

Case Study

**Philosophy's role for guiding theory and practice in
clinical contexts grounded
in a cultural psychiatry focus:
A case study illustration from southern Norway**
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Abstract. *The purpose of this article, influenced by research in northern European contexts, is twofold. First, it is to make the case for, and provide a working model of, the importance of having a foundational philosophy of mental health care for consistency in clinical decision-making relating to theory and practice in cultural psychiatry; and second, to illustrate this model in action through a brief case study from a clinical context in southern Norway.*

In Part I, a brief presentation of one of the overarching challenges for cultural psychiatry is noted, that being the disconnection between theory and clinical contingencies and practices. Use is made of the Mezzich and Caracci volume: Cultural formulation: A reader for psychiatric diagnosis (2008) to illustrate some of the underlying concerns, and consequent confusions, raised by the ways in which an approach to culture and cultural information was included or excluded from the DSM-IV. The findings of this critical review have implications not only for understanding the place of culture in current and coming nosologies as well as the utility and potential limitations of DSM-IV as a clinical and research tool in multicultural settings. More than this, it provides a thorough and very valuable base for understanding the sociopolitical process, a dimension of culture in itself, of constructing the DSM-IV.

What one is left with is certainly not seeing culture as a common core of analysis and a fundamental element of not only all psychiatric distress but also psychiatric resilience. Due to the very tangible reality of different, though not necessarily totally exclusive, operative mental health paradigms that result in different consequences for approaching both diagnostic and treatment processes, the paper's attention is then focused on the importance of articulating a clear and foundational philosophy of mental health care with reference to how culture and cultural information are to inform theory and practice. A working model of interacting levels for a clinical mental health context is provided. If the role of culture is considered essential for the foundational level of the operative philosophy of mental health then this needs to consistently inform the levels of theory and practice for diagnosis and treatment.

In Part II, the importance and consequences of the integration and interaction among the model's three levels for cultural psychiatry, are illustrated through a brief case study example from an outpatient psychiatry context for children and adolescents: The Department of Child and Adolescent Mental Health [Avdeling for barn og ungdoms psykiske helse, (ABUP)] is part of the local public hospital, Southern Hospital [Sørlandet Sykehus HF] in southern Norway. This clinical context, with a culture-focused perspective, has a population of primarily though not exclusively ethnic Norwegians. The centrality of culture, cultural information, and cultural expression for mental health programmes in Norway is briefly outlined as a background for understanding the centrality of culture in the particular clinical context. Drawing from interview data with the department director and treatment team members, as well as documentation, the characteristics of the philosophy of mental health based on the centrality of understanding culture and the need to gain access to the patient's and family's cultural interpretations of illness and health are explored. At the theoretical level a necessary competency in pathogenic knowledge needs to be completed by knowledge and methods from the social science and other disciplines, and the all important patient/family knowledge in order to most accurately engage in the diagnostic and treatment processes. Cultural knowledge is understood from a meaning-making perspective that views existential meaning as central for understanding cultural constructions of health and illness. The individual patient expressions of meaning-making in general and existential meaning in particular can be very varied. However, building a safe therapeutic space for understanding these expressions of meaning is central to the culturally-based process for all patients. This clinical context can not be viewed as representative of Norwegian mental health contexts. However, it serves as a living illustration, in cultural context, of the importance of the philosophy of care in relation to understanding and implementing a multi-dimensional, culture-informed mental health programme.

Keywords: Cultural psychiatry, cultural psychology, meaning-making strategies, existential meaning-making, cultural contexts.

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PART I: INTRODUCTION TO AN OVERARCHING CULTURAL CHALLENGE

Anyone working or doing research in or related to cultural psychiatry contexts, wherever one may be located, can no doubt to some degree resonate with the observation made by R. Littlewood when interviewed by S. Dein in the very first issue of this journal (Dein, 2006). Focused on the disconnection in cultural psychiatry between America and Europe at the time, Littlewood laments the fundamental disconnection between theory and clinical contingencies and practices, with the result that there have been consequences for both minority and majority patients as well. «Here [in Europe] we are unfortunately less interested in theory, and very few academic papers come out on transcultural psychiatry as opposed to from North America's much more theoretical position (but quite often distant from actual practice)» (Dein, 2006).

Though there may be notable exceptions, it is not unreasonable to propose that the disconnection between theory and clinical contingencies and practices is not an uncommon occurrence. This can be referred to here as an overarching cultural challenge. The purpose of this article, influenced by research in northern European contexts, is twofold. First, it is to make the case for, and provide a working model of, the importance of having a foundational philosophy of mental health care for recognizing and addressing challenges in clinical decision-making relating to theory and practice in cultural psychiatry; and second, to illustrate this model in action through a brief case study from a clinical context in southern Norway.

