conscious about not mixing up the two domains (Nergård, 2001). In Saami tradition, the *noaide* (traditional healer) handled this naturalistic religious domain on behalf of his or her community (Nergård, 1996). This tradition is transformed into new forms in contemporary modern life. The traditional healer is still at work and is seen as a mediator between the old tradition and modern life. He is still the caretaker of traditional Saami spirituality and cosmology. The extensive use of traditional healers may relate to this duality (Fuggelli, 1986).

Compared with the individualistic western Norwegian culture, Saami tradition more strongly emphasizes a familial self and more interdependent and hierarchical modes of relationship. Emotions are more often communicated indirectly and non-verbal communication is emphasized. A family conflict can be solved simply by the presence of a highly respected family member who visits the conflicting parties without mentioning the conflict at all (Somby, 1999). These cultural differences, which are well known among indigenous peoples in other countries, influence communication style and the way in which mental health needs are conceived and articulated, and have been reported to have negative consequences for the delivery of conventional mental health care (Gone, 2003; Hunter, 1997, Nilchaikovit, Hill, & Holland, 1993). Also, in psychiatric care, and in crisis intervention in particular, it is generally accepted that the use of one's emotional language, the mother tongue, is preferred.

When the University Hospital of North Norway was opened in 1961, the counties of Finnmark and Troms received their local psychiatric hospital, decades later than all other parts of the country. Earlier, when psychiatric patients from this region needed hospital treatment, they were sent to institutions farther south. The hospital was opened in a period of great treatment optimism owing to more effective psychopharmacology, the integration of a milieu therapeutic principles, and a better understanding of the importance of active rehabilitation in cooperation with the local network of families, friends, working places and professionals. Despite these innovations and extensive outreach to the communities where the patients were living, only limited efforts have been made to integrate Saami language and culture into clinical, educational and research activities. Nor has knowledge of Saami language and tradition been a criterion when hiring staff.

When adjusted for the number of inhabitants aged over 18 years (Statistics Norway, 2001), the relative number of hospital admissions and admitted persons from the Saami core areas was the same as from the areas where Norwegians were in the majority (Psychiatric Department, UNN, 2001). Thus, from a quantitative point of view, their use of the hospital appeared

similar. In the United States, ethnic minorities have been shown to be more likely than the majority population to obtain mental hospital treatment (Snowden & Cheung, 1990). In contrast to most ethnic minority groups studied in other countries, the Saami have the same level of education and employment rate as the majority Norwegians. The public primary health-care system that refers patients to mental hospitals is well developed all over the country and care in private mental hospitals is non-existent.

Despite this accessibility to services, we expected that cross-cultural differences between Saami patients and their Norwegian therapists might negatively influence various aspects of Saami patients' treatment. We hypothesized that Saami patients rarely were offered the option to speak Saami with their therapists, and that, compared with Norwegians, Saami made more extensive use of traditional helpers. We also expected that the therapists would not be aware of the use of traditional helpers. Furthermore, we hypothesized that Saami patients compared with Norwegians would: (i) receive a hospital treatment based more on psychopharmacological and less on psychological interventions, and be more frequently exposed to the use of restraints, seclusion, involuntary admissions, and have longer hospital stays; (ii) be less satisfied with their treatment and have less congruence with their therapists in their experience and evaluation of central treatment factors; and (iii) have poorer recovery from their illness.

The study was conducted on the hospital wards that primarily serve areas where most of the Saami live. One emergency ward with 15 beds and 430 yearly admissions (mean length of stay 12 days) and one intermediate ward with 9 beds and approximately 90 yearly admissions (mean length of stay 30 days) participated. On the emergency ward the patients usually arrive in an acute crisis. Nearly 40% of the admissions are involuntary. On the intermediate ward, almost all admissions are voluntary and planned. Patients are admitted either directly from home or are transferred from the emergency ward. Although most patients admitted to the emergency ward have serious mental disorders, many of the patients on the intermediate ward have long-lasting non-psychotic problems. Both wards are well staffed, with a patient to nursing staff ratio of 2.5 and 2.0 for the emergency and intermediate wards, respectively. In addition, there are psychiatrists, psychiatric residents, psychologists, social workers and occupational therapists among the professional staff. Individually tailored and multimodal treatment programs are emphasized on the emergency ward. More emphasis is placed on milieu and group therapeutic activities on the intermediate ward. Each patient has an individual therapist who is responsible for the continuity of contact with the patient and of the involved staff members. Cooperation between the hospital and the local network of family, friends, work place, local authorities and local professional helpers is central to the work on both wards.

