UiT The Arctic University of Norway

Faculty of Health Sciences

How Religion and Spirituality Impact Mental Health and Mental Help-Seeking Behavior in Arctic Norway: an Epidemiological Study Adopting the SAMINOR 2 Questionnaire Survey

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A dissertation for the degree of Philosophiae Doctor—November 2023

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Faculty of Health Sciences

Bodø, Norway
2023

Cover image: From Schefferus, J. (1678). Histoire de la Laponie: sa Description, l'Origine, les Moeurs, la Maniere de vivre de ses Habitans, leur Religion, leur Magie, & les choses rares du Païs. Paris, Chez la Veuve Olivier de Varennes.

Contents

Acknowledgments ... 7
Abbreviations ... 9
Abstract ... 13
Sammendrag ... 15
1. Introduction ... 17
1.1. Mental health and mental disorders: definitions ... 17
1.2. Religion and spirituality: defining the concept ... 19
1.3. The association of religion/spirituality with mental health and mental health-seeking behavior: a summary of the literature ... 23
1.3.1. Challenges in the study of religion/spirituality and mental health issues ... 23
1.3.2. Religion/spirituality and mental health ... 25
1.3.3. Religion/spirituality and mental health-service utilization and satisfaction ... 32
1.4. Demographics and religion/spirituality in Arctic Norway ... 33
1.4.1. Demographics of Arctic Norway ... 33
1.4.2. Religion/spirituality in Arctic Norway ... 35
1.5. Mental health and mental help-seeking behavior in Arctic Norway ... 38
1.5.1. Mental health in Arctic Norway ... 38
1.5.2. Mental health-service use and satisfaction in Arctic Norway ... 40
1.6. Religion/spirituality and mental health and mental help-seeking behavior in Arctic Norway ... 40
1.7. Research aims ... 42
2. Methods ... 43
2.1. Sample ... 43
2.2. Procedure ... 44
2.2.1. Paper I ... 44
2.2.2. Paper II ... 44
2.2.3. Paper III ... 45
2.3. Instruments and variables ... 45
2.3.1. Mental health outcome variables ... 45

2.3.2. Religious/spiritual exposure variables 48
2.3.3. Sociodemographic control variables 49
2.3.4. Health-related control variables 50
2.4. Statistical analyses 51
2.5. Ethical considerations 52
3. Results 53
3.1. Religion/spirituality, mental health, and mental health-service use and satisfaction across ethnic categories 53
3.2. The association of religion/spirituality with suicidal behavior and non-suicidal self-injury 54
3.2.1. Religious attendance and suicidal behavior and non-suicidal self-injury 54
3.2.2. R/S importance/view of life and mental health variables 55
3.2.3. Laestadian adherence and family background, and suicidal behavior and non-suicidal self-injury 55
3.3. The association of religion/spirituality with mental health-service use and satisfaction 56
4. Discussion 59
4.1. The impact of religious/spiritual importance and view of life on mental health in Arctic Norway 59
4.2. The impact of religious attendance on mental health in Arctic Norway 60
4.3. The impact of Laestadianism on mental health in Arctic Norway 61
4.4. The impact of religion/spirituality on mental help-seeking behavior in Arctic Norway 64
5. Strengths, weaknesses, and limitations 67
6. Conclusions 69
6.1. Summary 69
6.2. Implications for public mental-health policy, clinical practice, and religious/spiritual leadership 69
6.3. Suggestions for further research 70
References 71
Paper I 83
Paper II 99

Paper III 119
Appendices 135
Questionnaire—Norwegian 137
Questionnaire—Northern Sámi 147
Questionnaire—Lule Sámi 157
Questionnaire—Southern Sámi 167
Questionnaire—English translation 177
Invitation letter—Norwegian and Northern Sámi 187
Invitation letter—Norwegian and Lule Sámi 191
Invitation letter—Norwegian and Southern Sámi 195
Approval from the Norwegian Regional Committees for Medical and Health Research Ethics—Norwegian 199

Acknowledgments

First, I would like to thank my supervisor, Chief Psychiatrist Dr. Anna Rita Spein, for inviting me to her project on religion and health in Arctic Norway, for her support, and for allowing me to apply the breadth of my academic background and clinical experience in this Ph.D. project. Thank you also to my co-supervisors, Professor Geir Lorem and Assistant Professor Roald Kristiansen at UiT—The Arctic University of Norway, for their advice, the co-authors of my papers, Dr. Anne Silviken and Dr. Ann Ragnhild Broderstad, for their valuable discussions, Professor Tom Wilsgaard and Senior Engineer Marita Melhus at UiT for their statistical advice, and Senior Scientist Dr. Mette Kjær at Finnmark Hospital Trust for her support.

I am also grateful to the Sámi Norwegian National Advisory Unit on Mental Health and Substance Use, Nordland Hospital Trust, and Finnmark Hospital Trust for funding this study.

Furthermore, for facilitating this project, I would like to thank the Mental Health and Addiction Clinic at Finnmark Hospital Trust, including the Head of the Clinic, Inger Lise Balandin, and the two heads of the department, Robert Kechter and Mads Eriksen. I am also grateful to the Mental Health and Addiction Clinic at Nordland Hospital Trust, including the Head of the Clinic, Dr. Hedda Beate Soløy-Nilsen, and the two heads of the department, Britt-Eva Hansen and Dr. Karolina Palinauskaitė, for promoting this project.

Thank you to the data owner, the Centre for Sámi Health Research at UiT, and all the SAMINOR 2 Questionnaire Survey participants.

Finally, I immensely thank Åshild Kiærbech for reading through this work, her suggestions, and her endless support and patience during all these years.

Abbreviations

C	Confounding variable
CI	Confidence interval
d	Difference
e.g.	For example
F	F-value in analysis of variance
GAF	Global Assessment of Functioning
HSCL-10	Hopkins Symptom Checklist-10
i.e.	That is
ICD-11	International Classification of Diseases 11th Revision
IPW	Inverse-probability weights
IV	Inverse variance-weighted
M	Mediating variable
n	Sample size; number of observations
NAAHS	Norwegian Arctic Adolescents Health Study
NOK	Norwegian krone
NSSI	Non-suicidal self-injury
OR	Odds ratio
p	Probability value
r	Correlation coefficient
R/S	Religion and/or spirituality; religious and/or spiritual
RRR	Relative risk reduction
SAMINOR	The Population-based Study on Health and Living Conditions in Regions with Sámi and Norwegian Populations
SD	Standard deviation
SRH	Self-rated health
t	*t*-statistic in *t*-test with equal variances
US	United States of America
WHO	World Health Organization
β	Regression coefficient
φ	Mean square contingency coefficient
χ^2	Pearson's chi-squared test statistic

List of papers

Paper I:

Kiærbech, H., Silviken, A. C., Lorem, G. F., Kristiansen, R. E., & Spein, A. R. (2021). Religion and Health in Arctic Norway: the association of religious and spiritual factors with suicidal behaviour in a mixed Sámi and Norwegian adult population: the SAMINOR 2 Questionnaire Survey. *International Journal of Circumpolar Health*, **80**(1), 1949848. https://doi.org/10.1080/22423982.2021.1949848

Paper II:

Kiærbech, H., Silviken, A. C., Lorem, G. F., Kristiansen, R. E., & Spein, A. R. (2021). Religion and Health in Arctic Norway: The association of religious and spiritual factors with non-suicidal self-injury in the Sami and non-Sami adult population: the SAMINOR 2 Questionnaire Survey. *Mental Health, Religion & Culture*, **24**(7), 670–686. https://doi.org/10.1080/13674676.2021.1924125

Paper III:

Kiærbech, H., Broderstad, A. R., Silviken, A. C., Lorem, G. F., Kristiansen, R. E., & Spein, A. R. (2023). The association of religious factors with mental health-service utilisation and satisfaction in a mixed Sámi and Norwegian adult population: adopting the SAMINOR 2 Questionnaire Survey. *International Journal of Circumpolar Health*, **82**(1), 2223422. https://doi.org/10.1080/22423982.2023.2223422

Abstract

Objectives: Most international studies have shown that religion and spirituality (R/S) are related to better mental health, yet the Indigenous Sámi—being more committed to R/S than the majority population in the area—have poorer mental health and are more inclined toward suicidal behavior. Laestadianism—an important R/S factor for these people and this region—is related to poorer mental health and violence exposure. Among the Sámi, mental disorders are often believed to represent punishment from God or evil spirits sent by other persons, and traditional healing is commonly used against mental health problems in this area. The current study explored the relationship between R/S, ethnicity, suicidal behavior, and non-suicidal self-injury (NSSI) in the mixed Sámi and Norwegian adult population of Arctic Norway, as well as the association between R/S and help-seeking behavior in this context.
Methods: This study used cross-sectional data from the population-based SAMINOR 2 Questionnaire Survey (2012; *n* = 11,222; 34% Sámi affiliation; 22% Laestadian affiliation) in mixed Sámi-Norwegian areas of Mid and North Norway. The associations between R/S factors, suicidal behavior, NSSI, mental health-service use, and satisfaction were analyzed. Multivariate-adjusted regression models and mediation analyses considering sociodemographics and other risk factors were applied.
Results: When adjusting for Sámi ethnicity, sociodemographic, and other risk factors, religious attendance was significantly associated with no suicide ideation, NSSI, or psychological distress, whereas Laestadian family background was associated with no suicide attempts. Religious attendance was associated with no past-year use of mental health services.
Conclusions: R/S is not associated with poorer mental health in the Sámi and Norwegian populations of Arctic Norway. On the contrary, religious participation seems to buffer psychological distress and protect against poorer mental health in these areas, and is probably connected to the effect of received or perceived social support from R/S fellowships. Also, despite Laestadianism's association with disadvantageous sociodemographic factors, like Sámi ethnicity and exposure to violence, the Laestadian family networks probably contribute to better mental health. Religious participation is associated with less use of mental health services, possibly due to alternative R/S coping methods like prayer, congregational support, guidance from clergy, or the use of traditional healers and R/S family networks.

Sammendrag

Problemstilling: De fleste internasjonale studier har vist at religion og spiritualitet er forbundet med bedre psykisk helse. Samene, som er mer religiøst engasjerte enn marjoritetsbefolkningen, har likevel dårligere psykisk helse og er mer tilbøyelige til selvmordsatferd. Læstadianismen, en viktig religiøs/spirituell faktor hos samene og i regionen, er knyttet til dårligere psykisk helse og utsettelse for vold. Blant samene er det ofte en oppfatning at psykisk lidelse er en straff fra Gud eller er forårsaket av onde ånder sendt fra andre personer. Tradisjonell helbredelse blir også ofte brukt mot psykiske problemer i dette området. Denne studien undersøkte forholdet mellom religion/spiritualitet, etnisitet, selvmordsatferd og selvskading i den blandede samiske og norske voksenbefolkningen i Nord- og Midt-Norge. Sammenhengen mellom religion/spiritualitet og hjelpsøkende atferd ble også utforsket.

Metoder: Denne studien brukte tverrsnittsdata fra den befolkningsbaserte SAMINOR 2 spørreskjemaundersøkelsen (gjennomført i 2012; 11 222 deltakere; 34 % med samisk tilknytning; 22 % med læstadiansk tilknytning) i blandede samisk-norske områder i Midt- og Nord-Norge. Man analyserte sammenhengen mellom religiøse/spirituelle faktorer, selvmordsatferd, selvskading, samt bruk av og fornøydhet med psykiske helsetjenester. Det ble brukt regresjonsmodeller som kontrollerte for sosiodemografiske og andre risikofaktorer.

Resultater: Religiøs deltakelse var signifikant forbundet med fravær av selvmordstanker, selvskading og psykisk stress, mens læstadiansk familiebakgrunn var assosiert med fravær av selvmordsforsøk. Religiøs deltakelse var forbundet med manglende bruk av psykiske helsetjenester siste året.

Konklusjoner: Religion/spiritualitet er ikke forbundet med dårligere psykisk helse i den samiske og norske befolkningen i Nord- og Midt-Norge. Tvert imot synes religiøs deltakelse å fungere som en buffer mot psykisk stress og beskytte mot dårligere psykisk helse i dette området, noe som sannsynligvis er knyttet til effekten av mottatt og opplevd sosial støtte fra religiøse fellesskap. Til tross for at læstadianismen er knyttet til ugunstige sosiodemografiske forhold, som samisk etnisitet og utsettelse for vold, så bidrar sannsynligvis de læstadianske familienettverkene til bedre psykisk helse. Religiøs deltakelse er forbundet med mindre bruk av psykiske helsetjenester, sannsynligvis på grunn av religiøse/spirituelle håndteringsmetoder, som bønn, menighetsstøtte, veiledning fra religiøse ledere eller bruk av tradisjonelle helbredere og religiøse familienettverk.

1. Introduction

Although most studies have shown that religion and spirituality (R/S) are related to better mental health,[1-3] R/S—or some of its aspects—seem associated with poorer mental health outcomes in some Indigenous populations.[4,5] The Indigenous Sámi of Fennoscandia are more committed to R/S than the majority population in the area[6,7] but are also more inclined to suicidal behavior[8-10] and have poorer mental health.[11] Also, some R/S factors in the Sámi areas seem related to poorer mental health[12] and violence exposure.[13] Furthermore, among the Sámi, mental disorders are often believed to represent punishment from God or evil spirits sent by other persons.[14-17] Thus, traditional healing—an ancient R/S institution among the Sámi—is commonly used to deal with mental health problems in combination with or as a substitute for professional mental health services.[17,18]

Knowing whether R/S is a risk or preventive factor for poor mental health or affects the use of professional mental health services in Arctic Norway and among the Sámi is crucial for preventing, assessing, and treating mental disorders in this context. Does R/S cause mental health problems in Sámi or hinder their treatment, or does it represent a social or cultural resilience factor against mental disorders among the Indigenous people of Arctic Norway? No previous study (adjusting for ethnicity) has investigated the impact of R/S on mental health and mental help-seeking behavior in this population.

1.1. Mental health and mental disorders: definitions

There are many divergent definitions of the concept of mental health. The term is widely used as a euphemism for 'mental disorder' or rendered absence of mental illness.[19] The World Health Organization's (WHO) definition of mental health extracts the main themes of the past decade's debate,[19,20] so mental health is not merely defined as the absence of mental disorder but is "[a] state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities."[21]

Mental illness is often portrayed as the antipode of mental health, either categorically or on a continuous scale.[19] The International Classification of Diseases 11th Revision (ICD-11) groups mental disorders with behavioral and neurodevelopmental disorders, defining them as "syndromes characterised by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These

disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning."[22]

In contrast with the conditions of so-called somatic or physical medicine, the disease concept does not apply well to mental disorders. According to the disease model, a disease suggests a worked-out etiology giving rise to symptoms through a common pathogenic pathway.[23] For instance, Mycobacterium tuberculosis is the only causal agent of tuberculosis, a disease leading to specific symptoms, such as chronic and bloody cough, fever, and weight loss. Assessment by X-rays and microbiological tests is relatively easy, and after the eradication of the mycobacteria using antibiotics, the patient no longer has tuberculosis.

Mental disorders, on the other hand, are highly complex systems with multiple causal factors and appear as syndromic clusters of symptoms or features, leading to symptom- rather than etiology-based psychiatric diagnoses. Also, as different mental disorders typically share several symptoms, comorbidity is a considerable challenge in psychiatry.[24]

Contemporary psychopathological research no longer views the symptoms of a mental disorder simply as passive indicators or effects of a single latent common cause but as possible agents causing and affecting each other.[25] For example, the delusion that others can read one's mind may generate paranoia, leading to social isolation. The lack of correction from a social environment sustains and exacerbates the delusion in a feedback loop or vicious circle.[23] Other examples of mental disorders as self-sustained systems after removing the original external triggering factor are the lasting effects of childhood abuse long after the cessation of maltreatment or post-traumatic stress disorder enduring after the traumatic event itself has ended.[23]

The use of the network approach to psychopathology has grown exponentially among researchers during the past decade to better acknowledge the highly complex features of mental disorders.[25-27] The network model or theory assumes that mental disorders arise from the causal interaction between symptoms in a network or systems of networks.[23,28] Biological, psychological, sociological, and cultural conditions influencing symptoms in the network from the outside represent the system's external field—e.g., genetics, childhood adversities, abnormal brain functioning, substance abuse, traumas, chronic pain, or social factors.[23] Here, comorbidity results from the influence or activation of interconnected networks due to shared symptoms between networks of different mental disorders.[28]

According to network theory, during a state of low symptom activation, a network structure exhibiting high connectivity will represent a silent disorder or a vulnerability predisposing the individual to the onset or recurrence of the relevant mental disorder. Any

activation within such a system will rapidly cascade into a psychopathological state. This harmful and stable state of elevated symptom activation that endures even after the cessation of the external stressor is what we call a mental disorder. On the other hand, a weakly connected network represents a resilient and healthy system protecting the person from developing the mental disorder in question and giving only transient symptoms in the case of a time-limited external stressor.[25]

As expressions and measures of poor mental health, this study specifically examines suicide attempts, suicide ideation, and non-suicidal self-injury (NSSI), which are common maladaptive behavioral responses to psychological distress during a mental disorder. A suicide attempt is defined as the self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would cause their death.[29] Suicide ideation is thoughts about self-harm, with deliberate consideration or planning of possible methods of causing one's death.[29] Here, suicide attempts and ideation will collectively be called suicidal behavior. NSSI is defined as the direct, deliberate, and socially deviant destruction of one's body tissue in the absence of lethal intent.[29] Suicide is the hardest endpoint of poor mental health, suicide ideation and attempts are on the road leading to suicide, whereas NSSI is one of the strongest predictors of suicidal behavior.[30,31] Typically, NSSI functions as a regulator of internal emotions, thoughts, or sensations, as self-punishment or expression of distress.[32]

1.2. Religion and spirituality: defining the concept

Typically, R/S describes the antithesis of the secular, rational, or scientific, for instance, the things related to what the modern Western individual often calls the sacred, transcendent, divine, or supernatural. However, the number of efforts made throughout history to define the concepts of religion and spirituality is countless. The essentialist conception of religion—the idea of an innate, pure, and universal religious experience common to all humanity through all history and cultures—is perhaps best known through Schleiermacher's 1799 speeches on religion.[33] The religious evolution theory is a related view, even claimed by some contemporary scholars of R/S, for instance, Stausberg's idea of spiritual development from so-called primitive, less organized worldviews through the institutionalized real religions of the axial civilizations to secularization.[34] Sociology's approach to religion—being interested in the social systems of religions at the sacrifice of personal religious phenomena—also presupposes religion as institutional. The idea of religion as an essential experience is non-sociological, as social science denies any experience unmediated by culture and society.[35]

Thus, according to Beyer, religion is like any other global social system, constituting itself by distinguishing between members and non-members through rules, roles, communication, and apparent social boundaries.[36]

The postcolonial critique of the concept of religion claims it is biased by white ethnocentrism and Western imperialism and thus unjustly deployed on non-Western cultures.[35] Nongbri argues that the religious–secular division evolved in Europe from the mid-15th century, and the modern Western concept of religion began in the 16th and 17th centuries with the European colonization of the World and evangelization of non-Christian peoples.[37] Thus, Europeans call non-Western worldviews and beliefs religions according to their similarities with European church-based Christianity—typically Protestantism—in the English-speaking world.[35]

Much research has tried to uncover the neuroscientific foundations of R/S experience using neuroimaging.[38] However, efforts to isolate the phenomena of religious visions from non-religious hallucinations have so far failed.[39] Studies on meditating and praying subjects converge with a focus on limbic structures and the prefrontal cortex as the seats of R/S experience.[38] However, these studies are burdened by several problems,[38] and this review only mentions three. First, they presuppose the contested existence of a universal R/S experience that is different from all other perceptions or encounters. Second, the methods depend heavily on the chosen definition of an R/S experience. Finally, the conclusion of relating R/S to certain parts of the brain remains unclear.[38]

When delimitating the subject of religion, R/S scholars draw its borders with culture and politics differently. Stausberg's definition is comparatively narrow, whereas other scholars require a broad conception of religion, like Ninian Smart's remaking of religion as the larger concept of beliefs.[40] Woodhead lists five main groups of the most applied meanings behind the term religion used in contemporary research: culture (including belief, meaning, values, and tradition), identity, relationship, practice, and power.[35] Smart's multidimensional definition encompasses eight dimensions of belief: ritual/practical, doctrinal/philosophical, mythic/narrative, experiential/emotional, ethical/legal, organizational/social, material/artistic, and political.[40] Zinnbauer and Pargament, the psychologists of R/S, describe the phenomena of religiousness and spirituality as multilevel constructs: biological, affective, cognitive, moral, relational, personality/self-identity, social, cultural, and global.[41]

The construct of spirituality, once designating the ideal religiosity of faith traditions, has become a central part of the research field of religion in the past decades. In its religious sense, the word spiritual derives from the Latin translation (*spiritualis*) of the Greek

πνευματικὸς, used by the apostle Paul to describe the man possessing and influenced by the divine spirit, as opposed to the *ψυχικὸς*, the man who has nothing more than his ordinary human soul (1 Cor 2:14–15[42]). Although the Latin term *spiritualitas* first appeared in 5th-century Christian literature (Alcim. Ep. 12[43]), spirituality today describes phenomena in any religious context.