A working definition of culture from cultural psychologist A. Marsella (2005) includes attention to learned behaviour and meanings, socially transferred in various life-activity settings for purposes of individual and collective adjustment and adaptation. Cultures can be transitory or enduring (e.g., ethnocultural life styles), and always dynamic (i.e., constantly subject to change and modification). Cultures are represented internally (i.e., values, beliefs, attitudes, axioms, orientations, epistemologies, consciousness levels, perceptions, expectations, personhood), and externally (i.e., artifacts, roles, institutions, social structures). Cultures shape and construct our realities (i.e., they contribute to our world views, perceptions, orientations) and with this ideas, morals, and preferences (Marsella, 2005).

If we begin with this, or any other similar approach to defining culture, then it becomes clear that we can not escape engaging in a meta-cultural analysis of how our mental health care institutions function and the implicit or explicit cultural constructions of meaning in relation to conceptions of and approaches to both salutogenic and pathogenic constructions.

GETTING TO THE CORE OF CURRENT CONFUSIONS

However, this approach to culture is not a common denominator for the mental health professions. The very real situation that has resulted is that often times researchers, clinical programme directors, and mental health clinicians are wondering how to make sense of the debates that are underway and trying to understand how best to diagnose and treat their patients and clients. Researchers focusing on studies of psychopathology as well as on studies of psychological health are often not clear as to how to proceed in their research designs. And finally, and most importantly, numerous clients and patients belonging to ethnic minority and other societal minority groups, as well as majority ethnic populations, are experiencing the negative effects of mental healthcare treatments which do not make use of vital cultural information. And in some cases actually worsen their mental health condition. Consider here the importance of culture-bound syndromes as well as the multiplicity of other levels of cultural information necessary in working with ethnic minorities (see for example the excellent overview in psychiatry by Alarcón, 2009). Missing important cultural information for diagnosis and treatment with ethnic majority sub-group populations can also be included here (see for example in gender addiction research by DeMarinis *et al*, 2009). How can culture and cultural factors be at the heart of all of this?

A very useful resource for understanding some of the fundamental confusions surrounding the nature and use of the term culture in mental health is the edited volume of Mezzich and Caracci, *Cultural formulation: A reader for psychiatric diagnosis* (2008). One of the volume's central aims is to provide exacting information related to the complicated processes between development and final presentation of the

approach to culture and cultural aspects of diagnosis presented in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV; American Psychiatric Association, 1994). The findings of this critical review have implications not only for understanding the place of culture in current and coming nosologies as well as the utility and potential limitations of DSM-IV as a clinical and research tool in multicultural settings. More than this, it provides a thorough and very valuable base for understanding the sociopolitical process, a dimension of culture in itself, of constructing the DSM.

Through the collection of invaluable information and analysis in the volume at the very least two things become clear. First, the scholarly work of the NIMH-sponsored group on culture and diagnosis was included only to a limited degree in the DSM-IV. Second, the selection and editing processes in the final product, done independently of this group, to a great degree result in understanding 'culture' as associated with 'the other' and often as an exotic manifestation of a disorder, or the manifestation of very rare disorders. What one is left with is certainly not seeing culture as a common core of analysis and a fundamental element of not only psychiatric distress but also psychiatric resilience. The placement of, for example, the very useful 'Outline for Cultural Formulation' in the ninth appendix has resulted in the loss of this valuable information in at least the Swedish version of the MINI-D IV.

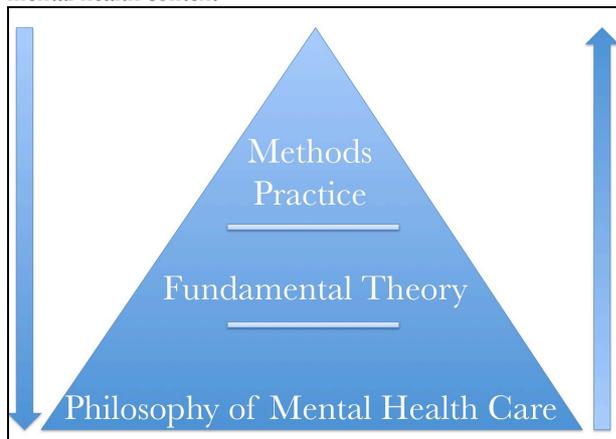
The overarching cultural challenge addressed in the Cultural Formulation volume can be, at least on one important level, succinctly and accurately captured in the observation by P. Collins in his review of the work: «Culture clashes abound in this journey into psychiatric diagnosis and formulation. The central conflicts do not lie, however, between nation states or races but rather between the differing tribes in psychiatry itself. Mezzich and Caracci certainly deserve immense admiration for willingly straying into territories where biological determinists and nosological pedants normally hunt» (Collins, 2009).