## METHOD

### *PROCEDURE FOR DETERMINING ETHNICITY AND GROUP ASSIGNMENT*

Most patients were admitted to the hospital in a psychiatric crisis. Some had severe impairment in their capacity for reality testing as defined by ordinary psychiatry assessment. Some patients fluctuated in their self-defined ethnicity during their hospital stay. The approval of the Regional Ethic Committee presupposed that the individual was able to realize all the implications of their participation in the project. To meet these challenges, three experienced Saami psychiatric nurses were engaged as co-workers. During the whole inclusion period, one of them was always available for contact with new candidates referred by the regular staff who had initially evaluated them as fit for participation. Following contact and more information about the project, patients eventually made their decision about participation. The Saami co-workers also assisted the patients in completing their questionnaires at the end of their hospital stay. Based on their experiences with the patients, the Saami co-workers made the final determination of patient ethnicity at the end of the hospital stay (consensus score). Several different aspects were included in this evaluation: the stable ethnic self-definition of the patient, use of the Saami language (their own, their parents, grandparents, among friends, at school), traditions related to the use of names, clothes, food, upbringing of children, Saami song or *joik*, use of traditional helpers, and so on). The single most important criterion for determining ethnicity and group assignment was the stable self-defined ethnicity of the patient.

All patients and therapists completed a questionnaire at discharge. This consisted of 20 items rated on a 5-point scale from 0 = *not at all* to 5 = *very much*, assessing their self-defined ethnicity, how their ethnicity was perceived by others and the use of language in different situations (Kvernmo & Heyerdahl, 1996).

### *PATIENTS*

The study population comprised 68 consecutively consenting patients, 31 Saami and 37 Norwegians, who were admitted to an emergency or intermediate ward at the University Hospital of Northern Norway between September 2000 and January 2002. Four of the Saami patients belonged to families that were still herding reindeer, seven had sea-Saami background (small-scale farmers/fishermen along the coastline in combination with reindeer herding) and 20 were from families that were permanently settled. There were 37 men and 31 women with a mean age of 40.3 years ( $SD = 12.3$ ) and 38.6 years ( $SD = 12.6$ ) for the Saami and Norwegian groups respectively. Seventeen were married or cohabiting, 15 were

separated, 35 were unmarried and 1 was widowed. The mean number of years of education was 10.2 ( $SD = 3.8$ ) and 9.7 ( $SD = 3.6$ ) for the Saami and Norwegian groups respectively. Only 4 were working; 27 were on sick leave, 28 had disability pensions, 2 were students and 7 were in various other situations. The mean length of time since first debut of illness was 11.0 years ( $SD = 10.7$ ) and 11.0 years ( $SD = 10.5$ ) for the Saami and Norwegians, respectively. Seventeen of the Saami and 22 of the Norwegians had previously been admitted to the hospital. The mean number of previous hospital stays was 5.0 ( $SD = 4.9$ ) and 4.8 ( $SD = 6.2$ ) for the Saami and Norwegian groups, respectively. Three of the Saami and three of the Norwegians had problems with drug abuse in addition to their mental disorder. There were no group differences in any of these variables. The diagnostic distribution was similar (Table 1).

### MATCHING PROCEDURE

In order to further minimize any group differences not related to ethnicity, we matched 25 pairs of Saami and Norwegian patients according to sex, age, diagnosis (including drug abuse) and duration of illness. This group was used when comparing all satisfaction scores, patient–therapist agreements and recovery measures.

### THERAPISTS

Thirty different staff members were involved as the primary staff therapist for the individuals in the study (19 were employed on the emergency ward

**TABLE 1**  
 Diagnostic distribution (ICD-10) among Saami and Norwegian patients admitted to an emergency ward and an intermediate ward in the Psychiatric Department, University Hospital of North Norway ( $N = 68$ )

<i>Diagnosis</i>	<i>Saami group (n = 31)</i>	<i>Norwegian group (n = 37)</i>
Depressive disorder	9	10
Manic/hypomanic disorder	2	0
Manic-depressive disorder	4	6
Schizophrenic disorder	6	2
Schizoaffective disorder	2	2
Paranoid psychosis	2	4
Drug-induced psychiatric disorder	3	3
Personality disorder	3	4
Other diagnosis (non-psychotic)	0	6

and 11 on the intermediate ward). There were 10 women and 20 men therapists with mean age of 39.9 (range 26–55) years. Fourteen psychiatrists/residents were therapists for 37 patients, 11 milieu therapists had treated 22 patients, 3 psychologists had treated 6 patients, and 2 occupational therapists had treated 10 patients, altogether there were 75 therapies. Seven patients had different therapists after being transferred from the emergency to the intermediate ward. When the therapists were grouped into two categories, i.e. psychiatrists/residents/psychologists and other therapists, they were equally distributed in the two patient groups.

All the therapists considered themselves as having a Norwegian identity. Five reported that they also had an equally strong Saami identity. Another five reported that they equally considered themselves as foreigners. Their mean duration of experience in psychiatry was 3.9 (range 0 to 12) years and 10 had specialized in psychiatry.

#### *ASSESSMENT PROCEDURE*

The Saami co-workers completed questionnaires at the patients' inclusion in the project and again at their discharge. The nurses in charge made daily recordings of the activities of the patients. Patients and their therapists completed questionnaires at the patients' discharge from the wards.