However, the meanings of religion and spirituality have changed over the past century. At the millennial shift, there emerged a more restricted definition of the former construct, which typically connotes the external, organized, and institutional components of the faith traditions, in opposition to the latter, often designating the internal and personal aspects of faith outside traditional and organized religion.[44] Zinnbauer and Pargament (2005)[41] offered a review of the use of religion and spirituality terms in contemporary research in the psychology of R/S. They presented the polarization of these constructs through five aspects or dimensions:

- Substantive religion vs. functional spirituality: Religion refers to the visible elements of formal, traditional, and institutionalized beliefs, whereas spirituality refers to the invisible elements of connecting with the transcendent and searching for meaning and universal truth.
- Static religion vs. dynamic spirituality: Religion refers to stable and unchanging belief structures and institutions, while spirituality refers to dynamic, flexible, and moving belief phenomena.
- Institutional objective religion vs. personal subjective spirituality: Religion refers to traditional group-based and organized beliefs and practices, whereas spirituality refers to the individual's personal relationship to the transcendent or a supreme transcendent being.
- Belief-based religion vs. emotional/experiential-based spirituality: Religion refers to cognitive or thought-based, dogmatic, and theological beliefs, while spirituality refers to emotional awareness of a transcendent dimension and the experience of connection to a transcendent being.
- Negative religion vs. positive spirituality: Religion refers to the negative side of outdated doctrine and institutional hindrances to human capabilities, whereas spirituality refers to the ultimate of human potential, pleasurable feelings, connectedness with the divine, and the meaning of life.

Zinnbauer and Pargament's (2005)[41] main criticism of this kind of polarization is that there is no spirituality without any cultural context and no major religion without any concern for personal beliefs. Both authors proposed an alternative way to define these constructs.

According to Zinnbauer, spirituality is the broader construct, the search for the sacred. Religion is spirituality within a traditional context, while Pargament holds that religion is the broader construct, defined as the search for significance in ways related to the sacred. Spirituality is the search for the sacred.

Wong and Vinsky (2008),[45] social work professors with non-Western immigrant and minority backgrounds, pointed to the ethnocentrism and racial dimensions behind the separation of spirituality from religion, suiting the need of people of Euro-Christian backgrounds to distance themselves from their Christian faith but not making any sense ontologically or epistemologically to many people of different historical-cultural contexts[45]. Although unconsciously exotifying, Indigenous peoples' native, dynamic, and emancipating traditions and practices are often described as spiritual, whereas Christian activities—usually a legacy of colonialism—in the same population are typically called religious.[5] The authors stated that the claimed hierarchy of a supposedly non-sectarian and pure spirituality above religion sets up a colonial othering of racialized ethnic groups often presented as more religious than spiritual.[45]

During the past decades, there has been an increasing use of the word spirituality, which includes non-religious and secular people,[46] often as an entity free of religious and social context.[47] This modern concept of spirituality is sometimes defined as the individual's striving for and experience of connection with the essence of life, an activity encompassing three main dimensions: connectedness with oneself, with others and nature, and with the transcendent—e.g., something beyond the physical world but not necessarily any divine being.[48]

Conclusion

The terms religion and spirituality are predominantly regarded as different aspects of the same phenomenon. However, the perceptions of these two concepts and efforts to demarcate the limit between them are innumerable. Also, scholars have frequently upheld opposite definitions of so-called spiritual and religious dimensions. Thus, the terms are often entirely interchangeable and synonymous. For simplicity, many researchers have denoted the subject by the combined name religion/spirituality (R/S) or spirituality/religiousness (S/R).[1,44,49] Accordingly, the current author holds a pragmatic stand and does not take any strict position regarding the delimitation of R/S, the definition of religion and spirituality, or their common boundary. Nevertheless, R/S is acknowledged as a multilevel and multidimensional phenomenon, but R/S will not differentiate between any spiritual or religious aspects unless

otherwise specified. When appropriate, R/S denotes the plural religion and spirituality or religious and spiritual, or the singular religion/spirituality or religious/spiritual.

1.3. The association of religion/spirituality with mental health and mental health-seeking behavior: a summary of the literature

1.3.1. Challenges in the study of religion/spirituality and mental health issues

Due to the concept's multidimensional and multilevel characteristics, the enterprise of measuring R/S in research is not straightforward. Also, the method depends heavily on the chosen definition of and theory about R/S, the research question at hand, and the theoretical assumptions behind the given hypotheses. Historically and still today, this has led separate parts of academia to use different approaches to R/S. For example, R/S sociologists and psychologists typically have different positions concerning the causes and effects of R/S. According to Durkheim's classical sociological view, R/S originates in people's social needs, like intimacy and belonging.[50] Thus, to sociologists, measuring the social aspects of R/S is paramount. On the other hand, the traditional psychological viewpoint since Freud has perceived R/S as a result of the human psychological need for comfort and meaning.[51] Hence, psychologists are more interested in assessing personal R/S experiences.

The phenomenon's complexity has given concern about the widespread use of single-item measures of R/S in research on mental health. Such single items, for instance, "How often do you attend church" or "How often do you pray?" should only be assessed if theorized as impacting mental health. However, too often, researchers use responses to such questions to infer a general effect of R/S on human well-being.[52] To solve the generalization problem, many studies have used composite measures combining several aspects of R/S. This also avoids multiple testing, increases sensitivity, and makes the studies cheaper. However, a disadvantage of using composite measures is that they complicate the comparison of studies.[3]

An often-used R/S measure is the frequency of R/S attendance or participation at social R/S activities—e.g., meetings and services. However, two individuals can attend church equally as often but for different reasons. Several non-R/S factors impact R/S attendance: somatic and mental health conditions—e.g., disabilities and social anxiety—family and job responsibilities, church location, and relationships with other members.[47] Also, changes in these factors may result in compensating involvement in noninstitutional forms of R/S.[52] Not accounting for such underlying factors may obscure the impact and role of R/S attendance on people's lives.[47]

The modern use of the word spirituality in a sense that includes non-religious and secular people encompasses characteristics like purpose and meaning of life, connectedness with others (including quality of social support), peacefulness, harmony, hope, and well-being.[46] Thus, the instruments measuring spirituality in research also reflect a conceptual overlap between spirituality and subjective well-being and good mental health.[46,48] Such overlap eliminates the possibility of identifying spiritual circumstances associated with poor mental health.[46] Accordingly, although spiritual well-being predicts less depression in most prospective studies,[3] the finding is tautological and probably meaningless.[46,53]

Inversely related to the spiritual well-being problem is the use of another R/S measure called religious and spiritual struggles (previously called negative religious coping), encompassing divine/demonic, interpersonal, and intrapsychic struggles.[54] Examples of divine/demonic struggles are anger at God, feeling punished by God, or feeling tormented by evil spirits or the devil. Interpersonal R/S struggles are disagreements about R/S or negativity toward organized religion. Intrapsychic R/S struggles encompass doubts about one's faith, struggles to follow moral principles, and concerns about whether there is a deeper, ultimate meaning to one's life.[54] Such struggles are closely associated with personality traits like neuroticism, affecting psychological well-being and contributing to a vulnerability to depression. Moreover, these struggles may represent signs or symptoms of depression.[3]

Religious affiliation is a dimension of R/S that researchers have been measuring since Durkheim (1915).[50] However, the term religious affiliation can have a range of meanings, for instance, (1) being an active member of a specific, physical, and living R/S fellowship, (2) being a passive or former member of a religious denominational organization, (3) sharing R/S beliefs with a particular denomination, (4) sharing some or more cultural elements with a religious denomination, or (5) having a family background in any of these four categories. This lack of precision makes it unclear what is being measured by the term religious affiliation and may complicate the interpretation of the research findings. A recent review by Lucchetti, Koenig, and Lucchetti (2021)[1] found sparse evidence for any association between R/S affiliation and mental health. Also, recent extensive systematic reviews and meta-analyses on R/S and mental health have not treated religious affiliation as an independent dimension of R/S.[2,3]

The meaning and significance of research findings on R/S depend on clear and precise measurements based on its operational definitions that are conceptualized and theoretically grounded.[47] Relevant measures of R/S are clear, uncontaminated, nonoverlapping, and differentiate between deeply religious, non-deeply religious, and secular persons.[49] Also, R/S

research should consider measures that take into account the dynamic processes of moving toward or away from R/S.[49]

1.3.2. Religion/spirituality and mental health

The overall effect of R/S on mental health

The past several decades have seen the emergence of a considerable research body on R/S and mental health from social sciences, clinical epidemiology, and psychiatry.[1-3] Luchetti, Koenig, and Lucchetti[1] found substantial evidence for a favorable impact of R/S on mental health, especially depression, suicidality, and substance use disorder. Also, R/S seemed to buffer post-traumatic stress. However, the results were mixed concerning anxiety. Regarding the relationship between R/S and psychotic disorders, obsessive-compulsive disorder, and eating disorders, the evidence has been weaker, and the studies have been few and have had mixed results[1]. A recent meta-analysis by Hodapp and Zwingmann (2019),[2] based on 67 studies including diverse R/S aspects and mental health outcomes from the German-speaking world found that R/S is minimally but significantly associated with better mental health (weighted mean effect size $r+ = 0.03$ [95% CI 0.01–0.05], a positive score indicating better mental health). However, the authors' analyses confirmed R/S as a multidimensional construct with both positive and negative effects on mental health.

Based on a systematic review of 138 prospective studies on the effect of R/S on depression (religious struggle and spiritual well-being were excluded due to potential confounding with depression), Braam and Koenig (2019)[3] found that about half of the studies reported fewer depressive symptoms over time. In contrast, 40% found no significant effect, and about 10% showed more depression. The mean effect size was absent to small in favor of less depression but with considerable variation ($d = -0.18$; median −0.18; SD 0.28; range −1.15 to 0.61). The authors found R/S attendance and importance as the R/S factors likeliest to predict a decrease in depression over time, whereas the effect of positive religious coping was weaker. Furthermore, R/S was more protective (little to moderately) among persons with psychiatric symptoms (median $d = -0.37$) and less protective in younger samples and among somatic patients. Also, the review found that studies from the US and Canada are likelier to report significantly less depression over time than European or East Asian studies. Finally, the authors found that linear regression and advanced longitudinal models yielded smaller effect sizes than logistic regression and other models.

R/S attendance or participation

Based on 10 effect sizes, Hodapp and Zwingmann's (2019)[2] meta-analysis found the effect of church attendance on mental health to be in general small but favorable ($r = 0.09$ [95% CI 0.04–0.14]). Braam and Koenig (2019)[3] reviewed 69 prospective studies on the effect of R/S attendance on depression. Being the most common measure of R/S among the studies, R/S attendance was the R/S factor that most likely predicted a decline in depression, with 44% of the studies showing significantly less depression, 1% finding more, and 55% having non-significant results. However, less evidence has been seen of the effect of R/S attendance on anxiety disorders. In a representative sample of 1,071 US adults, R/S attendance did not affect the odds of developing any anxiety disorders in a 10-year follow-up.[55]

Several extensive longitudinal studies have shown that R/S attendance not only protects against suicide ideation[56] and attempts[55] but also against completed suicides.[57-59] In VanderWeele et al.'s (2016)[58] study following 89,708 US female nurses over 17 years, attendance at religious services once per week or more yielded a five-fold lower suicide risk compared with no attendance (hazard ratio 0.16 [95% CI 0.06–0.46]), adjusted for sociodemographic factors. The effect was also independent of social integration, depressive symptoms, and alcohol consumption.

In their meta-analysis of studies on adolescents, Kelly et al. (2015)[60] found a weak inverse relationship between R/S attendance and behaviors like alcohol use (overall average correlation based on 23 studies, $r = -0.19$ [95% CI −0.25–−0.14]) and drug use (overall average correlation based on 18 studies, $r = -0.22$ [95% CI −0.28–−0.16]).

R/S attitudes, coping, belief, and importance

Whereas R/S attendance clearly distinguishes itself as social aspects and dimensions of R/S, the private, personal, attitudinal, or psychological sides of R/S are diverse, overlapping, and challenging to treat logically as one or more disparate entities. Among the most investigated areas of these R/S aspects are (1) the importance of R/S, (2) positive R/S coping, (3) positive relationship with the divine, (4) intrinsic religiosity, (5) R/S experience, (6) private R/S practice, and (7) R/S beliefs. Spirituality or R/S well-being and R/S struggles are related dimensions but are treated separately in this summary. Hodapp and Zwingmann's[2] meta-analysis found weak but significant correlations between several of these R/S aspects and better mental health in general: importance of R/S (based on 53 effect sizes, $r = 0.06$ [95% CI 0.03– 0.09]), positive R/S coping (based on 27 effect sizes, $r = 0.10$ [95% CI 0.05–0.14]), positive relationship with the divine (based on 17 effect sizes, $r = 0.06$ [95% CI 0.01–0.11]),

and private R/S practice (based on three effect sizes, $r = 0.21$ [95% CI 0.06–0.35]). The meta-analysis found no significant relationship with intrinsic religiosity, R/S experience, or R/S beliefs.

However, in longitudinal studies, the effect of R/S importance has been mixed. Braam and Koenig (2019)[3] found the importance of R/S—measured in 32 studies—to predict significantly less depression in 34% of studies but had no significant effect in 63% of these. Also, a large prospective study found no impact of R/S importance on completed suicides.[59] Regarding private R/S practices, Braam and Koenig (2019),[3] in their review of 28 longitudinal studies, found no significant effect on depression in 75% of the studies, significantly less depression in 21%, and more in 4% of these.

In dealing with major life stressors, many people turn to R/S. Positive R/S coping strategies include, for instance, forgiveness, comfort, meaning, search for help, and benevolent reappraisals.[54] Lucchetti et al. (2021)[1] found some evidence for better mental health outcomes among patients using positive R/S coping strategies.[1] However, in their systematic review of another 28 longitudinal studies, Braam and Koenig (2019)[3] found positive R/S coping predicted less depression in only 21% of the studies, had a non-significant effect in 71%, and predicted more depression in 7% of these.

Regarding the effect of psychological dimensions of R/S on non-suicidal self-injury (NSSI), Haney (2020)[61] recently completed a meta-analysis of 15 samples consisting of 24,767 participants aged 13 to 92. R/S measures used in the included studies were R/S beliefs, positive and negative R/S coping, R/S importance, spirituality, R/S well-being, and R/S affiliation. The meta-analysis found a negligible negative correlation between NSSI and R/S (aggregated effect size, using a random effects model, $r = 0.10$ [95% CI −0.14–−0.06]).

Kelly et al. (2015)[60] also included general religiosity in their meta-analysis of adolescent studies on R/S and alcohol and drug use. The authors found an overall weak negative correlation between religiosity and alcohol use (based on 26 studies, $r = -0.16$ [95% CI −0.19–−0.12]) and drug use (based on 28 studies, $r = -0.19$ [95% CI −0.23–−0.15]).

Spirituality and R/S well-being

In their meta-analysis, Hodapp and Zwingmann (2019)[2] found a weak correlation between R/S well-being and mental health in general (based on five effect sizes, $r = 0.15$ [95% CI 0.06–0.25]). Spirituality was not significantly associated with mental health (based on 15 effect sizes). In prospective studies, Braam and Koenig (2019)[3] found R/S well-being, based on 11 studies, predicted a significant decline in depression in 73% of the studies and no

significant effect in 27% of these. Based on another 12 studies reviewed by the same authors, other measures of spirituality were correlated with a significant decline in only 25% of the studies, no significant effect in 58%, and more depression in 17% of these.[3] However, as mentioned above, any protective correlation between spirituality and mental health is likely tautological because the measures are confounded by positive emotions.[3]

R/S struggles or negative R/S coping

R/S struggles or negative R/S coping—aspects of R/S reflecting a problematic relationship with the deity or religious fellowship—are usually related to poorer mental health. In their review, Luchetti et al. (2021)[1] found R/S struggles associated with lower life satisfaction, more anxiety and depressive symptoms, emotional distress, sleep disturbances, and suicidality in clinical samples. Also, Gerber, Boals, and Schuettler (2011),[62] in their cross-sectional analysis of 1,016 college students, found negative religious coping related to PTSD symptoms. The model adjusted for gender, race, and other coping styles.

Braam and Koenig's (2019)[3] systematic review included 22 studies on the longitudinal effects of religious struggle/distress on depressive symptoms, and found that R/S struggle predicted significantly more depression over time in 59% of the studies, whereas 41% of these yielded non-significant results. The mean effect size was small to moderate ($d = +0.30$; median 0.23; SD 0.36; range −0.04 to 1.50).

Hodapp and Zwingmann's (2019)[2] meta-analysis of studies from the German-speaking world—using different mental health outcomes—also showed a considerable correlation between negative religious coping (based on 28 effect sizes) and poorer mental health ($r+ = -0.21$ [95% CI −0.25–−0.17], the negative score indicating poorer mental health). The authors' analysis of studies regarding a negative image or negative relationship with God (12 effect sizes) also yielded some correlation with poorer mental health ($r+ = -0.16$ [95% CI −0.22–−0.11]).

As noted previously, however, R/S struggles are associated with factors predisposing to depression and the measures are confounded by depressive symptoms.[3]

R/S interventions

Several meta-analyses have examined the effect of R/S-oriented interventions in psychotherapy,[63-65] which may be relevant if the clients are religious or spiritually oriented and have consented to the intervention. Smith, Bartz, and Richards (2007)[63] conducted a meta-analysis of 31 outcome studies—18 of which were randomized clinical trials—on R/S-

oriented psychotherapies. The studies took place from 1984 to 2005 and included 1,845 clients, mainly Christians and Muslims. Applied R/S treatment components included teaching R/S principles, client prayer, reading sacred texts, religious imagery, and spiritual meditation. Most interventions were cognitive or cognitive–behavioral therapy-based, and the rest applied humanistic or non-psychological religious teachings. Most experimental studies involved a control group with an equivalent secular therapeutic intervention. Typical clinical issues were anxiety disorders, depression, stress, or problems related to R/S. The authors found that R/S-adapted psychotherapy may benefit religious/spiritual clients more effectively than secular psychotherapy (random-effects weighted average effect size: 0.56 [95% CI 0.43–0.70]). They also conducted analyses showing that any effect of possible publication bias did not threaten their overall results.

Oh and Kim (2012)[64] published a meta-analysis of 21 spiritual intervention studies, which included 1,411 participants, examining biological, psychological (depression and anxiety), and spiritual outcomes. The authors found a moderate overall effect size on spiritual and psychological outcomes ($d = -0.65$–-0.76, $p < 0.001$), suggesting that spiritual intervention can relieve depression and anxiety.

Also, Gonçalves et al. (2015)[65] undertook a systematic review and meta-analysis of 23 randomized clinical trials on spiritual or religious (Catholic, Jewish, or Muslim) interventions in mental health care published between 2005 and 2013. The study included populations of sick and healthy people, representing a total sample size of 2,721 participants, and comprised techniques such as spiritual meditation, pastoral services, psychotherapy with R/S approaches, and audiovisual resources with R/S approaches. The majority of control groups were on standard treatment or waiting lists. The meta-analysis found a significant effect of spiritual meditation (based on seven studies) against anxiety symptoms (total inverse variance-weighted [IV] standard mean difference: −0.48 [95% CI −0.68–−0.28]). Moreover, psychotherapy with R/S approaches (based on five studies) showed a significant effect against anxiety symptoms (total std. mean diff. IV: −0.35 [95% CI −0.65–−0.06]). The authors found no significant total effect of audiovisual resources with R/S approaches on anxiety symptoms (based on four studies). Finally, the meta-analysis revealed no significant total effects of spiritual meditation (based on four studies), psychotherapy with R/S approaches (based on five studies), or audiovisual resources with R/S approaches (based on eight studies) against depressive symptoms. The authors concluded that spiritual meditation and psychotherapy with R/S approaches yield additional benefits for treating anxiety symptoms, whereas the effect of R/S interventions on depressive symptoms is unclear.

The 2021 review by Lucchetti et al.[1] found evidence that R/S intervention reduced depression, anxiety, and hopelessness in patients with cancer weaker. The authors recommended more rigorous clinical trials to establish the efficacy of R/S interventions.