These cultural clashes are not, at least as represented by the psychiatric 'tribe' in the Mezzich and Caracci volume, composed of two completely opposing sides. It might be more accurate to say that the cultural psychiatry tribe raises critical questions to a number of foundational tenets in psychiatric diagnosis, most especially universal, categorisable forms, deriving solely from shared biological commonalities, with common symptoms, and common treatments. Mezzich and Caracci want to keep in focus more traditional concerns in psychiatry, but certainly question the absolute nature of biological determinism. The biological assessment needs to be in dialogue with cultural assessment that provides a more holistic, cultural formulation, which aids in the accuracy of the diagnostic process. By providing important information on environmental, social, and developmental factors, as well as constitutional predispositions, the diagnostic and treatment processes can be better informed and planned for with all patients/clients.

FOUNDATIONAL ROLE OF THE OPERATIVE PHILOSOPHY OF MENTAL HEALTH

The psychiatric tribal metaphor points to the need to make explicit the orientation that is operative in a particular mental health programme or clinical context in relation to the philosophy of mental health care being used. The orientation to the nature and function of culture plays a vital part in such a philosophy. **Figure 1** presents a working model of the interactions between a programme's or clinical context's philosophy of care and its operative theory as well as methods and practices (**Note 1**).

Figure 1 Working model of interactional levels for a clinical mental health context



As is evident in the model's configuration, the most important and foundational level is the operating philosophy level. In order to build a consistent model where there is a consequent interaction among all three levels, the philosophy level will and should be the guiding one. When this model is applied to mental health contexts with respect to how the nature and function of culture and cultural knowledge are concerned, the difference in philosophy of care plays an essential role. It is at this foundational level of the model that understandings of illness and health are found. If the role of culture is considered foundational for the work of mental health, for both the diagnostic and treatment processes, then this will be a guiding principle for informing the other levels of the model. A guiding principle does not presuppose a system that is closed, but it does mean a system that is consistent. Changes in one level would bring about critical questions for the others. The diagnostic and treatment processes coming under the theoretical framework in the middle level of the model may well reflect a careful interaction of interacting theoretical traditions, based on dynamic research knowledge, evidence-based results, and clinical wisdom. However, the fundamental theoretical approach built on the operating philosophy would remain consistent. Likewise, on the methods and practices level, the operating philosophy would be evident. Coming full circle to the opening point raised by Littlewood on the need for clinical contexts to have integrated theory and practice for cultural psychiatry, it is perhaps attention to the philosophical level that is the most critical for such to happen. The importance and consequences of the integration and interaction among the three levels of the model for cultural psychiatry, can be illustrated through a brief case study example from a psychiatric clinic in southern Norway.



PART II: NORWEGIAN CASE STUDY ILLUSTRATION In 2008 the first author was consulted in relation to research being planned in the area of using cultural and existential information in the therapeutic process, from both treatment team and patient perspectives at an outpatient psychiatry context for children and adolescents in southern Norway. In the course of working as a consulting professor within research projects in this area, it has become more and more evident to me that this context could serve as an informative brief illustration for better understanding the foundational workings of cultural information and analysis operating in a culture-focused psychiatry context. This clinical context is interesting on many levels and not in the least as its patient population, though including persons with other cultural and ethnic backgrounds, has a majority population of ethnic Norwegians. It can be noted here that the importance of cultural analysis and cultural psychiatry's insights for research and clinical work with members of the majority culture is under development in the Nordic contexts (DeMarinis *et al*, 2009; DeMarinis, 2008).

NATIONAL LEVEL It is necessary to note that the importance of culture and cultural understanding has been a part of a national Norwegian health and mental health focus over the past two decades. Just a few examples can be mentioned here. At the parliamentary level, in parliamentary proposition nr. 63 on an expansion plan for mental health 1999-2006 psychiatry has been given the following mandate:

A person with mental health problems should not be viewed only as a patient, but as a whole person with body, mind, and spirit. Necessary consideration needs to be given to spiritual and cultural needs, and not only the biological and social. Mental disorders touch foundational existential questions. The patient's needs must therefore be the starting point for all treatment and the core of all care, and this must affect the structure, practices and management of all health care. There is a particular challenge to design services in a way that also meets the needs of ethnic minorities (St. prp. nr. 63, 1997-1998; **Note 2**).