#### *MEASURES*

##### *Type and Amount of Treatment*

All medical and psychological treatment modalities, physical and pharmacological restraints, seclusions, milieu therapeutic activities, help for activities in daily living, social and leisure activities were recorded for each patient by nurse in charge twice a day.

##### *Satisfaction with Central Aspects of the Treatment Experience*

On discharge from the hospital, patients completed five category questions extending from 'nothing' to 'very much' assessing their thoughts about why they had been admitted (mistake, own psychiatric problems), their evaluation of their psychotherapeutic and medical treatment, their past and current use of traditional helpers, how they had perceived the staff's recognition and respect of their needs for traditional helpers and their need to use the Saami language in their treatment.

Based on their knowledge of each patient, therapists also completed similar questions. They evaluated the patients' need for traditional helpers, and their own need to use the Saami language in contact with them.

The patients completed a 26-item patient satisfaction questionnaire (Sørli, Sexton, & Sørli, 1997). A previous factor analysis yielded four

treatment-related factors that were used in the present study. The content of these dimensions; global treatment satisfaction, quality of contact with the nursing staff, quality of contact with the therapists, and the provision of adequate treatment information are detailed in Table 2.

Therapists completed the same questions about their experienced quality of contact with their patients. Using the same questions as the patients, they also assessed the degree to which they thought that their patients were satisfied with the treatment information and the treatment generally. The alpha values were adequate both for patients and therapists and are presented in Table 2.

We also used the 12-item, one-factor Working Alliance Inventory (Tracey & Kokotovic, 1989), both therapist and patient versions, to assess the perceived working alliance between patients and their therapists. Cronbach's alpha was .97 for the patients and .95 for the therapists.

The patients also completed 12 items selected from a patient satisfaction questionnaire (Ruud, 1994) concerning their satisfaction with different aspects of their hospital stay not covered by the previous questionnaires.

On discharge from the hospital, patients completed a three-item religious mindedness scale addressing the degree to which their internal belief systems had been supportive for them, whether they had been searching for spiritual help and used prayer for their health during their hospital stay (Sørлие, Sexton, Busund, & Sørлие, 2000) (Cronbach's alpha = .68).

The questionnaires were available in the Saami language, but all patients preferred to complete the Norwegian versions.

The Saami co-workers completed the following recovery measures for all patients at inclusion in the study and discharge.

### *Global Assessment of Functioning (GAF)*

Specific assessments of function (GAF-F) and symptoms (GAF-S) were recorded. The highest level of functioning within the previous 12 months was also assessed (Max GAF) (American Psychiatric Association, 1994). A GAF-S score < 40 was used as the criterion for a probable psychotic condition.

### *Brief Psychiatric Rating Scale (BPRS)*

The 24-item expanded BPRS (Lukoff, Neuchterlein, & Ventura, 1986) was used with the following five subscales (Burger, Calsyn, Morse, Klinkenberg, & Trusty, 1997): Thinking Disorder (five items; Cronbach's alpha = .59), Withdrawal (six items; Cronbach's alpha = .72), Anxiety–Depression (five items; Cronbach's alpha = .74), Hostility–Suspicion (three items; Cronbach's alpha = .60) and Activity (five items; Cronbach's alpha = .69).

The ICD-10 diagnosis was assessed by the hospital staff.



TABLE 2

Measures related to the experience of central aspects of the treatment situation

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Quality of contact with the nursing staff (8 items) <i>Cronbach's alpha</i> patients: .88	Were the nursing staff caring? Did the nursing staff communicate in an understandable way? Did the nursing staff engage in you as a whole person? Did you feel confidence in the professional skills of the nursing staff? Did the same group of nursing staff take care of you during the hospital stay? Did the nursing staff have enough time in speaking with you? Did the nursing staff have adequate time for you when helping/nursing you? Did you manage to convey to the nursing staff what was important about your condition?
Quality of contact with therapist (6 items) <i>Cronbach's alpha</i> patients: .90; therapists: .75	Did the therapist take care of you as a whole person? Did one therapist have the responsibility for you? Did the therapists communicate in an understandable way? Was the therapist available when needed? Did the therapist convey a caring attitude? Did you have confidence in the professional skills of the therapist?
Treatment information (6 items) <i>Cronbach's alpha</i> patients: .85; therapists: .77	Did you get adequate information about side effects of medications? Were you prepared about difficulties in the home situation after hospital treatment? If you had difficulties, was something done to reduce the problem? Did you get instructions about what to do yourself to improve or to prevent aggravation? Has the medical or nursing staff spoken to you about preventive self-care and lifestyle changes? Has the information you got during the hospital stay made you plan any changes in your life-style?
Global treatment satisfaction (6 items) <i>Cronbach's alpha</i> patients: .72; therapists: .65	Were you satisfied with the treatment? Were you discharged at the appropriate time? Were you treated incorrectly? Was the treatment important for your illness/health problems? Were your expectations of the medical treatment fulfilled? Did you get necessary information about the results of examinations and tests?