R/S and mental health in Indigenous populations and other ethnic minorities

The effects of R/S on mental health differ across ethnic groups, with minorities in North America being the most studied. Increasing evidence has suggested, for instance, that the favorable effects of R/S are stronger for Blacks than Whites.[66] Assari and Lankarani (2018)[67] conducted a prospective study of a national US sample comprising 1,493 Black and White older adults. Compared to Whites, Blacks enjoyed significantly more favorable effects of religious social support on depressive symptoms. Research on R/S attendance among Latino Americans found that this factor, as among the majority population, is associated with less depression, anxiety, suicide ideation and attempts, and substance use disorder.[66]

Regarding the effects of R/S on Indigenous peoples, Running Bear et al. (2019)[68] conducted a cross-sectional study of 1,636 Northern Plains American Indians aged 15–54 living on or near their reservation. The studied R/S dimension was called tribal cultural spirituality, defined as having perceptions, experiences, knowledge, and actions associated with American Indian cultural spiritual orientations, as opposed to the cognitive aspect of faith, often called the importance of R/S beliefs. The outcome was a compound measure of self-rated mental health, encompassing four major mental health dimensions: anxiety, depression, loss of behavioral/emotional control, and psychological well-being. The authors found that tribal cultural spirituality was associated with better self-rated mental health (β = 7.07 [95% CI 4.98–9.17]), whereas R/S importance was not related to mental health.[68]

In a longitudinal clinical study of 191 American Indians (Anishinaabe with type 2 diabetes) living on or close to a reservation, Gonzales et al. (2021)[69] found that using prayer and R/S beliefs to cope with the stress of adverse life events predicted self-rated positive mental health six months later (β = 0.15 [95% CI 0.06–0.28]). Also, following American Indian beliefs was associated with less pro-drug attitudes among urban American Indian youth.[5] In the same study, Native American Church affiliation was associated with a tendency to consume less alcohol and with less poly-drug use. Furthermore, following Christian beliefs was associated with less cigarette smoking and a tendency to drink less. Still, Christian church affiliation or attendance at religious services was not related to substance use.[5] In a cross-sectional study of 732 Native American adults living on reserves or reservations in the

northern Midwestern US and Ontario, Canada, Stone et al. (2006)[70] found that involvement in and importance of traditional spirituality was associated with alcohol cessation.

Garroutte et al. (2003)[71] conducted a cross-sectional study of 1,456 15–57-year-old members of an American Indian Northern Plains tribe living on or near a reservation. The authors found that high tribal cultural orientations were associated with fewer lifetime suicide attempts (OR = 0.5 [95% CI 0.3–0.9]) than low spiritual orientations. The model adjusted for sociodemographic factors, psychological distress, substance and alcohol abuse, and the importance of cultural spiritual and Christian beliefs.

Whereas most studies—as presented above—have indicated a favorable effect of R/S on mental health among ethnic minorities, some studies have found no such effect, or have found disadvantageous effects. Studying a sample of 1,628 individuals from three Asian-American subgroups, Ai, Appel, and Nicdao (2016)[72] found R/S coping and R/S attendance were associated with better self-rated mental health among the Chinese but not in the Vietnamese or Filipino subgroups. Also, in the urban American Indian youth study mentioned above,[5] the importance of spirituality was, in general, associated with pro-drug attitudes and a tendency toward poly-drug use. Finally, Stack and Cao (2020)[4] conducted a cross-sectional study of a nationally representative sample comprised of 15,294 Indigenous Canadians—Inuit, First Nations persons living off reserve, and Métis. The authors found that affiliation with traditional Indigenous spirituality was significantly associated with lifetime suicide ideation compared with a lack of religious affiliation. Also, being Christian was no different from having no religious affiliation. The model adjusted for sociodemographic factors, social integration, psychiatric symptoms, drug abuse, and self-rated health.[4]

Proposed mechanisms of R/S on mental health

Although the effect of R/S on completed suicides is—at least partly—independent of social integration,[58,73] one of the most commonly proposed mechanisms behind the impact of R/S on general mental health has been its framework of social support.[74] For example, same-faith social bonds are known to be significantly likelier sources of help in times of need.[75] Also, perceived and anticipated emotional support from the R/S fellowship is the only aspect of R/S social support significantly associated with less suicidal behavior.[76] That is, the comfort of knowing about available support strengthens mental health more than the intensity of the contact itself.[76]

Another central theory behind the mental health-protective effects of R/S is its essential part in the reorienting process of coping and meaning-making.[74] Also, positive religious coping is known to have a role in developing post-traumatic growth.[62]

Furthermore, R/S is associated with several health behaviors—e.g., less alcohol and drug use—and virtues like forgiveness, gratefulness, and altruism, factors mediating the relationship between R/S and mental health.[77]

Conclusion

Although most studies have shown that R/S is associated with better mental health, R/S is a multidimensional and multilevel construct with a mixture of positive and negative effects. The impact of R/S may also vary between different populations.

1.3.3. Religion/spirituality and mental health-service utilization and satisfaction

Despite having poorer mental health, many religious and ethnic minorities and Indigenous peoples are often under-users of mental health services[78-81] or have an increased risk of disengaging from treatment.[82] This phenomenon is often a result of language and cultural barriers, the lack of culturally sensitive services, alternative conceptions of the etiology of mental disorders, social stigma, and mistrust of Western psychiatry.[78,79,83] R/S is often an essential factor of attitudes toward mental health services, especially among ethnic minorities.[78,83-91]

Also, among American Indians, traditional healing is a significant and independent source of health care for mental health problems, and is used more often in this population than alternative and complementary medicine in the majority population.[78] Besides, traditional healing is associated with high spirituality and strong American Indian identity scores.[78] Among African Americans, the most religiously active ethnic group in the US,[85] the Church is a strong social, psychological, and religious support system.[84] The Church's religious counseling services for mental health problems are an essential substitute for and are often preferred to professional mental health treatment in this population.[84,85]

This literature summary found two main rationales for the association between R/S and negative attitudes toward or the insufficient use of professional mental healthcare. The first is holding religious or spiritual beliefs about the etiology of mental disorders, as typically seen in Muslim and Asian minorities in Western countries. Professional help-seeking often depends on a scientific perception of mental disorders.[83,86,91] The second is the belief in or use of R/S methods of handling mental health problems. For example, positive R/S coping,

finding meaning in suffering, and believing in the efficacy of R/S counseling for mental health problems are common among Filipino Americans,[88] Latino Americans,[89] and US rural veterans, respectively.[92]

However, studies on the relationship between R/S and the use of and attitudes toward mental health services have shown differing results. In some studies, the importance of R/S is associated with negative attitudes toward or insufficient use of mental health services, for instance, among US adolescents[93] and African Americans.[85] In other populations, R/S importance is related to the frequent use of professional mental health services, as among African immigrants in the US.[94] Other studies have found no such associations—e.g., the US rural veteran study,[92] another African American study,[95] and a Canadian Latter Day Saints survey.[96] R/S attendance was associated with the use of mental health services among Korean women but not in Korean men,[97] in the latter African American sample,[95] nor in the sample of Canadian Latter Day Saints.[96] Finally, Smyth et al. (2022)[82] recently conducted an extensive longitudinal study of 9,904 male users of two psychological treatment services in London. The authors categorized the participants by R/S affiliation and found that Christian men were at a lower risk of disengaging from treatment than non-religious men (RRR = 0.85 (95% CI 0.72–1.00). Asian Muslim men, however, were at an increased risk of disengaging compared to non-religious men (RRR = 1.31 [95% CI 1.12–1.53]).

The association between R/S and mental health-service use and satisfaction differs across populations, R/S groups, and R/S dimensions. Nevertheless, this summary reveals some patterns. Among culturally integrated individuals in Western populations, R/S importance or self-ascription seems to be associated with accepting and using mental health services.[82,98] On the other hand, within poorly integrated R/S groups in Western countries, R/S is related to the rejection of mental health services.[82,83] Also, among African Americans affiliated with the Black Church, R/S indicators are related to negative attitudes toward mental health services.[84,85] In non-Western populations, however, being Christian is associated with accepting mental health services, whereas non-Christian R/S is related to refusing mental health services.[99-101]

1.4. Demographics and religion/spirituality in Arctic Norway

1.4.1. Demographics of Arctic Norway

This thesis uses the toponym Arctic Norway almost synonymously with North Norway. However, whereas the reader could not interpret the former term immediately, the latter

explicitly denotes Norway's northernmost mainland region, comprising the provinces of Nordland, Troms, and Finnmark. Nordland is the county with the same name, while Troms and Finnmark constituted two separate counties from 1919 to 2020 but have since been one united bearing the name of both provinces.

The term Arctic has several meanings, all related to the circumpolar region of the midnight sun and polar night north of the Polar Circle, at about 66° 34'N. However, the southernmost part of North Norway lies below this line. Also, because of the warming influence of the North Atlantic Current, the ecological Arctic definition would not apply to all areas of North Norway. Furthermore, as an Arctic people having adapted to the region's cold and extreme conditions, the Sámi do not live exclusively above the Polar Circle. Their traditional area includes the central and southern parts of Sweden and Norway and thus extends the cultural definition of the Arctic region. As this thesis studies the population of Sámi-Norwegian areas in both North and Central Norway, the term Arctic Norway is often more applicable than North Norway.

Most people living in Arctic Norway are ethnic Norwegians, speaking the majority Norwegian Indo-European language. The Sámi, the Indigenous people of northern and central Fennoscandia, living mainly in the northern parts of Norway, Sweden, and Finland, and the Russian Kola Peninsula, constitute a minority. They call their land *Sápmi* (in Northern Sámi), and although they speak a Finno-Ugric and Uralic language, archeological, genetic, and linguistic research supports their presence in the region since the Mesolithic.[102-104] After being mainly hunters and gatherers until the end of the Medieval period, the Sámi have traditionally practiced reindeer nomadism, fishing, and farming.[102] Although the exact size of the Sámi population is unknown, a crude estimate is 80,000–115,000, most of whom live in Norway.[105] An estimated 20,000 Sámi speak Sámi languages.[105] Despite being a genetic outlier as a people,[103] they are by appearance usually not significantly different from the majority population.

Another nationally recognized minority in Arctic Norway is the Kvens, traditionally farmers, foresters, and fishermen descended from Finnish immigrants in the region, especially during the 18th and 19th centuries. The estimated size of the Kven population ranges from a few thousand to 10,000.[106] In 1845, the Sámi were still the majority ethnic group in what is today Finnmark.[107] However, from the mid-19th to the mid-20th centuries, the Kvens and Sámi suffered from an enforced Norwegian governmental assimilation program.[108] In the program's last 50 years, the number of Sámi and Kven language users in Norway reduced by 50% and 75%, respectively, with the near extinction of these languages in Troms County.[109]

Apart from Norwegians, Sámi, and Kvens, 6.4% of the population in North Norway are either immigrants from non-Western countries or born to parents who immigrated from non-Western countries (the national percentage in Norway is 11.2). Immigrants from other Western countries and their Norwegian-born children comprise 5.8% of the population in the region—and 7.7% nationally.[110]

1.4.2. Religion/spirituality in Arctic Norway

Until the end of the Viking Age, the northernmost Norse or North Germanic tribe, the Háleygir—inhabiting the outer coastal areas of Arctic Norway from Namdal to Troms—still practiced the polytheist Old Norse religion.[111] Their conversion to Christianity was part of the unification of the Norwegian state in the early 11th century, including two royally led missionary campaigns to the region. The Christian mission, the movement of Christian Norwegians into the Sámi areas, and the erection of churches were closely connected to the Kingdom's ambitions of dominion in the Arctic, in competition with the neighboring Sweden, Novgorod, and—from 1478—Moscow.[111] It is still debated whether the Norwegian Christianization process was swiftly rooted in the people or parts of the Old Norse belief extended into the Lutheran Reformation—starting in 1536. The Sámi, however, do not seem to have been the main subjects of the Medieval Christian mission in Arctic Norway.[111]

The Sámi Indigenous religion was compatible or shared at least some similarities with the Old Norse religion. The Sámi enjoyed high respect among the Norse for their alleged magic skills, which they regarded as better than their own.[112] We can tell from their drums, terminology, toponyms, and missionary accounts, that the Sámi Indigenous religion contained animism—including the use of sacrificial places in nature—and *Noaidevuohta*—named after their ritual specialist called *noaidi* (plural *noaiddit*) in the Northern Sámi language.[113] Through a trance condition, the *noaidi*—often using a ceremonial drum—could allegedly leave his body and travel throughout the visible and invisible world in search of knowledge or healing. Among his helpers were supposedly magic birds that could also harm other people.[113] Due to the Christianization of the Norse, the Sámi were subsequently regarded as pagans and idolaters. Henceforth, the two peoples' formerly close relationship ended.[112] However, several signs—e.g., keeping Catholic fast days and worshiping Mary—indicate a strong Roman Catholic influence on the Sámi in Scandinavia during the Medieval period despite their continued use of Indigenous religious practices.[112]

From the 16th century onwards, the Danish-Norwegian, Swedish, and Moscovian (since 1721, the Imperial Russian) states accelerated their dividing of Sápmi among themselves, and

their missionary activities toward the Sámi intensified. The Eastern Sámi—from Varangerfjord and eastwards—were henceforth Christianized through Russian Orthodox missionary activity, whereas persecution of the Sámi *noaiddit* would characterize the Post-Reformation period in Scandinavia.[112] The 17th century was the Scandinavian era of Lutheran Orthodoxy—focused on eradicating so-called Catholic practices and pagan rites—and was the period of the Sámi mission in Sweden. The 18th century, characterized by Pietism's focus on personal faith, ethical behavior, and spiritual experiences, was the time of the Sámi mission in Norway.[112] The Norwegian missionary districts were established in 1724 and lasted until 1814.

Sámi Indigenous religion, in the sense of the Sámi's faith before the completion of the Christian mission of the 17th and 18th centuries, has received several problematic labels in the research literature. Although one might correctly describe a belief as relatively nature-oriented, the term nature religion—along with so-called ethnic religion or pagan religion—gives an association of something primitive in contrast to the cultures of historically more powerful civilizations. Also, the category (classical) of shamanism as a homogeneous and unitary form of R/S has never existed in real life. The term is a simple European classification of many different non-Western cultural phenomena perceived as exotic, primitive, or genuine.[114] Still, we should respect the claim of some modern Sámi R/S practitioners to represent what they call Sámi shamanism.[115] Furthermore, despite the Sámi's status as missionary subjects at that time, using the terms pre-Christian or non-Christian to designate the Sámi religion of the 17th and 18th centuries is problematic. The sources mostly describe Christian, baptized Sámi practicing rituals with influences from Catholic, Orthodox, and Protestant Christendom and local non-Sámi Indigenous customs. Moreover, the descriptions are made by Lutheran Orthodox or Pietist theologians who served as scrutinizing representatives of majority cultures.[112,114]

In the second half of the 19th century, the Laestadian revival—a conservative, Lutheran congregationalist lay movement—swept the northern parts of Sweden, Finland, and Norway. The movement arose in the Finnish/Kven and Sámi-speaking milieu around the Swedish-Sámi state church vicar Lars Levi Laestadius (1800–1861) and later spread to Swedes and Norwegians, the rest of Finland, and North America. The estimated total number of Laestadians worldwide today is about 180,000.[116] However, the precise number is impossible to assess due to Nordic countries' lack of membership lists. Laestadius was a zealous abstentionist who referred to alcohol as "liquid devil shit" (*wuotawa pirun paska*) even in his sermons (e.g., on the 2nd Sunday after Epiphany 1852).[117] Thus, in its early years,

Laestadianism was a temperance movement that reduced alcohol consumption in its settlement areas.[118]

Laestadianism's influence on the Sámi people has been more extensive than its effect on any other nation.[118] Some scholars even claim that the revival, in a way, represented the definitive and inner completion of Sámi Christianization.[119] However, the myth of a Sámi nature religion, allegedly having changed little since the pre-Christian era and surviving disguised under Laestadian Christianity,[120] needs empirical evidence and lacks support among historians of religion.[121] The movement's pietist revivalist theology—focusing on the personal conversion from dead knowledge to living faith—translated religious conversion into the social context by rejecting mainstream society's conduct and ideals and accepting the Indigenous people's traditional values.[122] Like no other ethnic group, the Sámi embraced Laestadianism and adopted it as their version of Christianity.[118] During the assimilation period, many Sámi and Kvens sought refuge in the movement, where their culture was accepted and their languages widely used.[122] Due to conflicts concerning leadership, activity organization, and theology, the Laestadian movement split—partly geographically—into several subgroups around 1900.[119] In Norway, the movement mainly comprises the West Laestadians or "First-born"—their core area being Ofoten and Lofoten—the East Laestadians in the Alta area, and the Lutheran Laestadians in the Lyngen area, from Tromsø to West Finnmark. The latter group experienced further fractioning in the 1990s, resulting in social and personal conflicts, bitterness, and divided communities and families.[123]

Several observations suggest that the Sámi are still more committed to R/S today than the majority population in Arctic Norway. They are more often affiliated with the Laestadian Revival Movement than non-Sámi,[6] and the movement is believed to cause the higher religious attendance rate in Sámi compared to non-Sámi municipalities in Finnmark.[7] When comparing the register of voters for the Sámi Parliament of Norway[124] with the service attendance rate per member of the Established Church[125] in the districts of Finnmark and Troms, the municipalities with the highest percentage of Sámi voters also have the highest religious participation rate in the area.

Until 1845, Evangelical Lutheranism was the only legal confession in Norway and has remained the dominant belief in the Nordic region and Sápmi, even after the abolition of state religion in Finland (1809), Sweden (2000), and Norway (2012).[126] Sámi and Laestadians have historically been part of their country's established church. Despite increasing R/S pluralism[127] in Norwegian society during the past 50 years, two-thirds of the population are still members of the Established Church[125]—the former State Church—and Christendom has

remained the major religion.[127] However, secularization has been a significant religious trend in Norway, like in many Western countries. On the societal level, this process means that as the ties between the State and Church loosen, religion is privatized and becomes less of a public concern. On the internal level, the denominations experience a development of moral and dogmatic liberalism, and the members become more like the general population. Also, despite high denominational membership rates, people in general society are religiously less engaged and fewer find R/S relevant.[126] A final characteristic of today's Norwegian society is R/S individualization and subjectivation, which means that individuals are less dependent on religious institutions and their doctrines and believe and practice as they like.[127]

However, the R/S development in Norway and the rest of the Nordic countries is a complex process on different levels, including a pattern of R/S becoming a more visible topic in public debates in media and parliaments,[126] especially concerning certain conservative religious elements,[127] suggesting a simultaneous deprivatization of religion.[126] An example of the discussion is the democratic dilemma that freedom of speech means freedom from religion.[128] Furthermore, since the 1990s, churches and R/S organizations have become more socially active and politically involved in, for instance, poverty, climate, and exclusion issues.[127,128] These observations are in accord with the replacement of the secularization theory—the proposition that modernity must bring about a decline of religion—by a desecularization, religious complexity, or pluralization theory.[126,129]

There have been some recent religious movements among the Sámi, typically in the urban contexts of Southern Norway. Contextual theology has received some position after the 1990s, and Sámi shamanism has been around since the beginning of the 21st century, for instance, as a search for identity, claiming Sámi land rights, or in combination with performing or visual arts, offerings of healing sessions, or tourism.[115]

1.5. Mental health and mental help-seeking behavior in Arctic Norway

1.5.1. Mental health in Arctic Norway

Some unfavorable mental health outcomes have been associated with the general population of Arctic Norway compared to the Norwegian national mean. For instance, Finnmark had the highest suicide rate among the Norwegian counties from 1987 to 2016.[130] Also, in 2009, the number of involuntary commitments in psychiatric hospitals per 10,000 inhabitants (18 years or older) peaked nationally in Troms and Finnmark.[131] Furthermore, the Arctic counties had

among the country's highest use of primary health care for mental symptoms and disorders (per 1,000 inhabitants) among individuals aged 15–24 years.[132]

However, most studies on mental health in Arctic Norway have focused on the Indigenous population. Research has shown that the Sámi, like other Indigenous Circumpolar peoples, have poorer mental health than their fellow citizens from the majority population, despite better mental health compared to, for instance, the Inuit in Alaska and Greenland.[133] A register study by Silviken, Haldorsen, and Kvernmo (2006)[8] of the period from 1970 to 1998 found that the adult Sámi of Arctic Norway had a 30% higher suicide mortality rate—with a peak among males aged 15–24 years—compared to non-Sámi. However, the rate was not significantly higher among the nomadic reindeer-herding Sámi.

In a study of 4,881 Sámi and non-Sámi adolescents in all junior high schools in North Norway from 2003 to 2005 (The Norwegian Arctic Adolescents Health Study [NAAHS]), Reigstad and Kvernmo (2017)[9] found that Sámi youth reported more suicide attempts, concurrent adversities, suicide among friends, and adult and youth violence than their non-Sámi peers. Sørvold (2017),[10] in another NAAHS publication that included 3,987 respondents, found that the Sámi youth reported more suicidal thoughts than non-Sámi. These two studies reproduced findings in a smaller and older study showing an insignificantly higher prevalence of suicide ideation and attempts among Sámi adolescents than non-Sámi.[134] Among Swedish Sámi, young adults were also found to have a significantly increased occurrence of suicide ideation, death wishes, and life weariness, including an insignificantly higher prevalence of suicide attempts compared to their majority Swedish peers.[135]

Regarding non-suicidal self-injury (NSSI), another NAAHS study by Eckhoff, Sørvold, and Kvernmo (2019)[136] of 4,881 10th graders found that the NSSI lifetime prevalence (30%) among Sámi adolescents was not significantly different from that of non-Sámi peers. The authors confirmed the findings of a study from 1990 on self-harm irrespective of suicidal intent among 487 Sámi and non-Sámi 13–16-year-old adolescents in Finnmark.[137]

Eriksen et al. (2018)[11] conducted an extensive study of 10,790 Sámi and non-Sámi adults from Sámi-Norwegian areas in Northern and Central Norway (The SAMINOR 2 Questionnaire Survey). The authors found the prevalence of symptoms of anxiety, depression, and post-traumatic stress, as well as exposure to emotional, physical, and sexual violence during childhood, to be significantly higher among both Sámi females and males compared to the majority population.