In the National Strategy Plan for Child and Adolescent Mental Health it is noted that: «Knowledge and skills are of great importance for how children and young people are safeguarded. This means that research and education must be based on the children's and young people's needs and embrace the diversity of children's and young people's lives. [...] One of the biggest challenges today is to strengthen a culture of public services such as respect for children and young people based on their life and experiences» (Helsedepartementet, 2003; Note 2). Within the Research Council of Norway's research programme on Mental Health (period 2006-2010) there is a special focus on the importance of social and cultural factors for mental health. (<http://www.forskningsrådet.no>). An analysis of these national documents in terms of what is considered essential to be included at the philosophy of mental health care level, the foundation of the model in Figure 1, reveals the following: a focus on patients' rights, patient involvement, integrated care that includes an existential dimension, family/group perspective, and the central role of understanding the patient's cultural context.

REGIONAL LEVEL The Department of Child and Adolescent Mental Health [Avdeling for barn og ungdoms psykiske helse, (ABUP)] is part of the local public hospital, Southern Hospital [Sørlandet Sykehus HF]. This southern Norway department has units in Flekkefjord, Farsund, Mandal, Kristiansand and Arendal, as well as outreach services. Services are provided to children and youth under 18, and their families. The department has about 120 employees with extensive professional backgrounds in mental health care and related specialty areas. In the strategy document for the hospital, Sørlandet Sykehus, the vision is described with the sentence: "Safety when you most need it". As part of the larger hospital structure, ABUP reflects the hospital's central values:

The core values of SSHFS' values are respect, accessibility and professionalism. The health company's main goal is a unified hospital service for the entire South Coast, with good availability of high quality specialization. Quality should be strengthened through a continuous focus on culture, competence, leadership, quality and safety, interaction and resource utilization. In a future perspective one expects, through 2025, challenges on the basis of ethnicity, trauma and culture by including refugees and asylum seekers. These groups are at risk for the development of mental disorders, and knowledge is a prerequisite for prevention, treatment and integration (ABUP: Strategiplan 2009-2013, 2009).

CULTURE OF AND IN THE CLINICAL CONTEXT Child psychiatry specialist, Karl Erik Karlsen, MD, has been the administrative and academic director of the department since 1995. He has greatly influenced the profile of the department with its emphasis on culture as a starting point, and the inclusion of cultural assessment and cultural activities into the therapeutic context in order to find ways to work with the young patient (and family) to help her/him

find a voice. In an interview he explains his approach to essential knowledge and integrated knowing for mental health care.

Pathogenetic knowledge is essential and obviously must be there, but in addition, I believe in a very broad approach to the discipline and knowledge of what it means to be children and youth anno 2009/10. This knowledge is obtained not only from medicine and psychology, but also from sociology, social science, anthropology, philosophy, literature, etc. This is an essential [not essentialist] approach because we do not live on an isolated island; we have to understand the sources we are influenced by.

Exploration of the cultural context and surrounding environment in which the young children and adolescents live is essential for identifying, «separate resources in the network or environment that can be activated there and that might mean that one does not need any special assistance from other health care services». The department's focus, Karlsen notes, is on culture, knowledge, and health. «This is the working paradigm but it is essential that we have a willingness and readiness to change and to understand ourselves and the society around us». The paradigm is dynamic and its development needs to be continually adjusted and updated in its implementation.

Karlsen's interest in and support of the current research projects in the research area related to the exploration of existential material in the therapeutic process can be understood from a meaning-making perspective in that «existential information is absolutely an essential element of a human life. Therefore, it is also interesting for us as a discipline and as a department to run with this research. (...) I think we have long had a strange fear of mixing religious aspects into the therapy relationship. It can be understood in this [geographically] pietistic area that has been dominated by Puritanism and piety, and where there has been a lot of madness and insanity not infrequently with religious connotations in a way. (...) This meaning-making dimension, the existential dimension, will always somehow be there. Therefore, it is also quite natural to be investigating it for both clients and therapists».

The approach to existential information in this clinical context, as is the case in certain clinical contexts in Sweden (DeMarinis & Jacobsson, 2009) is not shaped by a particular religious tradition or spiritual expression. Rather, it is viewed as a type of information that is at the core of understanding the patient's way of making-meaning, and in this sense privileged in terms of cultural information. As all persons have some way of making meaning, each person has existential information which goes to the core of what is most meaningful in his/her meaning-making. The importance of this information in the therapeutic process varies from case to case. It can be of relevance for identifying areas of dysfunction as well as function and resilience.