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*TRAINING PROCEDURE AND TESTING OF INTER-RATER RELIABILITY*

The co-workers completed a training program in the use of these instruments prior to the project. During the whole inclusion period, the co-workers' ratings of every sixth patient included in the study ( $N = 10$ ) were compared with the ratings of an external expert who was the same psychiatrist that had conducted the training program. When there were discrepancies, the basis for these was analyzed and consensus was established. The co-workers who were all employed at the same psychiatric centre (Lakselv, Finnmark), also tested their inter-rater reliability on patients they all knew during the whole inclusion period ( $N = 6$ ).

The inter-rater reliability between the raters and the external expert and among the raters was calculated following the recommendations given by Shrout and Fleiss (1979). The ICC (3,1) among the raters was .77 on GAF-S, .82 on GAF-F and .98 on BPRS.

*STATISTICAL ANALYSIS*

All the initial psychosocial and medical data of both patient groups were compared, using *t*-tests and cross-tabulation. The mean difference between groups was compared using independent-sample *t*-tests. The agreement between the ratings of the patients and their therapists of similar factors was analyzed by using paired *t*-tests. Cross-tabulations with exact statistics were used to compare dichotomous variables. The General Linear Model (GLM) was used to adjust for the effects of co-variables upon the group means and to test the significance of multivariate comparisons. Owing to multiple comparisons (30), the significance level was set to .02.

**RESULTS**

*SELF-DEFINED ETHNICITY IN THE PATIENTS*

Saami patients considered themselves to be as much as Norwegian as Saami, whereas the Norwegian patients almost exclusively considered themselves as Norwegian (Table 3).

*PATIENTS' AND THEIR THERAPISTS' USE OF AND NEED TO SPEAK SAAMI*

Only one patient spoke Saami with the therapist, the remainder spoke Norwegian. Fifteen of the patients, 14 in the Saami group and 1 in the Norwegian group, reported that they would have preferred using the Saami language in their treatment situation; either to 'speak with the staff,' to 'express themselves more clearly,' to 'ask questions,' to 'get better help,'

TABLE 3

Self-defined ethnicity among Saami and Norwegian patients admitted to an emergency ward and an intermediate ward at the Psychiatric Department, University Hospital of North Norway ( $N = 50$ )

Ethnic affiliation	Matched group ( $N = 50$ )		<i>t</i> -value
	Saami group <i>n</i> = 25 <i>M</i> ( <i>SD</i> )	Norwegian group <i>n</i> = 25 <i>M</i> ( <i>SD</i> )	
Norwegian	3.0 (1.2)	3.8 (0.3)	-2.9**
Saami	2.8 (1.2)	0.6 (0.9)	6.3***
Kvensk	0.2 (0.6)	0.2 (0.4)	-0.2
Finnish	0.3 (0.5)	0.7 (1.2)	-1.3

\*\*  $p < .01$ ; \*\*\*  $p < .001$ .

to 'solve their own problems better' or simply because they 'wished that the staff could speak Saami with them.'

The therapists reported that they would have preferred to speak Saami with 8 of the 15 patients who reported a wish to speak Saami; to improve their communication and understanding of the patients, their ability to ask questions, their ability to help the patients solve their own problems, or simply because they regretted not being able to use Saami language skills in their contacts with the individual patient.

#### USE OF TRADITIONAL HELPERS

Saami patients scored higher on 'religious mindedness' than the Norwegian patients ( $M = 4.7$ ,  $SD = 3.3$  vs.  $M = 3.0$ ,  $SD = 3.0$ ,  $t(66) = 2.1$ ,  $p < .05$ ).

Twenty of the Saami and 14 of the Norwegians reported that they had previously used traditional helpers ( $\chi^2(1) = 5.1$ ;  $p < .05$ ). Eleven of 30 Saami patients and 5 of 37 in the Norwegian group reported that they had used traditional helpers during the current crisis ( $\chi^2(1) = 4.9$ ;  $p < .05$ ).

When we asked the therapists whether they had recognized this use in their patients, therapists had noted it in 6 of the 11 patients in the Saami group. In addition, the therapists identified use of traditional helpers in another six patients that had not reported any use themselves. The therapists did not identify more patients among those who had reported a use of traditional helpers than among those who had not ( $\chi^2(1) = 1.3$ ;  $p > .05$ ).

In the Norwegian group, the therapist had identified two of five patients who had reported current use of a traditional helper. They had not misjudged any of the remaining 32 patients who had not reported any current contact with traditional helpers ( $\chi^2(1) = 13.5$ ;  $p < .01$ ).

Only 5 of the 16 patients who had had current contact with traditional helpers confirmed that their hospital therapists had recognized this.

*TYPE AND AMOUNT OF TREATMENT (MATCHED GROUP)*

Data about type and amount of treatment were adequate for the intermediate ward, but were missing for 7 of the 37 patients who were admitted to the emergency ward.