Quantitative and qualitative studies have explored possible causes of poorer mental health among the Sámi. In a quantitative study by Hansen and Sørlie (2012),[138] the experience

of more frequent and severe discrimination and socioeconomic conditions were found as some attributable factors. In a qualitative study by Stoor et al. (2015),[139] suicide among Sámi was seen as a result of the loss of Sámi identity.

1.5.2. Mental health-service use and satisfaction in Arctic Norway

There have been few studies on mental health-service utilization and satisfaction across ethnic groups in Arctic Norway. However, despite their poorer mental health conditions and relatively equal access to mental health services compared to the majority population,[140] the Sámi are underrepresented among users of mental health services in Northern Norway, for instance, among Sámi adolescents with behavioral problems,[141] and in treatment facilities for alcohol and substance abuse.[142] Nevertheless, the few studies behind these findings are old and show low generalizability. A somatic healthcare expenditure analysis found no significant differences between Norway’s Sámi and non-Sámi municipalities.[140] Møllersen, Sexton, and Holte (2005)[143] conducted a study on mental health services in the district of Finnmark, including 347 patients and 32 therapists. The authors found that neither drop-out rates nor patients’ perceptions of therapeutic alliance were related to ethnicity. However, in the large population-based 2003–2004 SAMINOR 1 Study, which included 15,612 respondents aged 36–79 years, Nystad, Melhus, and Lund (2006)[144] found that Sámi-speaking patients were less satisfied with their local general practitioner than their Norwegian-speaking counterparts. Finally, in the SAMINOR 2 Questionnaire Survey, Eriksen (2017)[145] found that non-Sámi male victims of emotional, physical, or sexual violence were twice as likely as Sámi males to confide the event to a professional. The author discussed Sámi gender roles and values of male endurance of hardship and pain as possible explanations.

1.6. Religion/spirituality and mental health and mental help-seeking behavior in Arctic Norway

R/S and mental health, or mental help-seeking behavior, is a poorly explored subject in Norway and the Nordic countries. The only previous Nordic study identified by this author is a population-based study from 1990 by Årnes et al. (1996)[12] on R/S and mental health among 4,387 adults in Finnmark—part of the current study area. The authors found that persons affiliated with a Laestadian congregation reported significantly more insomnia, the use of psychiatric medication, and poorer self-reported health compared to individuals affiliated with the Established Church. However, the study did not adjust for Sámi ethnicity, a factor that the authors discussed as a relevant confounder.

Among the Sámi, just like in other ethnic groups committed to R/S,[83,86,91] mental disorders are often perceived differently than in the majority population and are sometimes believed to represent punishment from God or evil spirits sent by other persons.[14-17] Traditional healing is a commonly used and free-of-charge service in Arctic Norway for mental and physical health problems.[17] The healing procedure (literally called reading or *lesing* in Norwegian) typically involves the reading of a biblical text, a prayer, an instrument—e.g., a knife—and some form of action—e.g., the laying of hands or the throwing of an object against a surge, symbolizing the power of the Word.[146] Especially in Sámi areas, traditional healing plays a significant role in local society and is a well-known and accepted healthcare modality among local professional health workers.[147] This healing tradition is a religious and spiritual phenomenon that also existed as part of the *Noaidevuohta* until the completion of the Christian mission in the 17th and 18th centuries.[113] The historical transition process of the Sámi healing office from the *noaidi* to the modern-day healer is unknown.[17] However, the present Sámi healing institution is an integrated part of Christian cultural heritage[15,17,148] and many respected healers are also Laestadian leaders.[17]

Sørlie and Nergård (2005)[149] conducted a clinical study of 68 Sámi and Norwegian patients admitted to psychiatric emergency and intermediate wards at the University Hospital of Northern Norway from 2000 to 2002. The study included both voluntary and involuntary commitments, with 22% of the patients having an initial Global Assessment of Functioning (GAF) score at a psychotic level (< 40/100). Compared to the Norwegian patients, the authors found that the Sámi patients scored significantly higher on religious-mindedness, a measure including how much they had found support in their belief, if they had searched for spiritual help, and whether they had used prayer for their health during their hospital stay. The use of traditional helpers was also more frequent among the Sámi than the Norwegians, with 37% of Sámi patients having used traditional helpers during the current mental crisis, which was 2.7 times more frequent than among the Norwegian patients. Despite no significant differences between the ethnic groups regarding the type and amount of treatment or symptom change during the hospital stay, the Sámi patients reported less satisfaction with all explored treatment parameters, including treatment alliance, contact with staff, information, and global treatment satisfaction.

Later, Sexton and Sørlie (2008)[18] conducted a cross-sectional study of 186 Sámi and Norwegian psychiatric patients in Finnmark and Northern Troms, 84% of whom were treated as outpatients. The authors found that at some point in their life, 50% of the Sámi patients had contacted therapists or helpers outside the professional health services, in person or by phone,

for psychological problems. This was significantly higher than within the Norwegian group (31%). The authors regarded such helpers or therapists as traditional or complementary healing modalities. The Sámi users also reported higher R/S importance and were less satisfied with their psychiatric treatment than the Sámi patients who had not used traditional or complementary healers.

Besides being an influential religious element in the region's Indigenous population, the teetotalist Laestadian Revival Movement is an essential social factor for large swaths of the Sámi people.[6,150] It is believed to cause lower alcohol consumption in Sámi municipalities in Finnmark.[6,7] Spein et al. (2011),[6] in their 1994–1995 North Norwegian Youth Study, found that Laestadian affiliation and R/S importance were associated with less drinking and more abstinence among non-Sámi and Sámi 15–19-year-old high school students. On the flip side, however, and according to the Laestadian acceptance of tobacco, Spein, Sexton, and Kvernmo (2004a)[151] found in their study more experimental smoking among the Laestadian-affiliated Sámi. Moreover, in the SAMINOR 2 Questionnaire Survey from 2012, Eriksen et al. (2015)[13] found that Laestadian adherence or family background (combined variable) was associated with higher lifetime exposure to physical, emotional, or sexual violence (pooled variable) among women when adjusted for sociodemographics, including Sami self-ascription.

1.7. Research aims

The primary objective of this project was to explore the relationship between R/S, ethnicity, suicidal behavior, and non-suicidal self-injury (NSSI) in the mixed Sámi and Norwegian adult population of Arctic Norway. The second aim was to study the association between R/S and help-seeking behavior in this context, measured by mental health-service utilization and satisfaction.

2. Methods

As the only previous study on the association between R/S and mental health in this region was published in 1996, the research topic could benefit from new qualitative and quantitative studies. Preferably, initial qualitative methods could provide more insight into the issues, generate hypotheses, and guide the planning of an observational quantitative pilot study, facilitating more extensive quantitative analytic studies.[152] Although it does not offer evidence of a temporal relationship between risk factors and disease nor is ideal for hypothesis testing, a cross-sectional survey is relatively quick, easy to perform, and helpful for hypothesis generation and preparing the way for future longitudinal studies.[152] As the author—as a Sámi—is an insider of the study population, a quantitative study risks less author bias than a qualitative approach. Also, a cross-sectional analysis is appropriate in this state of knowledge. However, based on the study results from other populations, the sample needs to be large and include at least several thousand participants.

As this project could benefit from existing statistical material from an extensive cross-sectional population-based questionnaire survey already conducted in the concerned population, the author did not need to collect new data.

2.1. Sample

The data sample was derived from the *Population-Based Study on Health and Living Conditions in Regions with Sámi and Norwegian Populations—The SAMINOR 2 Questionnaire Survey.*[153] The survey succeeded the SAMINOR (1) Survey from 2003–2004 and was conducted in 2012 by the Centre for Sámi Health Research, UiT—The Arctic University of Norway. The SAMINOR 2 Questionnaire Survey aimed to explore the health and living conditions of Sámi and non-Sámi populations. The survey is the most essential and extensive (n = 11,600) population-based study of Sámi areas, and by November 2023, it had contributed to 12 scientific papers and one PhD thesis. For the survey, all residents aged 18 to 69 years in 25 municipalities or municipality subdivisions with mixed Sámi and Norwegian settlements in Central and North Norway were invited. The following municipalities (or municipality subdivisions) were included (listed from south-west to north-east): Røros (Brekken), Snåsa (Vinje), Røyrvik, and Namskogan (Trones and Furuly), Grane (Majavatn), Hattfjelldal (Hattfjelldal), Tysfjord, Narvik (Vassdalen), Evenes, Skånland, Lavangen, Lyngen, Storfjord, Kåfjord, Kvænangen, Kautokeino, Alta, Loppa, Kvalsund, Porsanger, Karasjok, Lebesby, Tana, Nesseby, and Sør-Varanger. The overall response rate was 27%, but

below 11% for those aged 30 and younger. The complete SAMINOR 2 Questionnaire Survey data set comprises 11,600 participants, of whom 33.9% have Sámi affiliation, and 68.6% are from Finnmark, 18% from Troms, 7.8% from Nordland, and 5.5% from Trøndelag districts.[153]

2.2. Procedure

Using study samples from the SAMINOR 2 Questionnaire Survey, this project conducted three studies organized as Paper I and Paper II, published in July 2021, and Paper III, published in June 2023.

2.2.1. Paper I

Religion and Health in Arctic Norway: the association of religious and spiritual factors with suicidal behaviour in a mixed Sámi and Norwegian adult population – the SAMINOR 2 Questionnaire Survey

The study, using a SAMINOR 2 subsample of 11,222 participants, analyzed the associations between R/S factors (religious attendance, congregational affiliation, Laestadian family background, and R/S importance and view of life) and lifetime suicide ideation and attempts, age at the first attempt, motives, and the number of attempts. Multivariate-adjusted regression models were applied considering sociodemographics, Sámi background and self-ascription, and health-related risk factors.

2.2.2. Paper II

Religion and Health in Arctic Norway: the association of religious and spiritual factors with non-suicidal self-injury in the Sami and non-Sami adult population – the SAMINOR 2 Questionnaire Survey

The study used a SAMINOR 2 subsample of 10,717 responders. It examined the association of R/S factors (religious attendance, congregational affiliation, Laestadian family background, and R/S importance and view of life) with non-suicidal self-injury (NSSI). It also applied multivariate-adjusted regression models and mediation analyses to explore how religious participation transmits its effect on NSSI through violence exposure and psychological distress.

2.2.3. Paper III

The association of religious factors with mental health-service utilisation and satisfaction in a mixed Sámi and Norwegian adult population: adopting the SAMINOR 2 Questionnaire Survey

The study used a SAMINOR 2 subsample of 2,364 individuals. It analyzed the associations between R/S factors (religious attendance, R/S importance and view of life, Laestadian adherence, and Laestadian family background) and past-year mental health-service utilization and satisfaction among individuals reporting mental health problems, substance use, or addictive behaviors. Multivariate-adjusted regression models considering sociodemographic factors, including Sámi ethnicity, were applied.

2.3. Instruments and variables

The SAMINOR 2 Questionnaire Survey applied a self-administered questionnaire on paper sent by mail to all participants and provided a corresponding web-based version. The questionnaire included 97 questions regarding physical and mental health, lifestyle factors, and socio-economic and living conditions. It was written in Norwegian and in the Sámi language relevant to the area: Southern Sámi, Lule Sámi, or Northern Sámi.

2.3.1. Mental health outcome variables

Lifetime prevalence of suicide ideation

The question covering suicide ideation was: "Have you considered taking your life?" The possible answers were "Yes, during the past year," "Yes, earlier," and "No, never." Due to the small number of positive answers concerning past year ideation (n = 303), the data were pooled into a dichotomous variable: lifetime prevalence of suicide ideation vs. no lifetime suicide ideation.

Lifetime prevalence of suicide attempts

The question "Have you tried to take your life?" tapped suicide attempts, the possible answers being "Yes, during the past year," "Yes, earlier," and "No, never." Due to the small number of positive answers regarding past year attempts (n = 26), the data were pooled into a dichotomous variable: lifetime prevalence of suicide attempts vs. no lifetime attempts.

Suicide motives

A question assessing the suicide motives had three multiple-choice answers: “A clear wish to die,” “The situation felt unbearable,” and “I wanted help from someone.” Only responders explicitly reporting suicide attempts were included.

Age at first suicide attempt

We included only responders explicitly reporting suicide attempts.

Total number of suicide attempts

Only responders explicitly reporting suicide attempts were included.

Lifetime prevalence of non-suicidal self-injury (NSSI)

The question tapping non-suicidal self-injury was: “Have you injured yourself deliberately?” with the possible answers being “Yes, during the past year,” “Yes, earlier,” and “No, never.” The results were pooled into a dichotomous variable: lifetime prevalence of NSSI vs. no lifetime NSSI. We excluded respondents reporting suicide attempts and used this variable for Paper II only.

Past-year suicide attempts, suicide ideation, or self-injury

For Paper III, a pooled dichotomous variable of past-year suicide attempts, ideation, or (non-suicidal) self-injury (yes or no) was created.

Psychological distress

The Hopkins Symptom Checklist-10 (HSCL-10) is a short instrument tapping symptoms of psychological distress during the past four weeks. The HSCL-10 consists of two subscales, anxiety symptoms (five items) and depression symptoms (five items), giving a total score from 0 to 4 measuring overall psychological distress. A total score above the clinical cut-off level of 1.85 predicts mental disorder.[154] The instrument and its cut-off level are validated for Norwegian and Sámi populations, including subgroups with a Sámi family background without Sámi self-ascription.[155]

Problematic drinking behavior

The questionnaire tapped three indicators of possible problematic drinking behavior: past-year periodic drinking patterns, drinking four times or more per week during the past year, and

past month alcohol intoxication three times or more. A pooled dichotomous variable of problematic drinking behavior (yes or no) was created.

Drug use

A pooled dichotomous variable of past-year use of hashish or illegal drugs (yes or no) was created.

Problematic gambling behavior

The questionnaire tapped three indicators of possible problematic gambling behavior: past-year need to gamble with increasing amounts of money, lying to intimates about gambling activities, or returning to gamble after losing money. A pooled dichotomous variable of past-year problematic gambling (yes or no) was made.

Past year use of mental health services

The questionnaire tapped respondents' past-year use of mental health services, the questions being: "During the past 12 months, have you been examined or treated for mental health problems at a psychiatric hospital, district psychiatric center, private specialist, or none?" The respondents could check off separately for the different categories. The positive answers were summarized and a dichotomous variable made: past-year mental health-service utilization vs. no past-year use of such services.

For the analyses of mental health-service utilization in Paper III, only respondents revealing current mental health problems, substance use, or addictive behaviors were included. Mental health problems were defined as reports of at least one of the following difficulties: past-year suicide attempt, suicide ideation, or (non-suicidal) self-injury, or past-month psychological distress. Substance use and addictive behaviors were defined by reports of at least one of the following difficulties: past-year use of drugs, problematic drinking behavior, or problematic gambling behavior. To allow for other mental health problems not revealed or covered by available questions, the analyses included all persons reporting past-year use of mental health services, thus expanding the Paper III subsample by 179 individuals.

Mental health-service satisfaction

The survey questions regarding mental health-service satisfaction were not explicitly addressed to past-year users of mental health services only. Thus, the answers may have included reports concerning previous years: "All in all, how satisfied are you with the care

and treatment you received?" The respondents checked off on a Likert scale from 0 (least satisfied) to 10 (most satisfied), and a final dichotomous variable of mental health-service satisfaction: "little satisfaction" (0–5) or "moderate to high satisfaction" (6–10) was made.

2.3.2. Religious/spiritual exposure variables

The measures of R/S in the SAMINOR 2 Questionnaire Survey are suitable for studying social, cultural, and private aspects of a religiously homogeneous Norwegian study population dominated by pietist-influenced or traditional Lutheranism—particularly the Established Church.[156] Laestadian affiliation was also explored due to its historical importance in the study area.[122]

Religious attendance rate

The R/S attendance rate during the past six months at (a) a church, (b) congregation house, or (c) other religious building was reported separately as "more than three times a month," "1–3 times a month," "1–6 times," or "never." The total participation rate at all three building categories was pooled and categorized as "regularly" (once per month or more often in the past six months, as rural church services are usually held once or twice a month[157]), "irregularly" (1–6 times in the past six months), or "never or rarely" (not in the past six months). Due to the small sample of Paper III, the "regularly" and "irregularly" categories were pooled into one category, "religious attendance" (once or more during the past six months).

Congregational affiliation: five variables

Regarding personal adherence to a religious group or fellowship of belief, the respondents could check off one or more categories: "Established Church," "Laestadian congregation," "other religious congregation," "non-religious denomination," and "not a member of any denomination." Five dummy variables of congregational affiliation were made accordingly.

Laestadian family background

Laestadian family background may indicate Laestadianism as a possible cultural affiliation and psychosocial factor during childhood, for instance, influencing drinking behavior.[6,158] The congregational adherence question was repeated for grandparents and both parents, yielding a variable of Laestadian family background by at least one parent or grandparent versus other family backgrounds.

R/S importance and view of life

The final R/S parameter was a scale combining the view of life (atheist, agnostic, or believer in a god) and religious importance or commitment (religious or not-so-devoted believer) and comprised four categories: "I am a believer/confessing or personally Christian" (referred to as "religious"), "I believe there is a god, but religion is not so important in my everyday life" ("less devoted believer"), "Unsure," and "I do not believe there is any god" ("non-believer").

2.3.3. Sociodemographic control variables

The sociodemographic factors included gender, age, education level (1–9 years; 10–12 years; 13–15 years; > 15 years), total household gross income (< NOK 301,000; NOK 301,000–NOK 750,000; > NOK 750,000), living arrangement (living with someone or alone), municipality, and ethnicity.

Ethnicity

Sámi ethnicity is not only related to sociodemographic factors usually adjusted for in epidemiological studies—e.g., lower levels of education and income[159,160]—but also attendance at boarding schools, ethnic discrimination, bullying,[159] and exposure to emotional, physical, and sexual violence.[13,161] Also, due to "Norwegianization," many individuals with a Sámi family background consider themselves Norwegian, not Sámi. The total effect of this assimilation on mental health in this group has not yet been investigated but is assumed to be significant.[108] Thus, adjustment for Sámi ethnicity and family background is relevant.

The ethnicity report included home language (of the respondent, parents, and all grandparents), ethnic background (of the respondent and both parents), and self-ascription (the multiple-choice alternatives being Norwegian, Sámi, Kven, and other). The final ethnic categories in Paper I and Paper II were "non-Sámi" (89.7% unmixed Norwegian self-ascription and 7.1% non-Norwegians), "Sámi self-ascription," and "Sámi background without Sámi self-ascription" (95.4% Norwegian self-ascription) considering the effect of assimilation.[108] The individuals of Kven self-ascription, being considerably few (n = 349, comprising 3.1% of the total sample) and mainly ethnically mixed (85.1%), were divided among the non-Sámi (n = 125), the Sámi (n = 162), and the Sámi background categories (n = 62) according to their alternative ethnic self-ascriptions. Due to the small study sample, the ethnicity variable in Paper III had only two categories based on the subjective criteria[162] in the participants' reporting of their ethnic self-ascription and personal ethnic background. The final ethnic categories of Paper III were "Sámi" (Sámi self-ascription or ethnic background,

including 16.2% bi-ethnic Kvens) and "non-Sámi" (mainly ethnic Norwegians and 4.1% Kvens).

Regarding Paper III, Sámi-speaking patients may be less satisfied with health services.[144] However, significance tests of Sámi as the home language (n = 336) showed no significant association between home language and the outcome variables in the bivariate and multivariate analyses. Therefore, Sámi home language was not included in the presented models.

2.3.4. Health-related control variables

Laestadian and many other R/S groups endorse health-related norms—e.g., related to alcohol and substance use and extramarital sexual intercourse—and social modeling of healthy behaviors. These are lifestyle factors that potentially affect the mental health outcome variables, and some of these have been included as control variables in the analyses to adjust for such effects. First, tobacco use and alcohol consumption are well-known risk factors for suicidal behavior[163,164] and relevant confounders when studying a temperance movement like Laestadianism. Also, less alcohol consumption is a known partial mediator of the protective effect of R/S attendance on completed suicides.[58] Furthermore, self-rated health (SRH) measures general health, and poor SRH is a risk factor for suicide[165] and is associated with suicidal thoughts in Sámi adolescents in Norway.[166] Finally, exposure to emotional, physical, or sexual violence is a well-known strong risk factor for suicidal behavior[167] and relevant confounders explaining the low prevalence of suicidal behavior in R/S social settings.