In ABUP's own status and strategy document related to the development of its culture and mental health initiative from 2011, the underlying importance of cultural expression to mental health is clear:

ABUP [Department of child and adolescent mental health] has long focused on the relationships between mental health and arts/culture. We receive about 1700 new referrals of children and young people annually and are responsible for specialist mental health care to all children and young people in Agder. Our point is that development issues and psychological problems are multifaceted and have many causes. We believe this to be addressed through a broad mental health perspective, which requires community involvement and community-based networking to change the interaction and living conditions in the contexts in which children and young people live. We have as a central premise in this work, and use, culture as a tool to explore the mental health-related issues, increase understanding, promote vitality, and to create good experiences. ABUP has thus achieved a position as a spearhead in developing the mental health field and in influencing the educational and research field of culture-based mental health care (Strategidokument ABUP, 2011).

LEVELS OF CULTURAL AWARENESS The central focus on culture is apparent in the ongoing study with treatment staff members related to cultural and existential information in the therapy process. An initial analysis of the semi-structured interview data has provided a rich and complex set of examples of culturally-relevant information operating at different contextual levels with

implications for identifying and addressing mental health concerns in the actual clinical setting. These include:

Socio-political context levels:

- global cultural context(s)
- national context culture(s) - majority and minority
- regional culture

Clinical context levels:

- clinical context culture including implementation of national and regional regulations/guidelines
- cultural awareness and information used in diagnosis and treatment planning
- cultural meaning-making analysis with special emphasis on the existential dimension of meaning

It is interesting to observe that these contextual levels well represent the complexities of trying to understand and operationalise 'culture' found in Marsella's definition of the term.

Analysis of treatment staff member interview material has identified the following emerging themes related to working in the current clinical context:

- clarity of the philosophy of approach for shaping the clinical process;
- centrality of the philosophy of approach and its salutogenic focus for team discussions and decision making;
- deepening appreciation for the variety of cultural expressions and understandings of illness and health conceptions from families (both minority- but also majority culture variations);
- evidence from case analysis that creating a therapeutic space for working with cultural and existential information creates both a safer space for the children/adolescents and families, and provides necessary information for the treatment process;
- need for more analytical tools to work with, at a deeper and more consistent level, cultural and existential information;
- encouragement and necessity for team members to explore their own cultural ways of making meaning as professionals in their different competencies as well as persons;
- encouragement and necessity for team members to understand their own existential questions and concerns;
- a strong sense of encouragement, empowerment, and respect in the workplace; and,
- this type of clinical context and way of working requires a deep commitment, but the rewards are many for both the treatment team members and more importantly for those using these services.

ABUP's philosophy of mental health care with its salutogenic, culture-centered, multi-professional, team approach can be summed up in the following quote from the interview with Karlsen: «Those who come to ABUP often have problems with emotions, thoughts and/or behaviours. Together we will try to find out what it takes to make it better. It also means that we emphasize the strengths and healthy interests of the children and youth».

That this philosophy is understood by treatment team members makes it possible to have a successful and integrated programme of care. That this philosophy is experienced by those using the services is the most important point. From the ongoing research study on cultural and existential information in the therapeutic context, the following excerpts from an interview with a 17 year-old patient capture the experiencing of the clinical context's philosophy:

I brought up existential questions myself and she [the psychotherapist] had some knowledge of the Bible and the way I believed. It helped that I could ask about things, right? But of course, one can not expect that a therapist can know the Koran in and out or the Bible in and out or things like that. (...) But just to have a general knowledge of it, which is important.

I think it [having a chance to raise existential questions and information in the sessions] was very important because the problems I had were very spiritual. (...) Certainly if I knew or felt I could not talk about such things with her, I would not be doing as well as I am today.

Not everyone is religious or spiritual in this way, and some may not want to talk about this information. However, it is important to give people a chance as this information is really an important part of the person's personal information.

In concluding this brief case study it needs to be noted that this clinical context can not be viewed as representative of all such Norwegian contexts. At the time of this publication the authors are unaware of any other Norwegian clinical context with this type of culture-based philosophy and clinical programme. However, it serves as a living illustration in cultural context, of the importance of the philosophy of care in relation to understanding and implementing a multi-dimensional culture-based mental health programme.

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NOTES

1. This model is an adaptation of a working model used in a multicultural palliative care unit in Sweden (DeMarinis, 1997), and later adopted for an external evaluation of an EU funded project in transcultural psychiatry in Sweden (DeMarinis & Jacobsson, 2009).
2. All translations from the Norwegian texts in this article are done by the authors.

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PHILOSOPHY'S ROLE IN CULTURAL PSYCHIATRY: AN ILLUSTRATION FROM SOUTHERN NORWAY

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