There were no group differences in therapeutic activities including use of psychopharmaceuticals and psychotherapy, nor were there any differences in use of seclusion or in physical or pharmaceutical restraints. There were no recorded differences in need for assistance with daily activities, total number of individual sessions with staff, being together with family/friends, independent activities outside the hospital or in the hospital's co-operation with external institutions and persons.

*COMMITTALS AND LENGTH OF HOSPITAL STAY (MATCHED GROUP)*

Twelve of the Saami patients and nine of the Norwegians were admitted involuntarily ( $\chi^2(1) = 0.7; p = .39$ ). At discharge, seven of the Saami patients and three from the Norwegian group were subject to compulsory aftercare ( $\chi^2(1) = 2.0; p = .15$ ).

When excluding three outliers with a hospital stay between 180 and 300 days (others < 103 days), the mean length of stay was 29.3 ( $SD = 23.1$ ) and 32.5 ( $SD = 25.1$ ) days in the Saami and Norwegian groups, respectively.

*TREATMENT SATISFACTION (MATCHED GROUP)*

The response rate for the patient surveys was 100%. Compared with the Norwegian group, Saami patients believed more strongly that they had been 'admitted by mistake' ( $M = 1.5, SD = 1.7$  vs.  $M = 0.4, SD = 1.1, t(48) = 2.5, p < .02$ ). Saami patients were also less satisfied with the quality of contact with the nursing staff ( $M = 17.7, SD = 8.6$  vs.  $M = 24.0, SD = 6.7, t(48) = -2.8, p < .01$ ) and their therapists ( $M = 12.9, SD = 7.1$  vs.  $M = 18.6, SD = 5.2, t(48) = -3.2, p < .01$ ), they were less satisfied with the working alliance with their therapists ( $M = 23.3, SD = 14.3$  vs.  $M = 33.0, SD = 14.5, t(48) = -2.4, p = .02$ ), treatment information ( $M = 7.2, SD = 5.7$  vs.  $M = 13.4, SD = 6.3, t(48) = -3.4, p < .001$ ), and were less satisfied generally ( $M = 10.9, SD = 4.6$  vs.  $M = 15.7, SD = 5.3, t(48) = -3.2, p < .01$ ). They also believed more strongly that they had been given too much medication ( $M = 2.3, SD = 1.6$  vs.  $M = 1.2, SD = 1.2, t(48) = 2.7, p < .02$ ). A multivariate GLM test for all comparisons was significant ( $F(7,42) = 4.69, p < .001$ ) (Table 4).

TABLE 4

Saami and Norwegian patients' evaluation of the background for their admission and their satisfaction with different aspects of their treatment at an emergency ward and an intermediate ward at the Psychiatric Department, University Hospital of North Norway ( $N = 50$ )

Variables	Matched group ( $N = 50$ )		<i>t</i> -value
	Saami group $n = 25$ <i>M</i> ( <i>SD</i> )	Norwegian group $n = 25$ <i>M</i> ( <i>SD</i> )	
Believes admission was due to mistake	1.5 (1.7)	0.4 (1.1)	2.5*
Treatment evaluation:			
Quality of contact with nurses	17.7 (8.6)	24.0 (6.7)	-2.8**
Quality of contact with therapist	12.9 (7.1)	18.6 (5.2)	-3.2**
Working alliance	23.3 (14.3)	33.0 (14.5)	-2.4*
Treatment information	7.2 (5.7)	13.4 (6.3)	-3.4***
Global treatment satisfaction	10.9 (4.6)	15.7 (5.3)	-3.2**
Got too much medicine	2.3 (1.6)	1.2 (1.2)	2.7*

Note. The multivariate GLM test for all comparisons was significant ( $F(7,42) = 4.69^{***}$ ).

\*  $p < .02$ ; \*\*  $p < .01$ ; \*\*\*  $p < .001$ .

None of these factors was related to the profession of their therapists (psychiatrists/residents/psychologists vs. other therapists). The quality of contact with therapists and nursing staff, treatment alliance, treatment information and global treatment satisfaction were highly correlated ( $.61 < r < .77$ ). All these factors were correlated with patients' belief that they had been admitted 'because of their own psychiatric problems' ( $.34 < r < .43$ ). In the Saami group there were low to moderate negative correlations between a wish to speak Saami and all these factors ( $-.30$  [global treatment satisfaction]  $< r < -.05$  [alliance]).

Compared with patients in the Norwegian group, Saami patients also reported less satisfaction with the possibilities for meaningful activities on the ward, information about different treatment alternatives and the degree to which their own views had been taken into account in treatment planning.

A multivariate GLM test for all comparisons was significant ( $F(3,46) = 5.48$ ,  $p < .001$ ) (Table 5).