Smoking and snuffing

Smoking and snuffing were tapped separately, the possible answers being "never," "former," "sometimes," or "daily," and finally pooled and categorized as "never or previously" (snuffing or smoking), "current cigarette or snuff user" (either snuffing or smoking—daily or occasionally), or "current dual user" (snuffing and smoking—daily or occasionally).

Drinking frequency

Past-year drinking frequency was reported on an eight-point scale and categorized as "never or not during the past year," "a few times to weekly," or "more than two times per week."

Self-rated health (SRH)

SRH was reported on a four-point scale from “poor” (1) to “very good” (4) and then dichotomized into “good” or “poor.”

Violence exposure

Lifetime exposure to emotional, physical, or sexual violence was reported separately for the past year, earlier in adulthood, and during childhood, and then merged into a dichotomous variable of lifetime violence exposure vs. no violence exposure.[13]

2.4. Statistical analyses

For the statistical analyses in Paper I and Paper II, Stata version 16 was used, and for Paper III, Stata version 17. Using a 5% significance level, chi-square tests were applied to estimate the unadjusted total effect of the different R/S categories on suicide attempts, suicide ideation, NSSI, psychological distress, mental health-service utilization, and mental health-service satisfaction. Pairwise comparisons were conducted with ANOVA, t-tests, and Bonferroni tests to compute differences across the continuous variables.

Mixed-effect logistic regression models—including sociodemographic and (for Paper I and Paper II) health-related risk factors—were used to estimate the association of all R/S categories (together and one by one) with suicide ideation, suicide attempts, suicide motives, NSSI, psychological distress, mental health-service utilization, and mental health-service satisfaction. Differences across gender and ethnic categories were analyzed by including terms for interaction effects between ethnicity and each of the R/S factors in the regression models. Municipality was added as a random effect in the analyses, considering local clusters of poorer mental health and assumed unmeasured differences, including variations between the Laestadian groups. As a quality control of the models, corresponding fixed-effect logistic regression analyses—excluding municipality from the models—was also undertaken.

To adjust for age-dependent NSSI recall bias in Paper II, a logistic regression model of reporting lifetime NSSI as a function of age was used, and then the inverse-probability weights (IPW) was computed.[168] In the IPW method, for participants reporting NSSI, the weight is equal to the reciprocal of the predicted probability of recounting NSSI. For participants not recounting NSSI, the weight equals the reciprocal of the predicted probability of not reporting NSSI. Thus, the oldest responders reporting NSSI and the youngest responders not recounting NSSI received more weight in the analysis. The regression models were tested in Paper II with and without the IPW term.

The mechanisms by which religious attendance affects NSSI were studied through mediation analyses in Paper II. Mediation analysis examines the potential pathways through which a predictor influences an outcome. These pathways are intervening variables or mediators, at least partially transmitting the effect to the response variable.[169] An important note is that mediation analysis cannot prove causality. It requires some necessary fundamental conditions, such as association, temporal precedence of the cause before the effect, isolation of confounders, and no interaction effects of predictors and mediators.[169] Thus, the paper's mediation model presupposed that the religious participation rate during the past six months corresponded to a lifelong pattern, a premise with some evidence.[170] It was likewise presumed that clinical levels of psychological distress (symptoms of anxiety and depression) during the past four weeks represented anxiety and depression earlier in life.[171] The first step of the mediation analysis was to establish a conceptual model showing how violence exposure (M_1) and symptoms of anxiety and depression (M_2) potentially mediate the effect of religious attendance (X_n) on NSSI (Y).[172] Sociodemographic factors ($C_{1\text{-}6}$), being potential confounders, were included in the model, comprising one direct (c') and two mediated indirect effect paths of interest (a_1b_1 and a_2b_2). The total effect of religious participation on NSSI—adjusted for sociodemographic factors—is the sum of the impact of the direct and indirect paths ($a_1b_1 + a_2b_2 + c'$, Paper II, Figure 2). For the mediation analyses, regression models estimated the adjusted effect of R/S attendance on psychological distress (anxiety and depression symptoms) and violence exposure, respectively. The effect size of the mediated indirect effect of religious participation on NSSI was reported as a ratio of the total sociodemographics-adjusted effect.[173]

2.5. Ethical considerations

This project was approved by the Norwegian Regional Committees for Medical and Health Research Ethics (reference code 2006/1766/REK nord). Moreover, the SAMINOR 2 Questionnaire Survey is based on participant consent. Finally, the project followed the Declaration of Helsinki and adhered to the Ethical Guidelines for Sámi Health Research, adopted by the Sámi Parliament of Norway in 2019.

3. Results

In this summary of the central findings presented in Papers I–III, the results are not given paper-wise but arranged according to the project's primary objectives. Along with the main results, a significant and relevant finding was the ethnic differences in the distribution of R/S factors, particularly the association between Laestadianism and Sámi ethnicity. The frequency of personal Laestadian adherence was four times higher among those with a Sámi identity or background than in non-Sámi persons. Laestadian family background was three times higher in the Sámi groups (Paper I). The correlation between Laestadian family background and Sámi self-ascription or origin was estimated to be moderate (vs. non-Sami, $\varphi = 0.34$, $p < 0.001$, Paper II). Sámi identity or background was also significantly related to religious self-ascription and regular religious attendance.

Although the SAMINOR 2 Questionnaire Survey afforded the examination of several R/S factors, the data had some limitations that affected the focus of the current presentation. Due to unclear instructions regarding congregational affiliations in the questionnaire, many respondents made contradictory fill-ins, influencing the validity of the non-religiously affiliated and unaffiliated groups (3.4% and 8.6% of the total sample, respectively). Also, the group of other religiously affiliated (including only 3.6% of the sample) was a very religiously and ethnically heterogeneous collection of presumably marginal R/S groups with geographically dispersed members, many reporting immigrant backgrounds. These limitations created an undefined and fuzzy group in contrast to the dominant category of Established Church members.

On the flip side, being a member of the Established State Church, which comprised 86% of the total sample, hardly made sense as an R/S category. The proportions of regular attendees (23%) and the self-ascribed religious (16%) were the same in the Established Church group as in the total sample. Also, Sámi and Laestadian affiliations were practically equivalent to being members of the Established Church, and State Church membership was significantly more common in the Sámi categories than among the non-Sámi (Paper I).

3.1. Religion/spirituality, mental health, and mental health-service use and satisfaction across ethnic categories

In every logistic regression model for all study outcome variables, interaction effects between ethnicity and each R/S factor were tested. However, no significant ethnic differences in the effect of R/S on lifetime suicide ideation or attempts, NSSI, or mental health-service

utilization or satisfaction were found. Gender did not affect the association between R/S and the outcome variables either. Thus, the presented findings refer exclusively to the mixed Sámi and Norwegian sample, comprised of 65.9% non-Sámi and 34.1% individuals of Sámi self-ascription or family background.

3.2. The association of religion/spirituality with suicidal behavior and non-suicidal self-injury

Here is considered the relationship between three R/S factors or dimensions with the mental health outcome variables in the study sample: religious attendance, R/S importance and view of life, and Laestadian affiliation—either as personal adherence or as family background. These three factors are treated separately below.

3.2.1. Religious attendance and suicidal behavior and non-suicidal self-injury

In the fully fitted logistic regression model of Paper I, adjusting for R/S, sociodemographic, and health-related risk factors, regular (OR = 0.74, 95% CI 0.61–0.91) and irregular attendees (OR = 0.82, 95% CI 0.71–0.96) had significantly less lifetime suicide ideation compared to the non-attending group. Compared to non-attendance, irregular religious attendance was associated with no lifetime suicide attempts in a model adjusting for R/S and sociodemographic factors (OR = 0.72, 95% CI 0.56–0.93). However, this favorable association was rendered insignificant after adjusting for health-related variables, suggesting a mediating effect of health-related circumstances on suicide attempts. For example, it was found that non- or rare attendees more frequently reported suicide risk factors like violence exposure and a clinical level of mental distress.

In Paper II, the logistic regression analyses adjusted for sociodemographic factors suggested a protective total effect of regular attendance on lifetime NSSI (OR = 0.59, 95% CI 0.42–0.83) compared to the non-attending group. However, the mediation analyses found the direct effect of regular attendance on NSSI to be only borderline significant (OR = 0.70, 95% CI 0.49–0.99, $p = 0.048$). Although there was a strong significant association between lifetime violence exposure and NSSI (OR = 3.18, 95% CI 2.45–4.13) and psychological distress (HSCL-10 above clinical cut-off level, OR = 3.59, 95% CI 3.10–4.16), there was no significant association between religious participation and violence exposure. However, a robust inverse relation was found between regular attendance and psychological distress (OR = 0.71, 95% CI 0.58–0.87), which was strongly associated with NSSI (OR = 4.30, 95% CI 3.30–5.60). The findings suggested a highly significant mediating effect of regular attendance

via less psychological distress, accounting for 95% of the impact of religious participation on NSSI.

Finally, from the unadjusted analyses in Paper I, the total number of suicide attempts was found to be 1.17 attempts lower among irregular and regular attendees pooled together than within the group of non-attendees (3.29 attempts, $F[1,411] = 8.91$, $p = 0.003$).

3.2.2. R/S importance/view of life and mental health variables

In models adjusting for other R/S factors and sociodemographics, the analyses revealed hardly any significant findings regarding R/S importance/view of life and the mental health variables. As published in Paper I, it was found, for instance, that there was no relationship between R/S importance/view of life and lifetime suicide ideation or attempts in the adjusted models. However, compared to non-belief, in the fully fitted logistic regression model, having a want for help as one's suicide motive was significantly more frequent among the unsure (OR = 7.00, 95% CI 2.55–19.20), the less devoted believers (OR = 3.17, 95% CI 1.28–7.85), and the self-ascribed religious (OR = 4.74, 95% CI 1.37–16.38). Nonetheless, the total number of suicide attempts did not vary between these categories.

3.2.3. Laestadian adherence and family background, and suicidal behavior and non-suicidal self-injury

Laestadianism was found to be associated with some unfavorable sociodemographic factors in the analyses. Respondents with a Laestadian family background had a lower income and education level (mean 13.3 years vs. 13.6, $t[9,974] = 3.55$, $p < 0.001$, Paper I), compared to those with no Laestadian background. Also, although the effect size was small, lifetime exposure to violence was more frequent in those of Laestadian family background. However, after stratification for ethnicity, this association was only found among persons of Sámi self-ascription ($\chi^2[1] = 5.4$, $p = 0.020$, Paper I), indicating an ethnic confounder.

A higher frequency of alcohol abstainers was found among those of Laestadian background, but this finding was insignificant after stratification for personal Laestadian adherence. Also, a weak correlation was found between Laestadian family background and regular attendance (vs. no or rare participation, $\varphi = 0.20$, $p < 0.001$).

The Laestadian adherents also had a lower income and education level (mean 12.3 years vs. 13.5, $t[10,765] = 6.83$, $p < 0.001$, Paper I) than the non-Laestadians. The Laestadians also reported lower levels of SRH, but this was not significant after ethnic stratification. On the flip side, they were more frequently abstainers from tobacco and alcohol. Furthermore,

Laestadian adherence was moderately correlated with regular participation (vs. no or rare attendance, $\varphi = 0.27$, $p < 0.001$).

Regarding the mental health outcome variables, two significant favorable main findings were related to Laestadianism. In the analyses of Paper II, adjusted for sociodemographic factors, Laestadian adherence was significantly associated with no lifetime NSSI (OR = 0.32, 95% CI 0.13–0.80) compared to no Laestadian affiliation. Also, in Paper I, the fully fitted model, adjusted for religious, sociodemographic, and health-related risk factors, revealed that Laestadian family background was significantly associated with no lifetime suicide attempts (OR = 0.66, 95% CI 0.47–0.93) compared to no Laestadian family background. Laestadian family background was also inversely associated with lifetime suicide attempts in a model adjusting for sociodemographic factors, municipality, religious attendance, and R/S importance and view of life (OR = 0.75, 95% CI 0.57–0.99, results not published). Laestadian family background was not related to NSSI.

3.3. The association of religion/spirituality with mental health-service use and satisfaction

In Paper III, the past-year use of mental health services among individuals reporting mental health problems or substance use/addictive behaviors was studied. The logistic regression analysis adjusting for R/S and sociodemographic factors showed an association between religious attendance and no past-year use of mental health services (OR = 0.77, 95% CI 0.60–0.97) compared to non-attendance. As the bivariate analyses revealed that the attendees reported problematic drinking behavior, suicidal behavior/NSSI, and drug use significantly less frequently than the non-attendees, this could indicate less of a need for the use of mental health services among the religious attendees. Therefore, a *post hoc* stratification by psychological distress above clinical level (HSCL-10 ≥ 1.85) was made. However, the stratification only intensified the relationship between religious participation and no past-year mental health-service utilization in the psychological distress group (OR = 0.59, 95% CI 0.43–0.80, results not published).

On the other hand, a positive interaction effect on service use between religious self-ascription and age (OR = 1.03 per year, 95% CI 1.00–1.05) was found. A *post hoc* Bonferroni test of the oldest age group revealed that the mean level of psychological distress among the religiously self-ascribed (HSCL-10 score 1.92) was significantly higher than within the non-believing group (HSCL-10 1.58, $p < 0.001$), the unsure (1.58, $p < 0.001$), and the not-so-devoted believers (1.73, $p = 0.016$; $F[3,618] = 8.44$, $p < 0.001$, note the typing error in the

published paper regarding the latter group), indicating more need for the use of mental health services in this age group.

Laestadian family background was not related to service use. Finally, none of the R/S factors were significantly associated with lifetime mental health-service satisfaction.

4. Discussion

Using data from the 2012 *Population-based Study on Health and Living Conditions in Regions with Sámi and Norwegian Populations—The SAMINOR 2 Questionnaire Survey*—this project investigated how R/S factors are related to suicidal behavior, NSSI, and mental health-service use and satisfaction in the mixed Sámi and Norwegian adult population of Arctic Norway. It applied both bivariate tests and multivariate-adjusted logistic regression models controlling for R/S, sociodemographic, and health-related risk factors, as well as mediation analyses. This is the first study on R/S and mental health in Arctic Norway and among the Sámi people adjusting for ethnicity.

Following the extensive research body on R/S and mental health in other populations,[1-3] an overall favorable association was found between R/S—including Laestadianism—and mental health in the mixed Sámi and Norwegian adult population of Arctic Norway. Also, this is the first study on the relationship between religious attendance and NSSI and suggests that religious participation may buffer the effect of violence exposure on the development of NSSI.

R/S was not related to satisfaction with mental health services. However, in line with studies of other religious groups in Western countries,[83-85] R/S—in our case, religious attendance—was associated with less use of mental health services. Finally, the analyses revealed no significant ethnic or gender differences in the association of R/S with mental health, mental health-service utilization, or mental health-service satisfaction.

4.1. The impact of religious/spiritual importance and view of life on mental health in Arctic Norway

The adjusted models did not show significant relationships between R/S importance/view of life and mental health in the sample. However, regarding non-believers' tendency not to have a want for help as their suicide motive, this could affect the lethality of their attempt, despite the odds ratio for lifetime attempts and their total number of attempts not being different from the other categories.

Nonetheless, this author believes that the general findings follow previous evidence from extensive longitudinal studies showing no protective effect of R/S importance or strength on suicide[59] or major depression[174] after controlling for religious participation or social network, respectively. Thus, the protective effect of R/S on mental health seems to be

due to the social aspects of R/S—e.g., religious attendance—and a strong R/S belief does not necessarily entail the development of social networks.[59]

4.2. The impact of religious attendance on mental health in Arctic Norway

The results showing a significant association between religious attendance and less suicide ideation, NSSI, and psychological distress are in line with a large amount of research exhibiting the protective effect of R/S participation on both major depression,[174] suicide ideation, attempts, and completed suicides.[57-59] The current findings not only suggest that religious participation moderates the effect of childhood maltreatment on NSSI but probably also buffers the effects of adverse life events on mental health in general in this study area. Chen, Kim, and VanderWeele (2020)[175] published an extensive prospective study on religious service attendance and subsequent health and well-being, which included 92,008 US adults. Their statistical models applied a rigorous control for potential confounding and reverse causation, involving adjustment for sociodemographics, physical health, psychological symptoms, health behaviors, and baseline outcomes. The authors found that weekly or more frequent religious attendance vs. no attendance was significantly associated with subsequent no depression diagnosis, fewer depressive and anxiety symptoms, fewer feelings of hopelessness and loneliness, more positive affect, higher life satisfaction and social integration, and more purpose in life. However, religious attendance was not associated with subsequent physical diseases, such as hypertension, stroke, or heart disease.

Kleiman and Liu's (2018)[59] extensive study of the prospective association between religious attendance and suicide in 30,650 American adults from 1978 to 2010 showed that religious attendance had a significant protective effect only in the last studied decade. The authors suggested that earlier religious attendance was a social norm, whereas religious attendees today are resilient to suicide due to the motivations of social connection and meaning in life. In cross-sectional and longitudinal studies, social support and social connectedness are associated with better mental health.[176-179] Studies also show that both the actual social support and the perception and anticipation of support—e.g., the comfort of simply knowing about this available support—strengthen mental health.[76] However, some evidence indicates that the perception and anticipation of support from R/S fellowships—where you share your fundamental values, beliefs, and purpose in life—are higher than in non-R/S social settings.[75]

4.3. The impact of Laestadianism on mental health in Arctic Norway

In the current study, Laestadian adherents did not report poorer SRH than non-Laestadians after stratification for ethnicity. This supports Årnes et al.'s (1996)[12] suggestion that poorer SRH among Laestadians is not related to R/S but to Sámi ethnicity, which is known to be associated with poorer mental health due to several other conditions, such as sociodemographic factors and colonialism.[8-11] However, it was found by the current study that in the Sámi self-ascription category, Laestadian family background was significantly associated with lifetime exposure to emotional, physical, or sexual violence if the types of violence were pooled. No significant relationship was found between violence exposure and Laestadian background in the groups of non-Sámi and those of Sámi family background without Sámi self-ascription. Personal Laestadian adherence was not related to violence exposure. Eriksen et al. (2015),[13] also adopting the SAMINOR 2 Questionnaire Survey, found that Laestadianism was associated with lifetime exposure to emotional, physical, or sexual violence (pooled variable) among women but did not discriminate between Laestadian family background and personal Laestadian adherence. In the current analyses, compared to Laestadian family background, personal Laestadian adherence was more strongly correlated to religious attendance, an R/S factor associated with several favorable aspects of mental health in this study sample. Also, many individuals who grew up in R/S settings may have abandoned their congregation and families due to R/S struggles, such as anger at God, interpersonal disagreements, or other negative experiences from R/S fellowships.[54] Thus, it is relevant to discern between these two Laestadian categories.

In 2017, Norwegian police documented 151 cases of sexual abuse, including child rape, in Tysfjord, a small Sámi community of 2,000 people.[180,181] Here, the Laestadian Movement was a major R/S factor, and many of the victims and perpetrators belonged to the local Laestadian congregation. The abuses were committed over a span of sixty years, mostly against children, and included a total of 92 charged or prosecuted individuals. One of the convicted offenders was a trusted traditional healer. Earlier, Laestadian congregations in another Sámi-Norwegian community (but not related to the Tysfjord congregation) also tracked attention in the regional newspaper due to several cases of sexual abuse, one of the perpetrators being a Laestadian leader.[182,183] Although there is no evidence that the frequency of sexual abuse is higher in these settings than in other R/S or non-R/S communities in the region, Norbakken (2012)[183] discussed, among other factors, two mechanisms contributing to the silence surrounding sexual maltreatment in Laestadian congregations. The first is a cultural factor connected to the close ties between Sámi ethnicity and Laestadianism in these

communities. Steinlien (1999),[184] studying the role of Laestadianism in a Sámi coastal village in Arctic Norway, found that the movement represents the primary identity-defining values of the local Sámi population. Here, as part of the assimilation process, Laestadianism gives the individual a place to live out a Sámi identity, avoiding ethnic stigmatization by society. Norbakken pointed to a common characteristic between Sámi communities and these Laestadian congregations: the expectations of loyalty to the family and the congregation and, to prevent dishonor or disrepute, keeping the processes of putting things to rights inside the family.[183]

The second mechanism Norbakken discussed involves the keys of the Kingdom of Heaven (Matt 18:18[185]), a central theological institution in Laestadianism related to the sacrament of confession and absolution. A central dogma of this office is that if a person repents and confesses their sin to a Christian, the believer is expected to forgive and accept the transgressor unconditionally. Also, if a sin is forgiven, it will never be evoked again. However, any absolution depends on the willingness to forgive the offenses committed against oneself (Matt 6:15[185]). Thus, a victim of sexual abuse from a fellow believer is forced to choose between the congregation by forgiving one's perpetrator and living on as if nothing had happened or justice by prosecuting the offender, thereby abandoning the Christian fellowship and breaking the bonds to one's family.[183] Norbakken suggested that the cultural and theological mechanisms have a joint effect on hindering the openness about sexual abuse in these Laestadian congregations. The current study could not ascertain if these factors contribute to any higher frequency of sexual maltreatment in Laestadian fellowships located in Sámi communities compared to the non-Laestadian part of the Sámi society.