#### PATIENT-THERAPIST AGREEMENT IN THE EVALUATION OF CENTRAL TREATMENT FACTORS (MATCHED GROUP)

Saami patients were less satisfied with the quality of their contact with their therapists than were the therapists ( $M = 13.1$ ,  $SD = 6.9$  vs.  $M = 18.1$ ,  $SD = 3.1$ ,  $t(24) = -3.5$ ,  $p < .01$ ). The mean satisfaction score of the

TABLE 5

Satisfaction with different aspects of treatment in Saami and Norwegian patients admitted to an emergency ward and an intermediate ward at the Psychiatric Department, University Hospital of North Norway (N = 50)

<i>Aspects of treatment</i>	<i>Matched group (N = 50)</i>		<i>t-value</i>
	<i>Saami group n = 25 M (SD)</i>	<i>Norwegian group n = 25 M (SD)</i>	
The possibility for meaningful activities at the ward	2.3 (1.0)	3.3 (1.0)	-3.4***
Information about different treatment alternatives	1.9 (1.6)	3.3 (1.3)	-3.4***
Having influence upon ones own treatment	2.1 (1.7)	3.4 (1.5)	-2.9**

Note. The multivariate GLM test for all comparisons was significant ( $F(3,46) = 5.48^{***}$ )

\*\*  $p < 0.01$ ; \*\*\*  $p < 0.001$ .

Norwegian patients and their therapists was equal. Correlations between the patient's score and that of their therapists were, however, low in both groups.

Saami patients experienced that their alliance with their therapists had been less functional than their therapists had experienced ( $M = 21.8$ ,  $SD = 12.9$  vs.  $M = 29.1$ ,  $SD = 9.1$ ,  $t(24) = -2.8$ ,  $p < .02$ ). The mean score for the Norwegian patients and their therapists was equal. The correlations between the score of the patients and their therapists were moderate to low (.35 and .25 respectively for the two groups).

There was a high level of agreement on the quality of the alliance between four of the Saami/Norwegian therapists and their four Saami patients ( $r = .95$  and equal mean scores) and a low level of agreement between the same therapists and their nine Norwegian patients ( $r = -.47$ , unequal mean scores).

Therapists over-evaluated the amount of information their Saami patients had received during their hospital stay ( $M = 12.2$ ,  $SD = 3.0$  vs.  $M = 7.6$ ,  $SD = 5.4$ ,  $t(24) = 3.7$ ,  $p < .01$ ), while there was good agreement between the scores of the therapists and their Norwegian patients.

Saami patients were less satisfied generally than their therapists thought ( $M = 11.2$ ,  $SD = 4.6$  vs.  $M = 16.6$ ,  $SD = 3.3$ ,  $t(24) = -4.8$ ,  $p < .001$ ), while there was good agreement between the scores of the therapists and their Norwegian patients (Table 6).

#### RECOVERY (MATCHED GROUP)

There were no group mean differences in the initial scores or in the changes of any of the recovery measures (GAF-S, GAF-F and BPRS sum

**TABLE 6**  
 Patient–therapist agreement in experienced quality of contact and alliance and therapists’ perceptions of patients’ satisfaction with treatment information and treatment generally at an emergency and intermediate ward at the Psychiatric Department, University Hospital of North Norway ( $N = 50$ )

Variables	Saami group ( $n = 25$ )				Norwegian group ( $n = 25$ )			
	Patient score <i>M</i> ( <i>SD</i> )	Therapist score <i>M</i> ( <i>SD</i> )	<i>t</i> -value	<i>r</i>	Patient score <i>M</i> ( <i>SD</i> )	Therapist score <i>M</i> ( <i>SD</i> )	<i>t</i> -value	<i>r</i>
Quality of contact	13.1 (6.9)	18.1 (3.1)	−3.5**	.12	18.6 (5.2)	18.1 (2.3)	<i>ns</i>	.13
Working alliance	21.8 (12.9)	29.1 (9.1)	−2.8**	.35	30.2 (14.0)	28.0 (7.9)	<i>ns</i>	.25
Treatment information	7.6 (5.4)	12.2 (3.0)	−3.7**	−.06	13.0 (6.0)	12.1 (3.0)	<i>ns</i>	.15
Global treatment satisfaction	10.8 (4.6)	16.6 (4.0)	−4.8**	−.11	15.4 (5.0)	17.1 (2.4)	<i>ns</i>	.02

\*  $p < 0.02$ ; \*\*  $p < 0.01$ ; \*\*\*  $p < 0.001$ .

**TABLE 7**

Initial GAF-S, GAF-F and BPRS scores and their change in Saami and Norwegian patients admitted to an emergency ward and an intermediate ward at the Psychiatric Department, University Hospital of North Norway (*N* = 50)

<i>Variables</i>	<i>Matched group (N = 50)</i>		<i>t-value</i>
	<i>Saami group</i>	<i>Norwegian group</i>	
	<i>n = 25</i> <i>M (SD)</i>	<i>n = 25</i> <i>M (SD)</i>	
GAF-S – initial score	49.8 (14.8)	45.6 (10.1)	1.2
GAF-F – initial score	49.4 (18.6)	46.0 (9.0)	0.8
GAF-S – change	5.2 (7.5)	9.7 (9.7)	-1.8
GAF-F – change	5.4 (10.8)	9.2 (10.8)	-1.2
BPRS – initial sum score	48.0 (14.6)	42.0 (8.7)	1.8
BPRS – sum score change	12.7 (10.7)	8.9 (9.2)	1.3

GAF-S = Global Assessment of Functioning – symptoms.

GAF-F = Global Assessment of Functioning – function score.

BPRS = Expanded Brief Psychiatric Rating Scale.

score and subscales) (Table 7). Ten Norwegians and five in the Saami group had an initial GAF-S score < 40 (usually considered as the ‘psychosis limit’). Three Norwegians and two in the Saami group were below this score at discharge.

## DISCUSSION

Whereas Saami patients reported dual Saami and Norwegian identity, the Norwegians almost exclusively identified themselves as Norwegians (Table 3). It may appear strange that one patient in the Norwegian group would have preferred to speak Saami. This illustrates that ethnic affiliation is not a simple construct determined by language alone (Kvernmo & Heyerdal, 1996; Okazaki & Sue, 1995). The single most important criterion for determining ethnicity and group assignment was the stable self-defined ethnicity of the patient.

Although only one patient used the Saami language in the treatment situation, 15 others reported that they would have preferred using the Saami language; either to ‘speak with the staff,’ to ‘express themselves more clearly,’ to ‘ask questions,’ to ‘get better help,’ to ‘solve their own problems better’ or simply because they ‘wished that the staff could speak Saami with them.’ That the therapists reported a need to speak Saami with half of these patients indicates some sensitivity to the limitations in their communication and co-operation with the Saami patients. However, the patients’ need to use the Saami language had not been systematically evaluated.



It was not surprising that Saami patients scored higher on 'religious mindedness' than their Norwegian fellow patients and had more frequently availed themselves of traditional helpers both previously (64.5 vs. 37.8%) and in connection with the current crisis (36.7 vs. 13.5%). A similar figure was found in a survey of a small Saami community in Finnmark, where 27% of the Saami patients who consulted a general practitioner had also used traditional helpers (Fuggelli, 1986). It was more striking that therapists only recognized half of the patients who had current contact with traditional helpers. They also had a high number of misjudgments in the Saami group and only five patients could confirm that their use of traditional helpers had been taken into consideration by their therapists. Cooperation between the hospital therapists and traditional helpers may be even more occasional. This is in contrast to the successful co-operation between traditional medicine men and women and medical professionals taking place in other countries (Gone, 2003; Kahn, Lejero, Antone, Francisco, & Manuel, 1988). The therapists' lack of awareness of patients' use of traditional helpers may partly relate to the patients' need to keep their traditional Saami and Norwegian identity separate.

We found no support for our original hypotheses that Saami patients would receive treatment based more on psychopharmacology and less on psychological interventions or that they would be more frequently exposed to the use of restraints and seclusion. We found no support for our hypotheses that Saami patients would be more frequently committed and have longer hospital stays and there were no statistically significant group differences in initial symptoms or in their change during the hospital stay.

Despite these negative findings, Saami patients were less satisfied with various aspects of their treatment experience and agreed less with their therapists on the experience and evaluation of central treatment factors (quality of contact with therapists, treatment alliance, treatment information and global treatment satisfaction) than the patients in the Norwegian group. Particularly among the Norwegian patients, these factors were correlated with patients' belief that they had been admitted 'because of their own psychiatric problems,' indicating insight. After adjusting for the influence of insight, the significant group differences remained in all factors except for treatment alliance. Insight is an underlying dimension in several of the 12 items in the Working Alliance Inventory (Tracey & Kokotovic, 1989), but to a lesser degree in the other treatment factors. A lower level of insight may reflect ambivalence towards psychiatric illness and diagnostic practice that is inherent in Saami tradition.

Saami patients believed more strongly that they had been given too much medication and reported less satisfaction with the opportunity for meaningful activities on the ward, information about different treatment alternatives and of having influence upon their own treatment.

Poorer quality of the experienced contact with the therapists and nursing staff probably represents the most essential shortcoming in the treatment experience of Saami patients and may have generated dissatisfaction with several other aspects of their treatment. The experienced quality of contact with the treatment staff was highly correlated with treatment alliance, treatment information and global treatment satisfaction ( $.61 < r < .77$ ) and probably reflected a common relational treatment factor. This is consistent with previous studies (Sørli et al., 1997, 2000). The strong association between the quality of contact with the therapists and treatment alliance ( $r = .77$ ) is consistent with the current focus on the association between the emotional bond in the patient–therapist relationship and treatment alliance in alliance research (Bordin, 1994; Orlinsky & Rønnestad, 2000). The negative therapeutic consequences of limitations in these dimensions are supported by 50 years of research which has documented a robust relationship between treatment alliance and the outcome of psychological therapies (Horvath & Greenberg, 1989; Orlinsky, Grawe, & Parks, 1994; Rønnestad, 2000). The negative correlations between the central treatment factors and a wish to speak Saami in the Saami patients ( $-.30$  [global treatment satisfaction]  $< r < -.05$  [alliance]) suggest that the opportunity to speak Saami with therapists might have improved their treatment satisfaction.