In the current study area, Laestadian family background correlated considerably to self-reported Sámi affiliation. Also, due to the assimilation or "Norwegianization" of the Sámi,[108] reporting one's grandparents as Laestadians may be less stigmatic than admitting their speaking Sámi at home, which would expose the respondent's own Sámi family background. Thus, the actual percentage of individuals with Sámi affiliation may be higher than reported in the Laestadian family background group. Sámi ethnicity is related to several unfavorable health-related and sociodemographic factors—e.g., attendance at boarding schools and lower levels of education and income.[159,160] Hansen et al. (2008),[159] adopting the first SAMINOR Study from 2003–2004 of 12,265 adults in Sámi-Norwegian areas, investigated the prevalence of self-reported experiences of bullying and ethnic discrimination among Sámi, Kven, and ethnic Norwegians. The authors found that the Sámi were the group reporting the highest lifetime prevalence of bullying and that this prevalence was proportional to the degree

of Sámi ethnicity. For male respondents with the strongest Sámi affiliation (respondent, both parents, and all grandparents speak Sámi at home), the lifetime prevalence of bullying was reported 2.7 times more often than among ethnic Norwegian males. Females with the strongest Sámi affiliation reported lifetime bullying 2.4 times more often than ethnic Norwegian females. Past-year bullying against respondents with the strongest Sámi affiliation was mainly reported to have occurred at the workplace and in the local community. In contrast, earlier bullying in this group typically happened in school (reported by 55%) or boarding school (reported by 30%). Furthermore, in this group, the lifetime prevalence of ethnic discrimination was 10 times higher than among ethnic Norwegians.

Eriksen et al. (2015)[13] conducted a thorough study of the prevalence and ethnic differences of emotional, physical, and sexual violence in the SAMINOR 2 Questionnaire Survey sample. The authors found that Sámi women, irrespective of Laestadian affiliation, reported emotional, physical, and sexual violence more often than non-Sámi women. Sámi men were also likelier to report emotional and physical—but not sexual—violence compared to non-Sámi men. Furthermore, Sámi respondents reported exposure to past-year violence more often. Typically, violence was reported to have occurred during childhood and to have been performed by someone known to the victim. Also, in a recent study applying the SAMINOR 2 Questionnaire Survey, Eriksen et al. (2022)[161] found a higher prevalence of emotional and physical intimate partner violence among Sámi than non-Sámi women. Eriksen (2017)[145] discussed a more extensive cultural experience regarding colonization as one possible explanation for the higher prevalence of violence among Sámi—e.g., boarding school experiences and structural violence.

Bullying is an example of emotional and physical violence; its prevalence in this study area is proportional to the degree of Sámi ethnicity and is mainly related to childhood school bullying, often experienced in boarding schools. The cited studies do not seem to have explored childhood maltreatment occurring at home, and a possible higher prevalence of parental violence in Sámi-Laestadian families has not been investigated. Such violence could, for instance, be motivated by moral demands related to drinking and sexual behavior. The Sámi and Laestadian culture of solving problems internally inside families and the congregation and keeping the authorities and the police out may contribute to an acceptance and continuation of maltreatment.[145,183] However, based on the published findings on violence and bullying in this population, it is likely that Sámi-Laestadian schoolkids experience a double stigma, an ethnic and a religious one, making them a minority within the minority and

more susceptible to bullying from non-Sámi and other Sámi. This may explain the association between Laestadian family background and violence exposure within the Sámi group.

In the current study, there was a strong association between lifetime violence exposure and NSSI and psychological distress. Also, Eriksen et al. (2018)[11] found that experiences of childhood violence were strongly associated with psychological distress and post-traumatic symptoms in this population. Childhood maltreatment, bullying, and other early traumatic experiences are known to be leading causes of NSSI[171,186,187] and are strongly associated with suicide ideation and attempts in extensive meta-analytical studies.[167] With these relationships in mind and considering the association between violence exposure and Sámi-Laestadian family background in this sample, why did the current analyses not reveal any poorer mental health in this group? As Laestadian family background correlated with religious attendance, the R/S factor having the strongest association with better mental health outcomes in the sample suggests a confounding buffering effect from religious participation. However, Laestadian family background was also associated with no suicide attempts when adjusted for religious attendance, indicating an independent buffering effect of the impact of violence exposure on mental health in this study area.[11,13]

Despite having some traits of a closed community, the Laestadian movement's strong family and social networks imply benefits, rights, alliance, loyalty, and support in case of tragedies or times of need.[150,183] Such strong social and family ties seem to buffer the effect of discrimination and acculturative stress among Sámi[8] and other ethnic and R/S minorities.[188,189] Whereas the Christian mission among the Indigenous Canadians destroyed much of the native culture and family structure and nurtured distrust toward Western religions,[4] the Laestadian revival was brought to the Sámi people by the ministry of their kin in their mother tongue.[122] Thus, the Laestadian form of Christianity took strong roots among the Sámi people, preserving and applying the social and family ties of the traditional Sámi *siida* (home or village) societies within the Laestadian communities.[150] Despite the lack of direct information on using Laestadian family networks in the current sample, a report on Laestadian family background may be a proxy measure.

4.4. The impact of religion/spirituality on mental help-seeking behavior in Arctic Norway

In the study of past-year use of mental health services among individuals reporting mental health problems or substance use/addictive behaviors, the adjusted model revealed that religious attendance was associated with no past-year use of mental health services across

ethnic groups. As stratification by psychological distress intensified this relationship, the finding could not be explained by a reduced need for mental health services in this group.

R/S importance was also associated with less mental health-service use in a study of 13,038 American adolescents by Xie, Wang, and Chu (2022).[93] Furthermore, in a sample of African American church attendees, Davenport and McClintock (2021)[85] found that a high level of subjective religiosity was associated with less positive attitudes toward mental health treatment. The authors of these papers discussed two main reasons for the relationship between R/S and the insufficient use of or negative attitudes toward professional mental healthcare. First, having R/S beliefs about the etiology of mental disorders may cause distrust in the professional mental health workers' abilities to cure such problems. Second, believers may seek to manage their psychological issues through R/S coping methods—e.g., prayers or consulting the clergy for guidance and support. For religious individuals with psychological problems, an R/S leader may be more available for consultation than a mental health professional[94] and more accessible to talk to than a non-believing psychologist.[84]

Harris, Edlund, and Larson (2006)[190] found opposite results in their longitudinal study of an extensive national American sample comprised of 64,450 individuals reporting emotional distress. In this general population sample, religious participation was unrelated to outpatient mental healthcare use among individuals with moderate distress. However, among persons experiencing serious distress, religious attendance was positively associated with service utilization, and a greater participation rate predicted more service use. The authors suggested that religious support networks may encourage the use of professional mental healthcare for the severely mentally ill in this population. These findings demonstrate that R/S has disparate roles and impacts in different populations and R/S groups.[82]

Sørlie and Nergård's (2005)[149] and Sexton and Sørlie's (2008)[18] studies of psychiatric patients in Arctic Norway found Sámi ethnicity associated with R/S importance and the use of traditional healers. Whereas the current study supports their findings on the relationship between Sámi ethnicity and R/S, no ethnic differences in the effect of R/S on the use of mental health services were found in the sample. Also, no significant differences were found in the overall use of mental health services between the Norwegian and Sámi groups. Clinical studies using R/S as outcome variables cannot easily be compared with the current population-based study analyzing R/S as exposure variables. Also, the current investigation did not involve any information about traditional healing. Nonetheless, the clinical findings may indicate an association between R/S and the handling of mental health problems using R/S coping strategies, like finding support in one's belief, prayer, search for spiritual help,

and traditional healing, that are integrated into the Sámi-Norwegian areas and not ethnically dependent.[146,147] In her qualitative study, Henriksen (2010)[146] investigated how the everyday use of various forms of traditional healing against diseases, wounds, and the forces of nature represents R/S practices and expressions of R/S worldview, beliefs, and values that are not exclusively Sámi but also pertains to R/S in other parts of the population of Arctic Norway.

Furthermore, an R/S fellowship may represent a social and psychological support system buffering mental distress and influencing the use of professional mental health services in this population, similar to the Church's effect among African Americans.[84] Langås-Larsen et al. (2018)[150] conducted a qualitative study of the extended R/S family networks' functions and roles as active contributors to the patient's healing process in two Sámi-Norwegian communities strongly influenced by Laestadianism. The villagers were organized in networks where they shared the responsibility for the patient, providing practical help and support for the family and contacting traditional healers, who were often more available than doctors in remote areas. Professional health workers were also contacted as diagnostic knowledge could ease the process by indicating each case's relevant traditional healing method. The authors found the traditional networks to be extra resources in these communities by handling and disseminating hope and manageability to both the individual and the village.

Furthermore, the adjusted analyses of the current sample did not reveal any significant association between R/S and reported satisfaction with mental health services. Thus, the underuse of mental health services among religious attendees in the Sámi-Norwegian areas cannot be explained by their having an upright distrust or lack of confidence in professional mental health care. Nonetheless, although lacking information about the application of such alternative R/S coping methods, the use of prayer, congregational support, guidance from clergy, traditional healers, or family networks may explain the underuse of mental health services in the current sample.

5. Strengths, weaknesses, and limitations

The theoretical conception of R/S behind the SAMINOR 2 Questionnaire Survey is the classical European view, focusing on the sociological dimensions corresponding to organized traditional Protestantism and Pietism,[37] not considering Sámi cultural spirituality, traditional healing, or non-Christian Sámi spirituality.[18,115,121] Accordingly, like other typical studies on contemporary Laestadianism in Norway—e.g., Myrvoll (2010)[17] and Olsen (2008)[191]—SAMINOR 2 has an approach to the R/S phenomenon as a well-organized, hierarchical structure gathering every Sunday in a chapel or a church building. However, there are hardly any services in many rural areas every month,[157] and many Laestadians continue the classical practice of meeting in private homes.[191] Also, disappointment with theological liberalization in the Established Church[191] and congregational fractioning[123] may affect the praxis of house meetings and give rise to marginalization.

Despite their centrality in the Laestadian Revival, the Kvens/Norwegian-Finns are poorly represented in SAMINOR 2, and the omission of the crucial Kven community of Nordreisa is noticeable. Also, the omitted municipality of Tromsø comprises significant parts of the Sámi and Laestadians in the region, both historically and contemporaneously.

Furthermore, there may be an under-reporting of suicidal behavior and the use of mental health services among devoted Christians, particularly Laestadians, due to moral objections,[192] thus representing a possible response bias affecting the internal validity of the current results. Also, the survey's meager response rate (27%), particularly among those younger than 30 years of age (< 11%), may have caused a selection bias, raising the question of the external validity and generalizability of the study.[153] Furthermore, SAMINOR 2 lacks information about marital or relationship status, an essential confounder associated with less suicidal behavior.[4,73] Finally, the main problem with using a cross-sectional design is the inability to address reverse causality and possible bidirectional feedback effects. For example, depressive persons are less likely to attend religious services over time.[193] Thus, the results must be interpreted with caution.

Nevertheless, with the above weaknesses and limitations in mind, this is the most extensive population-based study of Sámi areas (n = 11,222) and includes several dimensions of R/S, as well as all three main Laestadian subgroups represented in Norway—the Alta, Lyngen, and Ofoten groups.[119] Finally, the study adds essential knowledge to the limited research field of R/S, mental health, and mental health-service utilization and satisfaction among Indigenous peoples.

6. Conclusions

6.1. Summary

R/S is not associated with poorer mental health in the Sámi and Norwegian populations of Arctic Norway. On the contrary, following the vast amount of evidence from other populations, including extensive longitudinal studies, religious participation seems to buffer psychological distress and protect against poorer mental health among adults in these areas, probably connected to the effect of received or perceived social support from R/S fellowships.

Also, despite Laestadianism's association with some disadvantageous sociodemographic factors, such as lower income and education level and Sámi ethnicity, which includes attendance at boarding schools and more exposure to violence, the Laestadian family networks seem to contribute to better mental health in the Sámi-Norwegian areas.

Finally, although R/S is not related to mental health-service satisfaction, religious participation is associated with less use of mental health services across genders and ethnic categories, possibly due to alternative R/S coping methods like, for instance, prayer, congregational support, guidance from clergy, or the use of traditional healers and family networks.

6.2. Implications for public mental-health policy, clinical practice, and religious/spiritual leadership

From an Arctic Norwegian public mental-health perspective, decision-makers of healthcare services should consider R/S social activities as essentially preventive against mental disorders. Although it is associated with some unfavorable sociodemographic conditions, Laestadian affiliation should be regarded as a factor generally contributing to better mental health in the Sámi and Norwegian populations of the region.

In a Sámi-Norwegian clinical setting, religious attendance and Laestadian affiliation may represent therapeutic resources and components of resilience against psychological distress. Religious participation may also be considered a suicide preventive factor. For individuals already holding R/S beliefs, participating in R/S social activities may provide support and meaning in life and contribute to healing mental health problems.

In closed R/S fellowships, believers with mental health problems may not receive the necessary professional treatment. Thus, R/S leaders should consult and cooperate with psychiatric professionals regarding the detection and handling of mental health issues. Also,

clergy may be partners of mental health workers in the treatment and recovery of believers with mental disorders.

6.3. Suggestions for further research

The conclusions above are based on collating cross-sectional findings with longitudinal evidence from other populations. However, regarding the Arctic Norwegian population, further research is needed, and the current study recommends more extensive and longitudinal research that includes more Laestadians and Kvens/Norwegian-Finns. Also, future studies should address Sámi and Laestadian R/S appropriately, including the application of traditional healing and social networks and general attitudes toward mental health services. Finally, qualitative methods could provide more insight into the issues and guide the planning of new quantitative studies.

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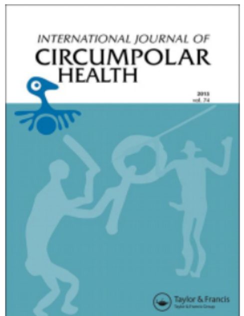
Paper I



International Journal of Circumpolar Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zich20

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To cite this article: Henrik Kiærbech, Anne Silviken, Geir Fagerjord Lorem, Roald E. Kristiansen & Anna Rita Spein (2021) Religion and Health in Arctic Norway – the association of religious and spiritual factors with suicidal behaviour in a mixed Sámi and Norwegian adult population – The SAMINOR 2 Questionnaire Survey, International Journal of Circumpolar Health, 80:1, 1949848, DOI: 10.1080/22423982.2021.1949848

To link to this article: https://doi.org/10.1080/22423982.2021.1949848

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INTERNATIONAL JOURNAL OF CIRCUMPOLAR HEALTH
2021, VOL. 80, 1949848
https://doi.org/10.1080/22423982.2021.1949848

Religion and Health in Arctic Norway – the association of religious and spiritual factors with suicidal behaviour in a mixed Sámi and Norwegian adult population – The SAMINOR 2 Questionnaire Survey

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ABSTRACT

Given the higher suicide rates among the adult population in the northernmost part of Norway and some unfavourable psychosocial outcomes associated with the Laestadian revival movement in this region, it is reasonable to investigate the relationship between religiosity/spirituality and suicidal behaviour in this context. This study used cross-sectional data from the population-based SAMINOR 2 questionnaire survey (2012; n = 11,222; 66% non-Sámi; 22% Laestadian-affiliated; 27% response rate) in mixed Sámi-Norwegian areas of Mid and North Norway. We analysed the associations between religious/spiritual factors and lifetime suicidal ideation and attempts, age at the first attempt, motives, and number of attempts. Multivariable-adjusted regression models considering sociodemographics, Sámi background and self-ascription, and health-related risk factors were applied. Sámi and Laestadian affiliations were significantly associated with religious self-ascription, regular attendance, and Established Church membership. In a fully adjusted model, Laestadian family background was negatively associated with lifetime suicide attempts (OR = 0.66, 95% CI: 0.47–0.93) compared with other family circumstances, whereas regular religious participation was inversely associated with suicide ideation (OR = 0.74, 95% CI: 0.61–0.91) compared with non- or rare attendance. The findings suggest that Laestadianism and religious attendance contribute to less suicidal behaviour among adults in Sámi-Norwegian areas.

ARTICLE HISTORY
Received 8 December 2020
Revised 25 June 2021
Accepted 26 June 2021

KEYWORDS
Suicidal behaviour; religion; Sámi; indigenous; Laestadianism; SAMINOR 2

Introduction

Religion and spirituality (R/S) describe the search for the sacred, transcendent, divine, or supernatural, as opposed to the secular, humanist, rational, or scientific [1]. Spirituality typically denotes either deep traditional religiosity or personal religiosity outside organised religion [1]. Several extensive longitudinal studies show that R/S is protective against suicidal behaviour [2–5], with religious service attendance being the strongest R/S factor [2] and even protective against completed suicides [3–5]. Social support received from fellow believers [6] and moral objections against suicide due to its proscription by several world religions, especially Christianity, seem to explain some of R/S's protective effects against suicidal behaviour[7]. However, this favourable effect varies across ethnic groups, e.g. between Latino and Black subgroups in the US [8], and a reverse effect is found in indigenous populations [9]. This study by Stack and Cao (2020) among indigenous Canadians (n = 15,294) found that affiliation with traditional indigenous spirituality was significantly associated with lifetime suicide ideation compared with lack of religious affiliation, whereas being Christian was no different from the latter. The study did not include other R/S indicators.

The northern and central parts of Norway have areas with a mixed population of Norwegians and Sámi, the latter being indigenous people primarily living in the northern territories of Norway, Sweden, Finland, and the Russian Kola Peninsula. Although the exact size of the Sámi population is unknown, the assumed largest proportion lives in Norway. The Sámi traditionally adhered to nature-oriented (shamanistic) religion, but missionary efforts during the 18th century caused a significant religious change. During the latter part of the 19th century, the teetotalist Laestadian revival movement strongly influenced this region. It originated about 1845 around the Swedish Lutheran state church vicar Lars Levi Laestadius (1800–1861) in the Finnish-

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Supplemental data for this article can be accessed here.

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Sámi population of Swedish and Finnish Lapland and was brought by Sámi and Finns to their ethnic peers in Norway. Laestadianism only later spread to the Swedish and Norwegian populations [10]. During the enforced Norwegian governmental assimilation programme from the mid-19th to the mid-20th centuries [11], Finns/ Kvens (an ethnic Finnish minority in North Norway) and Sámi found acceptance of their languages and cultures in the movement [12]. Laestadianism in the areas included in this study, is associated with ethnic (particularly Sámi) minority affiliation and represents an acculturative phenomenon different from Laestadianism in other parts of the world. Traditionally and also today, the established state churches are dominant denominations across native groups in the Nordic region and encompass most Laestadians as well.

The revival has had a considerable regional influence, especially on the Sámi people, presumably contributing to the higher religious participation rate and lower alcohol consumption in Sámi than non-Sámi districts of Finnmark County [13]. Laestadianism is also associated with abstinence and less drinking and intoxication among Sámi and non-Sámi adolescents and young adults in North Norway [14]. Nevertheless, the suicide rate of Finnmark is the highest in Norway (1987–2016) [15]. Furthermore, the Sámi of North Norway (1970–1998) have a 30% higher suicide mortality rate [16], and more recent and extensive studies reveal a higher prevalence of suicide ideation and attempts among adolescent and young adult Sámi in Sweden and Norway compared with their majority counterpart [17–19]. The Sámi also have asignificantly higher prevalence of anxiety; depression; post-traumatic stress symptoms; and childhood exposure to emotional, physical, and sexual violence [20], which are all well-known risk factors for suicidal behaviour [21]. Poorer self-rated health (SRH), another risk factor for suicide [22], was found among Laestadians in Finnmark [23], but the study (conducted in 1990) did not adjust for ethnicity. As among other indigenous populations, acculturative stress is a relevant explanation for the higher prevalence of suicidal behaviour among the Sámi [18,19]. However, Laestadian adherence or family background (combined variable) was associated with higher lifetime exposure to violence in women after adjusting for ethnicity [24].

Due to the higher suicide rates and the unfavourable psychosocial outcomes associated with the Laestadian revival movement in this context, we aimed to examine whether R/S, particularly Laestadianism, is a protective or risk correlate of suicidal behaviour in Sámi-Norwegian areas. Because of the considerable correlation between Laestadianism and Sámi ethnicity in this area, the enterprise would have to include ethnic self-ascription and background among its control variables. To our knowledge, this topic has not been studied earlier in the Nordic countries.

Methods

Procedure and sample

This study applied data from the second survey of the *Population-based Study on Health and Living Conditions in Regions with Sami and Norwegian Populations – The SAMINOR 2 Questionnaire Survey*. The survey (following the *SAMINOR 1 Survey*, carried out in 2003–2004) was conducted in 2012 by the Centre for Sami Health Research, UiT – The Arctic University of Norway – aiming to explore the health and living conditions in the Sámi and non-Sámi populations [25]. All inhabitants aged 18 to 69 years in 25 municipalities or districts with mixed Sámi and Norwegian settlements in Mid and North Norway were invited (27% response rate). After the exclusion of respondents without information regarding ethnicity, R/S, and suicidal behaviour, the study sample included 11,222 participants (consult Figure 1 for details concerning the inclusion process), of whom 65.9% were non-Sámi and 55.9% were females (Table 1).

Instruments and variables

Suicidal behaviour – outcome variables

Suicidal ideation was covered by the question “Have you considered taking your life?” The possible answers were “Yes, during the past year”, “Yes, earlier”, and “No, never”. The question “Have you tried to take your life?” correspondingly tapped suicide attempts. Due to the small number of positive answers concerning past year ideation (n = 303) and attempts (n = 26), we merged the data into two dichotomous variables: 1) lifetime prevalence of suicide ideation and 2) lifetime prevalence of suicide attempts. As the reported suicide attempts might be of different degrees of lethal intent and severity, there should be an assessment of some aspects of these attempts. Thus, three more questions assessed the suicide motives (“A clear wish to die”, “The situation felt unbearable”, and “I wanted help from someone”, multiple answers possible), the age at the first suicide attempt, and the total number of attempts. For these three questions, we only included the responders who explicitly reported suicide attempts.

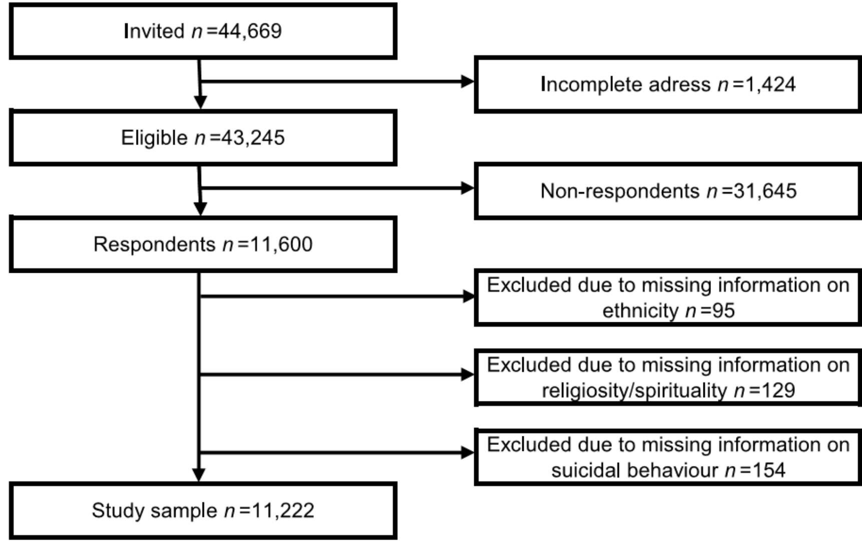

Figure 1. Flow chart of inclusion – Religion and Health in Arctic Norway – the SAMINOR 2 Questionnaire Survey, 2012.

Indicators of R/S – independent variables

Contemporary scholars apply a multidimensional-multilevel definition of R/S encompassing identity, culture, relationship, and practice [26] from the biological to the global level [27]. Thus, the measures of R/S in SAMINOR 2 are suitable for studying both social, cultural, and private aspects of a religiously homogeneous Norwegian study population dominated by pietist-influenced or traditional Lutheranism – particularly the Established Church [28]. In addition, Laestadian affiliation is explored due to its historical importance in the study area [12].

The religious attendance rate during the past six months at (a) a church, (b) congregation house, or (c) other religious building was reported separately as "more than three times a month", "1–3 times a month", "1–6 times", or "never". The total participation rate at all three building categories was pooled and categorised as "regularly" (once per month or more often in the past 6 months; rural church services are usually held once or twice a month [29]), "irregularly" (1–6 times in the past 6 months), or "never or rarely" (not in the past 6 months).

Regarding personal adherence to a religious group or fellowship of belief, the respondents could check off one or more categories: "Established Church", "Laestadian congregation", "other religious congregation", "non-religious denomination", and "not a member of any denomination". We accordingly made five dummy variables of congregational affiliation.

The adherence question was repeated for grandparents and both parents, revealing a Laestadian family background by at least one parent or grandparent versus other family backgrounds – indicating Laestadianism as a possible cultural affiliation and psychosocial factor during childhood, e.g. influencing drinking behaviour [14,30].

The final parameter is a scale combining the view of life (atheist, agnostic, or believer in a god) and religious importance or commitment (religious or not-so-devoted believer) and comprised four categories: "I am a believer/confessing or personally Christian" ("religious"); "I believe there is a god, but religion is not so important in my everyday life" ("less devoted believer"); "Unsure"; "I do not believe there is any god" ("non-believer").

Sociodemographic control variables

The sociodemographic factors included sex, age, education level (continous variable categorized as 1–9 years, 10–12 years, 13–15 years, or >15 years), total household gross income (<301,000 NOK; 301,000–750,000 NOK; >750,000 NOK), living arrangement (living with someone or alone), municipality (described in Brustad et al. [2014] [25]), and ethnicity. The ethnicity report (Norwegian, Sámi, Kven, and/or "other") included home language (respondent, parents, and all grandparents), ethnic background (respondent and both parents), and self-ascription. The final ethnic categories were "non-Sámi self-ascription" (89.7% unmixed Norwegian self-ascription and 7.1% non-Norwegians), "Sámi self-ascription", and "Sámi background without Sámi self-ascription" (95.4% Norwegian self-ascription), considering the effect of assimilation [31]. The Kvens (n=349), being few and mainly ethnically mixed (85.1%), were divided between the non-Sámi (n=125), the Sámi (n=162), and the Sámi background groups (n=62).

Table 1. Sample description showing the differences in religious/spiritual factors across gender and ethnic categories.

	Total		Gender: Male		Gender: Female		Gender comparison	Ethnicity: Non-Sámi		Ethnicity: Sámi self-ascription		Ethnicity: Sámi family background[c]		Ethnic comparison
	(*n* = 11,222)		(*n* = 4,952)		(*n* = 6,270)			(*n* = 7,399)		(*n* = 2,266)		(*n* = 1,557)		
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**	χ^2	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	χ^2
Religious/spiritual factors														
Family background							<0.1†							1141.7***
Laestadian family background	2,323	23.08	1,009	23.12	1,314	23.06		834	**12.72**	907	**43.29**	582	**41.28**	
Other family background	7,740	76.92	3,356	76.88	4,384	76.94		5,724	**87.28**	1,188	**56.71**	828	**58.72**	
Congregational affiliation[a]														
Established Church	9,354	86.05	4,125	86.46	5,229	85.74	1.2†	6,053	**84.55**	1,954	**88.70**	1,347	**89.32**	39.7***
Laestadian congregation	448	4.12	199	4.17	249	4.08	0.1†	155	**2.17**	180	**8.17**	113	**7.49**	204.1***
Other religious congregation	395	3.63	151	**3.16**	244	**4.00**	5.3*	294	**4.11**	59	**2.68**	42	2.79	13.4**
Non-religious denomination	366	3.37	150	3.14	216	3.54	1.3†	267	**3.73**	60	2.72	39	2.59	8.5*
No denomination	938	8.63	433	9.08	505	8.28	2.1†	662	**9.25**	166	**7.54**	110	**7.29**	10.2**
Religious attendance rate[b]							73.0***							37.2***
Never or rarely (not past 6 months)	3,127	28.18	1,571	**32.05**	1,556	**25.12**		2,135	**29.19**	549	**24.42**	443	28.86	
Irregularly (1–6 times past 6 months)	5,400	48.67	2,315	**47.24**	3,085	**49.80**		3,584	49.01	1,127	50.13	689	**44.89**	
Regularly (once pr. month or more past 6 months)	2,569	23.15	1,015	**20.71**	1,554	**25.08**		1,594	**21.80**	572	**25.44**	403	**26.25**	
Religious importance and view of life							222.2***							118.9***
I do not believe there is any god	1,882	16.96	1,047	**21.35**	835	**13.49**		1,358	**18.57**	293	**13.06**	231	**15.00**	
Unsure	2,083	18.77	1,050	**21.41**	1,033	**16.69**		1,473	**20.15**	353	**15.73**	257	**16.69**	
I believe there is a god, but religion is not so important in my everyday life	5,352	48.24	2,193	**44.72**	3,159	**51.03**		3,447	**47.15**	1,121	49.96	784	**50.91**	
Religious (I am a believer/confessing Christian)	1,778	16.03	614	**12.52**	1,164	**18.80**		1,033	**14.13**	477	**21.26**	268	17.40	

n = number of observations; Freq. = frequency; χ^2=χ^2-value. Bold values represent cells having adjusted residuals of *p*-value≤0.05.
* = *p*-value≤0.05; ** = *p*-value≤0.01; *** = *p*-value≤0.001; † = not significant.
[a]Multiple affiliations possible.
[b]At a church, congregation house, or religious building.
[c]Without Sámi self-ascription.

Health-related control variables

Both Laestadian and many other religious groups endorse health-related norms, e.g. related to alcohol and substance use and extramarital sexual intercourse, and social modelling of healthy behaviours might reduce the risk of suicidal behaviour in such settings [1]. To adjust for this effect in our analyses, we included five important health-related control variables. First, tobacco use and alcohol consumption are well-known risk factors for suicidal behaviour [32,33] and relevant confounders when studying a temperance movement like Laestadianism. Also, alcohol consumption is a known partial mediator of the protective effect of religious attendance on completed suicides [4]. Furthermore, SRH is a measure of general health, and poor SRH is a risk factor for suicide [22] and associated with suicidal thoughts in Sámi adolescents in Norway [34]. Finally, depression and anxiety disorders and exposure to emotional, physical, or sexual violence are well-known strong risk factors for suicidal behaviour [21] and relevant confounders explaining the low prevalence of suicidal behaviour in R/S social settings. Also, depressive symptoms partly mediate the protective effect of religious attendance on completed suicides [4].

Lifetime exposure to emotional, physical, or sexual violence was reported separately for the past year, earlier in adulthood, and during childhood and finally merged into a dichotomous variable of lifetime violence exposure [24].

Anxiety and depression symptoms were defined as a score above the clinical cut-off level (1.85) on the Hopkins Symptom Checklist (10-item version) during the past four weeks [35]. The instrument and its cut-off level are validated for Norwegian and Sámi populations and subgroups having Sámi family background without Sámi self-ascription [36].

Smoking and snuffing were tapped separately (“never”, “former”, “sometimes”, or “daily”) and finally pooled and categorised as “never or previously” (snuffing or smoking), “current cigarette or snuff user” (either snuffing or smoking – daily or occasionally), or “current dual user” (snuffing *and* smoking – daily or occasionally).

Drinking frequency during the past year was reported on an eight-point scale from “never consumed alcohol” to “4–7 times a week” and finally categorised as “never or not in the past year”, “a few times to weekly”, or “more than two times per week”.

SRH was reported on a four-point scale from “poor” (1) to “very good” (4) and dichotomised into “good” (“good” or “very good”) or “poor” (“poor” and “not so good”).

Statistical analyses

Using Stata 16 and a significance level of five percent, we applied chi-square tests to compute differences across categorical data and conducted t-tests and Bonferroni tests for the continuous data. Mixed-effect logistic regression models – including sociodemographic and health-related risk factors – were used to estimate the association of the different R/S categories with suicide ideation, attempts, and suicide motives. Municipality was added as a random effect in the analyses, taking local clusters of suicidal behaviour and assumed, unmeasured differences into account, including variations between the Laestadian groups.

Ethical considerations

The Norwegian Regional Committees for Medical and Health Research Ethics approved this study (reference code 2006/1766/REK nord).

Results

Sample description

The lifetime prevalence of suicide ideation in the total sample was 17.6% (Table 2), whereas 4.0% – 447 responders – reported lifetime prevalence of suicide attempts. Among those reporting suicide attempts, the mean age for the first attempt was 23.01 years (SD 11.30, not tabulated), and the mean total number of attempts was 2.62 (SD = 4.00). The most frequent motive for suicide attempts – reported by 93.9% – was that the situation felt unbearable (not tabulated). Overall, 56.0% reported a clear wish to die as a suicide motive, being more frequent among males (66.1%) than females (50.0%, $\chi^2[1] = 7.4$, $p = 0.007$). In total, 59.0% reported having made attempts that were calls for help, more frequently reported by females (64.5%) than males (48.1%, $\chi^2[1] = 7.7$, $p = 0.006$).

The sample comprised 86.1% Established Church-affiliated individuals, 4.1% Laestadian adherents, 3.6% affiliated with other congregations, 8.6% unaffiliated, and 3.4% affiliated with non-religious denominations (Table 1). Overall, 23.1% had a Laestadian family background (21.3% either Laestadian family background or personal adherence, not tabulated). The rates of regular religious attendance and religious self-ascription were 23.2% and 16.0%, respectively (Table 1).

In both Sámi categories, the frequency of Laestadian adherence was four times higher, and the frequency of Laestadian family background more than three times higher than among the non-Sámi. The regular attendees were also more common among those with Sámi

Table 2. Odds ratios for lifetime suicide ideation and attempts and want for help as suicide motive in unadjusted and multivariable-adjusted models

	Lifetime suicide ideation				
			Unadjusted		Fully fitted model*†
					n=8,305
Religious/spiritual factors	n	%	OR	(95% CI)	OR	(95% CI)
Total sample	1,964	17,57				
Family background			*n*=10,019			
Other background	1,431	18.57	1.00		1.00	
Laestadian background	370	15.99	**0.83**	(0.74 – 0.95)	0.86	(0.72 – 1.03)
Congregational affiliation[1]			*n*=10,825			
All other affiliations			1.00		1.00	
Established Church	1,506	16.17	**0.56**	(0.49 – 0.64)	**0.59**	(0.40 – 0.87)
Laestadian congregation	50	11.19	**0.58**	(0.43 – 0.79)	0.84	(0.55 – 1.29)
Other religious congregation	88	22.34	**1.38**	(1.08 – 1.75)	0.89	(0.56 – 1.42)
Non-religious denomination	92	25.21	**1.62**	(1.27 – 2.06)	0.97	(0.62 – 1.53)
No denomination	250	26.82	**1.84**	(1.58 – 2.15)	0.82	(0.55 – 1.23)
Religious attendance rate[2]			*n*=11,050			
Never or rarely (not past 6 months)	698	22.44	1.00			
Irregularly (1–6 times past 6 months)	860	15.98	**0.66**	(0.59 – 0.73)	**0.82**	(0.71 – 0.96)
Regularly (once pr. month or more past 6 months)	388	15.17	**0.62**	(0.54 – 0.71)	**0.74**	(0.61 – 0.91)
Religious importance and view of life			*n*=11,049			
I do not believe there is any god	411	21.94	1.00			
Unsure	373	17.97	**0.78**	(0.67 – 0.91)	1.04	(0.84 – 1.29)
I believe there is a god, but religion is not so important in my everyday life	839	15.73	**0.66**	(0.58 – 0.76)	1.07	(0.88 – 1.31)
Religious (I am a believer/confessing Christian)	331	18.73	**0.82**	(0.70 – 0.96)	1.28	(0.99 – 1.66)

	Lifetime suicide attempts						Want for help as suicide motive‡					
			Unadjusted		Fully fitted model*†				Unadjusted		Fully fitted model*†	
					n=8,314						n=247	
Religious/spiritual factors	n	%	OR	(95% CI)	OR	(95% CI)	n	%	OR	(95% CI)	OR	(95% CI)
Total sample	447	4.00										
Family background			*n*=10,033						*n*=291			
Other background	338	4.38	1.00		1.00		141	58.51	1.00		1.00	
Laestadian background	76	3.29	**0.74**	(0.58 – 0.96)	**0.66**	(0.47 – 0.93)	32	64.00	1.26	(0.67 – 2.37)	1.06	(0.41 – 2.71)
Congregational affiliation[1]			*n*=10,836						*n*=292			
All other affiliations			1.00		1.00				1.00		1.00	
Established Church	320	3.43	**0.49**	(0.39 – 0.62)	**0.44**	(0.21 – 0.93)	133	60.73	1.08	(0.63 – 1.85)	**0.03**	(0.00 – 0.63)
Laestadian congregation	10	2.25	0.56	(0.30 – 1.05)	0.70	(0.29 – 1.70)	6	85.71	4.06	(0.48 – 34.16)	1.95	(0.14 – 27.99)
Other religious congregation	30	7.69	**2.14**	(1.45 – 3.14)	0.90	(0.38 – 2.14)	10	66.67	1.34	(0.45 – 4.02)	**0.02**	(0.00 – 0.66)
Non-religious denomination	24	6.58	**1.78**	(1.16 – 2.73)	0.68	(0.30 – 1.54)	9	47.37	0.57	(0.22 – 1.45)	0.12	(0.01 – 2.49)
No denomination	62	6.62	**1.88**	(1.42 – 2.48)	0.55	(0.26 – 1.14)	28	57.14	0.86	(0.46 – 1.59)	0.06	(0.00 – 1.13)
Religious attendance rate[2]			*n*=11,066						*n*=304			
Never or rarely (not past 6 months)	167	5.36	1.00				68	53.54	1.00			
Irregularly (1–6 times past 6 months)	160	2.97	**0.54**	(0.43 – 0.67)	0.83	(0.62 – 1.11)	66	58.41	1.22	(0.73 – 2.03)	0.96	(0.46 – 1.97)
Regularly (once pr. month or more past 6 months)	110	4.30	0.79	(0.62 – 1.02)	1.28	(0.90 – 1.80)	44	68.75	**1.91**	(1.01 – 3.60)	1.08	(0.46 – 2.53)
Religious importance and view of life			*n*=11,064						*n*=306			
I do not believe there is any god	95	5.05	1.00				28	35.44	1.00			
Unsure	79	3.79	0.74	(0.55 – 1.01)	1.03	(0.70 – 1.53)	40	70.18	**4.29**	(2.06 – 8.90)	**7.00**	(2.55 – 19.20)
I believe there is a god, but religion is not so important in my everyday life	200	3.75	**0.73**	(0.57 – 0.94)	0.94	(0.65 – 1.36)	83	63.36	**3.15**	(1.76 – 5.64)	**3.17**	(1.28 – 7.85)
Religious (I am a believer/confessing Christian)	70	3.96	0.78	(0.57 – 1.06)	0.86	(0.53 – 1.39)	29	74.36	**5.28**	(2.25 – 12.41)	**4.74**	(1.37 – 16.38)

*Adjusted for ethnicity, age, sex, education level, total household income level, living arrangement, tobacco use, drinking frequency past year, self-rated health, anxiety and depression symptoms, and lifetime exposure to emotional, physical, or sexual violence. For simplicity, the control variables are not shown in the table. OR=odds ratio (95% confidence interval). †=mixed-effect logistic regression models where municipality is included as a random effect. The bold values are significant with *p*-value≤0.05. ‡=Among suicide attempters. [1]Multiple affiliations possible. [2]At a church, congregation house, or religious building.

identity or background, as were those of religious self-ascription. The proportion of the Laestadian adherents reporting regular religious attendance (80.0%) was more than three times higher than that of the Established Church-affiliated (23.3%, not tabulated). Also, the percentage of self-ascribed religious among the Laestadians (77.0%) was almost five times higher than among the Established Church members (15.6%, not tabulated). Moreover, the Laestadians typically reported affiliation with the Established Church (80.6%, not tabulated). Established Church membership was more common among the participants of Laestadian family background (90.6%) than in those from non-Laestadian families (84.8%, $\chi^2[1] = 48.0$, $p < 0.001$, not tabulated).

Laestadianism was associated with some unfavourable sociodemographic factors, also after ethnic stratification. Compared with those of other family circumstances, the respondents with a Laestadian *family background* had a lower income and education level (mean 13.3 years vs. 13.6, $t[9{,}974] = 3.55$, $p < 0.001$, not tabulated). They also had a higher frequency of alcohol abstainers, but this finding was insignificant after stratification on personal Laestadian adherence (not tabulated). Moreover, violence exposure was more frequent in those of Laestadian family background. However, after ethnic stratification, this association – the effect size being small – was only found among persons of Sámi self-ascription ($\chi^2[1] = 5.4$, $p = 0.020$, not tabulated), indicating an ethnic confounder. Participants of Laestadian family background were also more often living alone, but the finding was insignificant after stratification by age groups (not tabulated). The Laestadian *adherents* also had a lower income and education level (mean 12.3 years vs. 13.5, $t[10{,}765] = 6.83$, $p < 0.001$, not tabulated), compared with the non-Laestadians. However, they were also more frequently abstainers from tobacco and alcohol (ESM Table S1). The Laestadians reported lower levels of SRH, but this was not significant after ethnic stratification (not tabulated).