In all areas of medicine, and particularly in psychiatry, examinations, treatment planning, treatment and its monitoring and re-evaluation, take place within the context of a helping relationship. In severe psychiatric disorders where an alliance may be difficult to establish, it is even more essential to establish contact and cooperate with those aspects of the personality which are not dominated by the psychotic disorder and to instill realistic hope (Birchwood, 1999; Luborsky, Singer, & Luborsky, 1976). It is commonly accepted that a good quality of contact in the helping relationship and a well-functioning treatment alliance reduce stress and promote communication, reality orientation and mastery of experiential and situational problems (Birchwood, 1999; Luborsky et al., 1976).

When we compared the mutual scores of the patients and their therapists on the central treatment factors, we found lower group mean agreement between Saami patients and their therapists than between Norwegian patients and their therapists. Compared with the patients' scores, the therapists overestimated the quality of contact, working alliance, amount of treatment information and treatment satisfaction in their Saami patients, but not in their Norwegian patients. It was also interesting that the therapists' mean score for all these variables was equal in both groups of patients. Whereas the group mean agreement was high between Norwegian patients and their therapists, the corresponding correlational agreement between patients and therapists was low. A low

correlation between patients' and therapists' alliance scores is well known in alliance research (Rønnestad, 2000). However, although the number of subjects was small, there was a high alliance agreement between four of the Saami/Norwegian therapists and their four Saami patients ( $r = .95$  and equal mean scores) and a low agreement between the same therapists and their nine Norwegian patients ( $r = -.47$ , unequal mean scores). This would seem to further support the notion that common cultural background increases the quality of contact and the alliance and presumably also the satisfaction with other aspects of the treatment experience. This view is supported by evidence of a preference among some American Indians to seek ethnically matched providers (Haviland, Horswell, O'Connell, & Dynneson, 1983). Our findings indicate that Norwegian therapists had even greater difficulties in being aware of the experiential world of their Saami patients than that of their Norwegian patients.

The double Saami/Norwegian ethnicity reported by the Sami patients and the lack of opportunity to speak their own language may have contributed to the observed discrepancies between Saami patients and their therapists. Most Saami patients were skilled in using the Norwegian language, although their ability to verbalize more nuanced and complex feelings may have been more limited than their therapists realized. The Saami have a long history of suppressive Norwegianization. Individuals may also have their own painful experiences within Norwegian society. When admitted to a traditional Norwegian psychiatric institution where Saami culture and language cannot be adequately dealt with, adaptation to the dominant system appears a reasonable strategy. In this process the Saami may appear more Norwegian and less Saami than they actually are. Correspondingly, the therapists may thus think that they are more like the Norwegian patients and were more satisfied than they actually were.

Differences in the belief systems of western psychiatry and Saami tradition also may have contributed to the observed group differences in treatment satisfaction and therapist-patient agreement. In Saami tradition the domain of the mental and the spiritual are integrated. Integration of the two domains derives its deeper rationality from the way knowledge and experience are stored in everyday life practices and hence in the conscious awareness of these matters. Mental reactions as they are understood in ordinary psychiatry usually do not include this broader range of cultural phenomena that may influence how the individual perceives, understands and communicates a problematic life situation. These limitations of conventional psychiatry may create a fear of being misunderstood in Saami patients, with a corresponding need to hold back their personal experiences and beliefs. This tendency was certainly reinforced by the fact that half of the Saami patients were not given the opportunity to use their preferred language. The understanding of patients' self-concepts and

patterns of self–other relationships and how they are communicated is largely culturally determined and is essential for an adequate understanding of the patient's experience of illness and treatment. This understanding can profoundly affect the quality of the therapist–patient relationship and medical care (Nilchaikovit, Hill, & Holland, 1993).

That Saami patients were less likely than Norwegian patients to believe that they had been admitted because of their own psychiatric problems, and more likely to believe that they had been admitted by mistake, along with their extensive use of traditional helpers, indicates that they have perspectives on their own situation that differ from those of conventional psychiatry. These externalizing perspectives probably also negatively influenced the quality of the contact and alliance with their therapists.

### CONCLUSION

Knowledge of Saami cultural tradition and language should be considered as highly relevant professional qualifications on psychiatric wards serving Saami patients. Maintaining a continuous focus upon the importance of Saami language and culture and a possible cooperation with traditional helpers should be aspects of the treatment of every Saami patient. All treatment staff should complete a clinical ethno-cultural education including a focus upon their own ethnic background and its influence upon their attitudes and practice. This article will be followed up by a qualitative study of the different types of reactions we saw in the Saami patients and how they were understood by the patients and met by their therapists.

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