Association between R/S factors and suicidal behaviour – unadjusted analyses

Among the respondents with a Laestadian family background, significantly fewer reported suicide ideation (16.0%) and attempts (3.3%) compared with those from non-Laestadian families (18.6% and 4.4%, respectively, Table 2). These findings also applied to the personal Laestadian adherents (11.2% suicide ideation) compared with the non-Laestadians (17.8% suicide ideation, not tabulated), yet the frequency of attempters was insignificantly lower. Compared with non-membership, Established Church affiliation was inversely associated with suicide ideation and attempts (Table 2) and border-significantly associated with a 2.86 years older age at the first suicide attempt (23.86 years, $F[1{,}399] = 4.55$, $p = 0.034$, not tabulated). The regular and irregular attendees were less likely to report suicidal ideation (16.0% and 15.2%, respectively) and attempts (3.0% and 4.3%, respectively, with the latter number being only borderline significantly lower) compared with the non- or rare attendees (22.4% and 5.4%, respectively). The total number of suicide attempts was 1.17 attempts lower among irregular and regular attendees pooled together than non- or rare attendees (3.29 attempts, $F[1{,}411] = 8.91$, $p = 0.003$, not tabulated). The regular attendees were border-significantly more likely to report their attempts being calls for help, compared to non- or rare attendees (Table 2). Non-belief was significantly associated with suicide ideation – compared with all other categories – and suicide attempts – compared with being a not so devoted believer. Non-believing attempters also more rarely reported having made attempts that were calls for help. The debut age was higher among the not so devoted believers compared to the non-believers, but the difference disappeared completely after stratification by age groups. R/S was not associated with suicide motives being a wish to die or an unbearable situation (not tabulated).

Logistic regression models for suicide behaviour in multivariable-adjusted models

Both irregular (OR = 0.82, Table 2) and regular (OR = 0.74) religious attendance were significantly inversely associated with lifetime suicide ideation compared with non- or rare attendance in the adjusted model. Laestadian adherents were less apt to report suicide ideation in a model adjusting for religious and sociodemographic factors (OR = 0.57, 95% CI: 0.39–0.82, not tabulated). However, this beneficial association was rendered insignificant after adjustment for health-related variables. The respondents of Laestadian family background were significantly less likely to report lifetime suicide attempts (OR = 0.66, 95% CI 0.47–0.93, Table 2) than those from non-Laestadian families. Compared with non- or rare attendance, irregular religious attendance was inversely associated with suicide attempts in a model adjusting for R/S and sociodemographic factors (OR = 0.72, 95% CI: 0.56–0.93, not tabulated). However, this favourable association became insignificant after adjustment for health-related variables. Compared with non-membership, Established

Church affiliation was inversely associated with suicide ideation and attempts in the adjusted model (Table 2).

Due to the considerably small total number of suicide attempters, adjusting for multiple control variables increased the risk of over-adjustment bias when testing the association of R/S with the motives for suicide attempts. Thus, we made the regression analyses by a careful, stepwise introduction of each control variable into the models. In the unadjusted analyses, only one R/S factor was significantly associated with a suicide motive. This association and its significance level remained stable through all steps: Compared with the non-believers, the non-atheist suicide attempters were three to eight times more likely to report having made attempts that were calls for help (Table 2). There was a border significant association ($p = 0.045$) between being a regular attendee and having a want for help as a suicide motive in the unadjusted test. However, the significance disappeared in the very next regression step. Also, in the very final step, Established Church-affiliated and "other" affiliated had a border significant likelihood not to report having made attempts that were calls for help.

Discussion

Here, we studied the association of R/S factors with suicidal behaviour in a mixed Sámi-Norwegian adult sample using data from the population-based SAMINOR 2 Questionnaire Survey. The study applied multivariable-adjusted regression models controlling for religious, sociodemographic, and health-related factors. Following international research [2–5], we found that religious attendance was inversely associated with lifetime suicide ideation and fewer lifetime attempts. Laestadian family background was 34% less associated with suicide attempts than non-Laestadian family circumstances, whereas personal Laestadian adherence was not significantly associated with suicidal behaviour in the fully adjusted models. Both Sámi- and Laestadian-affiliated individuals more frequently reported religious self-ascription, attendance, and Established Church membership.

Laestadianism and other congregational affiliations, and suicidal behaviour

The Laestadian movement is a diverse phenomenon globally, within the Arctic region, and locally, and its significance on the personal level varies considerably. Still, this study applies crude categories like personal Laestadian adherence or non-adherence and Laestadian or non-Laestadian family background. However, up to the present, measures of Laestadian affiliation in epidemiological studies have predominantly been pooled variables of personal and parental adherence [14] and even grandparents' affiliation with the movement [20,24]. Our variables enable us to discriminate between the correlates of personal Laestadian adherence and Laestadian family background, including Laestadianism as a broader psycho-socio-cultural phenomenon. Also, the SAMINOR 2 study area included all three main Laestadian subgroups represented in Norway, the Alta, Lyngen, and Ofoten groups [37], named according to their geographical distribution. However, no theological analyses indicate differences in the application of norms related to suicidal behaviour among these groups. Nonetheless, using municipality as a random effect in the regression analyses, we could take unmeasured differences between the Laestadian subgroups into account.

The considerable correlation between Laestadianism and Sámi affiliation in this study sample necessitates a careful adjustment for ethnicity, especially considering the association between Sámi family background without Sámi self-ascription and Laestadian affiliation. The definition of Sámi ethnicity differs across the published studies, some demanding both Sámi language competence in the family *and* Sámi self-ascription [20,24], others requiring either Sámi parentage, family language competence, *or* self-ascription [14,17,18]. Eriksen et al. (2015, also SAMINOR 2 data) – finding higher exposure to violence among persons of Laestadian family background in their adjusted models – included only self-ascribed Sámi in their Sámi category, not considering the many respondents of apparent Sámi family background in their non-Sámi category. Thus, their finding and the earlier reported lower levels of SRH in Laestadians [23] might have been confounded by Sámi minority background. However, the association between Laestadianism and some disadvantageous socioeconomic factors in our sample – like lower income and education level – could not be explained by ethnicity alone.

Furthermore, the high frequencies of membership in the Established Church of Norway among the persons of Laestadian adherence and family background indicate no tendency of separation from the Established Church among the Laestadian-affiliated in this sample. On the contrary, the finding suggests that Laestadianism contributes to the social integration of Sámi and non-Sámi adherents into the wider Norwegian community. This acculturation strategy is a possible result of the movement's implementation of the Lutheran "two kingdoms" doctrine: accepting secular laws and taking an active part in society except when doing so compromises one's convictions [38,39].

We also found a beneficial relationship between Laestadian adherence and lifetime suicidal behaviour, and such relation seemed to be mediated or confounded by differences in health-related factors. This probably mediating effect was not explored by further analyses. However, in our sample, Laestadian adherence was inversely associated with suicidal risk factors, such as tobacco [21] and alcohol use [32]. The beneficial effects of Laestadianism on alcohol consumption have been studied earlier [14], and alcohol intoxication is known to be related to suicide attempts in Sámi adolescents in particular [40].

Furthermore, the respondents of Laestadian family background – independently of personal Laestadian adherence, religious participation, and belief – were significantly less likely to report suicide attempts. This finding – being independent of sociodemographic and health-related factors – might be due to psychosocial benefits connected to the movement's strong family and social networks [14,41,42]. Strong social and family ties and a firm belief are elements known to buffer risk factors, such as discrimination and acculturative stress in other R/S and ethnic minorities [43–45]. The kind of social support possibly associated with Laestadian family background – although not being assessed in the SAMINOR 2 Study – might represent benefits not gained by Laestadian congregational adherence alone.

Also, in contrast to the situation among indigenous Canadians, where Christian mission to a considerable degree destroyed the native culture and family structure and fostered distrust towards Western religions [9], the Laestadian version of Christianity established firm roots among the Sámi people by the ministry of their kin in their mother tongue [12]. The traditional Sámi *siida* societies' social and family ties were preserved and employed within the Laestadian communities [42].

However, this study did not adjust for other kinds of social support, except for living alone or with someone. For example, the social and family networks within the Sámi reindeer-herding communities [46] may protect against suicide risk in some contexts [16]. Also, the higher R/S measures in the Laestadian- and Sámi-affiliated individuals might be partly due to their relation with rural areas, typically associated with higher R/S involvement [13,29].

Finally, compared with non-membership, Established Church affiliation was significantly inversely associated with lifetime suicide ideation and attempts. However, this finding is probably due to its dominating status (86% of the sample reporting being members), representing the ethnic Norwegian majority population. In contrast, being a non-member of the Established Church in this context may indicate non-Sámi ethnic or R/S minority status, social marginalisation, or less integration, circumstances typically associated with risk factors for suicidal behaviour. Also, Established Church-affiliation was not associated with high levels of R/S, only 16% being self-ascribed religious and 23% reporting regular religious attendance. Thus, any association between Established Church membership and mental health is probably not due to R/S factors.

Religious attendance and suicidal behaviour

Although the religious attendees reported *fewer* suicide attempts, the analyses suggest health-related circumstances might mediate a possible impact of religious attendance on lifetime suicide attempts. However, we did not test such mediation effect, but, for instance, non- or rare attendees more frequently reported risk factors, such as violence exposure and anxiety and depression symptoms [21]. Also, depressive symptoms are earlier found to partly mediate the protective effect of religious attendance on completed suicides [4]. The negative association between religious participation and lifetime suicide *ideation* in our sample was independent of sociodemographic, health-related, and other R/S factors. This finding follows a large amount of research exhibiting the protection of religious attendance against not only suicide ideation and attempts but also completed suicides [3–5]. Although this effect is found to be independent of social integration [6], a well-known protective factor against suicide attempts [6], the suicide-protective component of R/S seems to lie in its social dimensions. Same-faith social bonds are significantly more likely sources of help during challenging times [47]. Perceived and anticipated emotional support from one's fellowship of believers is the only aspect of R/S social support that is significantly associated with reduced suicidal behaviour[48]. The comfort of *knowing* about this available support strengthens one's mental health more than does the level and intensity of the contact [48].

Religious importance and view of life, and suicidal behaviour

We did not find any association between religious importance and belief and suicide ideation or attempts in our adjusted models. These findings align with previous evidence showing no protective effect of R/S importance or strength on completed suicides [3] or major depression [49] after controlling for social network or religious attendance, although it is inversely associated with the risk factors, such as alcohol abuse, in this population [14]. Suicidal behaviour was not

reported more frequently by the believers. On the contrary, in both the unadjusted and adjusted models, being a *non*-believing suicide attempter was strongly associated with *not* having called for help through an attempt. This phenomenon might represent the feeling of hopelessness and entrapment characterising the suicidal state – the vicious spiral and tunnelling of vision, where the attempter sees no alternative to the suicide [50,51]. The non-atheists, on the contrary, seem to have retained hope of relief and help [48] or R/S objections against suicide [7].

Strengths and limitations

The survey's considerably low response rate (27%) is an obvious limitation that might have caused a selection bias. It raises the question of our study's external validity and generalisability, and the results must be interpreted with caution [25]. Still, SAMINOR 2 is the numeric most extensive population-based study (n = 11,222) in mixed Sámi-Norwegian areas, tapping both R/S factors and suicidal behaviour and adding essential knowledge to the limited research field of R/S and mental health in this region. Although the cross-sectional study design cannot determine any causal relationships, our main findings are in line with international longitudinal studies on the topic. However, SAMINOR 2 lacks information about marital/relationship status, which is associated with less suicidal behaviour [6,9]. There may also be an under-reporting of suicidal behaviour among more devoted Christians, particularly Laestadians, due to moral objections [7], affecting the internal validity of our results. Further, this study focuses on the sociological dimensions of organised traditional and Pietist Lutheranism, leaving out the assessment of less organised and non-Christian Sámi spirituality.

Conclusion

Religious participation seems to be protective against suicidal behaviour among adults in Sámi-Norwegian areas. Despite Laestadianism's association with some disadvantageous socioeconomic factors, like lower income and education level, Laestadian family background and adherence seem to contribute to less suicidal behaviour in the mixed Sámi-Norwegian population.

Acknowledgments

UiT professor Tom Wilsgaard and senior engineer Marita Melhus for statistical advice.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

Finnmark Hospital Trust [2015/2236–2];Sami Norwegian National Advisory Unit on Mental Health and Substance Use [06/2017, 12/2017, and 06/2019];

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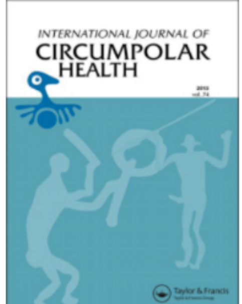
Paper II

Paper III



International Journal of Circumpolar Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zich20

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To cite this article: Henrik Kiærbech, Ann Ragnhild Broderstad, Anne Silviken, Geir Fagerjord Lorem, Roald E. Kristiansen & Anna Rita Spein (2023) The association of religious factors with mental health-service utilisation and satisfaction in a mixed Sámi and Norwegian adult population: Adopting the SAMINOR 2 Questionnaire Survey, International Journal of Circumpolar Health, 82:1, 2223422, DOI: 10.1080/22423982.2023.2223422

To link to this article: https://doi.org/10.1080/22423982.2023.2223422

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Published online: 18 Jun 2023.

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INTERNATIONAL JOURNAL OF CIRCUMPOLAR HEALTH
2023, VOL. 82, 2223422
https://doi.org/10.1080/22423982.2023.2223422

ORIGINAL RESEARCH ARTICLE

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The association of religious factors with mental health-service utilisation and satisfaction in a mixed Sámi and Norwegian adult population: Adopting the SAMINOR 2 Questionnaire Survey

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ABSTRACT

The Indigenous Sámi have poorer mental health than the majority population and fairly equal access to professional mental healthcare. Despite this condition, certain studies indicate that this group is underrepresented among the users of such services. Religion or spirituality (R/S) often influences mental health-service utilisation and satisfaction among other Indigenous peoples and ethnic minorities. Thus, this study examines the situation in Sámi-Norwegian areas. We utilised cross-sectional data from the population-based SAMINOR 2 Questionnaire Survey (2012; sub-sample $n = 2{,}364$; 71% non-Sámi) in mixed Sámi-Norwegian regions of Northern and Central Norway. We analysed the associations between R/S factors and past-year mental health-service utilisation and satisfaction among individuals reporting mental health problems, substance use, or addictive behaviours. Multivariable-adjusted regression models considering sociodemographic factors, including Sámi ethnicity, were applied. Religious attendance was significantly associated with infrequent past-year use of mental health services (OR = 0.77) and fewer mental health problems, indicating that the R/S fellowship may buffer mental distress and represent an alternative psychological support to professional services. R/S was not significantly associated with lifetime mental health-service satisfaction. We found no ethnic differences in service utilisation or satisfaction.

ARTICLE HISTORY
Received 14 February 2023
Revised 6 June 2023
Accepted 6 June 2023

KEYWORDS
Mental health-service utilisation; mental health-service satisfaction; religion; Sámi; Indigenous; SAMINOR 2

Introduction

The Sámi are Indigenous people of the northern and central regions of Norway, Sweden, and Finland and the Russian Kola Peninsula. Although their total number is difficult to assess, a crude estimation is 80,000–115,000, of whom the assumed largest portion of Sámi lives in Norway [1]. Historically, the Norwegian government subjected the Sámi to an intensive Christian missionary activity from the early 18th century. From the latter part of the 19th century, the Nordic Arctic region was strongly influenced by the teetotalist Christian Laestadian revival movement, named after the Swedish Lutheran state church vicar Lars Levi Laestadius (1800–1861). The movement originated about 1845 in the Finnish-Sámi population of Swedish and Finnish Lapland and was brought by Sámi and Finns to their ethnic peers in Norway. Only later, Laestadianism spread to the Swedish and Norwegian populations [2]. During the enforced Norwegian governmental assimilation programme from about 1850 to about 1980 [3], Sámi and Finns/Kvens (a national Finnish minority in North Norway) found acceptance of their native language and culture in the movement [4]. In Arctic Norway, Laestadianism is an acculturative phenomenon different from Laestadianism in other parts of the world and is still associated with Sámi ethnic minority affiliation [5].

Similar to other Indigenous peoples, the Sámi have poorer mental health than the majority population in their region, e.g. more prevalent suicidal behaviour [6–9], anxiety, depression, posttraumatic stress, and exposure to emotional, physical, and sexual violence during childhood [10]. Despite these conditions and fairly equal access to mental health services [11], the Sámi are underrepresented among users of mental health services in Northern Norway, e.g. in treatment facilities

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for alcohol and substance abuse [12], and among Sámi adolescents with behavioural problems [13]. However, these studies are few and partly old, showing low generalisability. An analysis of the somatic healthcare expenditure showed no significant differences between the Sámi and non-Sámi municipalities in Norway [11]. Another study on the mental health services in the district of Finnmark found neither drop-out rates nor patients' perception of therapeutic alliance related to ethnicity [14]. However, in the large population-based 2003–2004 SAMINOR 1 Study, Sámi-speaking patients are less satisfied with their local general practitioner than Norwegian-speaking patients [15]. On the contrary, the use of traditional healing, often involving prayers or the laying on of hands [16], is more frequent among the Sámi than non-Sámi psychiatric in- and outpatients in Sámi-Norwegian areas [17,18]. Among Sámi psychiatric patients, users of traditional healing give greater importance to religion and spirituality in dealing with illness than non-users [18]. Moreover, the Sámi are more often Christians, religiously active, and affiliated with the Laestadian Revival Movement than non-Sámi in the region [5,19]. Among Sámi, mental diseases and their causes are sometimes perceived differently than in the majority population and believed to represent punishment from God or evil spirits sent by other persons [20]. In the Sámi areas, traditional healing plays a significant role in the local society and is a well-known and accepted healthcare modality among local professional health workers [16]. This healing tradition is a religious or spiritual phenomenon. The religion of the Sámi was the animist *Noaidevuohta* until the completion of the Christian mission in the 17th and 18th centuries [21]. Nevertheless, the present Sámi healing institution is an integrated part of the Christian cultural heritage, and many Laestadian leaders are respected healers [22,23].

Following contemporary scholars, we define religion or spirituality (R/S) as a multilevel-multidimensional concept encompassing culture, identity, relationship, and practice. Religion typically means the external and organised aspects of faith traditions, whereas spirituality usually connotes the internal and personal dimensions of belief, also outside organised religion [24].

Despite having poorer mental health, Indigenous peoples and other ethnic minorities are often underusers of mental health services [25–28] or have an increased risk of disengaging from treatment [29]. This phenomenon is often due to language and cultural barriers, the lack of culturally sensitive services, alternative aetiological conceptions of mental diseases, social stigma, and mistrust towards Western psychiatry [25,26,30]. R/S is often an essential factor of attitudes towards mental health services among Indigenous peoples and other ethnic minorities [25,30–38]. Among American Indians, traditional healing is a significant and independent source of healthcare, particularly for mental health problems. The prevalence of its use in this population is much higher than the utilisation of complementary and alternative medicine in non-American Indian samples [25]. The use of traditional healing in these Indigenous contexts is associated with high spirituality and strong American Indian identity scores [25]. There is little research on other Indigenous peoples regarding R/S and mental health-service use, but among another ethnic minority, African Americans, the Church is a strong social, psychological, and religious support system [31]. They are the most religiously active ethnic group in the US [32]. Their religious counselling services for mental health problems are an important substitute for and often preferred to professional mental health treatment in this population [31,32].

Although little is published about Indigenous populations on R/S and attitudes towards mental health services, the literature we reviewed finds two main rationales for the association between R/S and negative attitudes towards or the insufficient use of professional mental healthcare in other ethnic minorities and religious contexts. The first explanation is having religious or spiritual beliefs about the aetiology of mental diseases, as found in the studies on ethnically mixed samples of Muslim and Asian minorities in Western countries, being the most studied groups. Professional help-seeking often depends on a scientific perception of mental disorders [30,33,38]. The second reason is the belief in or use of R/S methods of handling mental health problems. For example, positive religious coping, finding spiritual meaning in the suffering, and the belief in the efficacy of R/S counselling for mental health problems are common among ethnic minorities and religious contexts like Filipino Americans [35], Latino Americans [36], and American rural veterans, respectively [39]. However, studies on the association between R/S and the use of and attitudes towards mental health services show differing results. In certain studies, the importance of R/S is associated with negative attitudes towards or insufficient use of mental health services, e.g. among American adolescents [40] and African Americans [32]. In other populations, the importance of R/S is related to the frequent use of professional mental health services, as in African immigrants in the US [41]. Other studies find no such correlations, e.g. the American rural veteran study [39], another African American study [42], and a survey of a small sample ($N = 119$) of Canadian Latter Day Saints [43].

Furthermore, church attendance is associated with the use of mental health services among Korean women but not in Korean men [44], the latter African American sample [42], nor in the small sample of Canadian Latter Day Saints [43].

This study examines the association between R/S and mental health-service satisfaction and utilisation in a Nordic and Arctic context. Due to certain under-representation of Sámi among users of mental health services in Northern Norway [12,13], along with the importance of R/S and traditional healing in this population, we aimed to examine the association between R/S factors and mental health-service utilisation and satisfaction in Sámi-Norwegian areas.

Methods

Procedure and sample

This study used data from the second wave of the "Population-based Study on Health and Living Conditions in Regions with Sámi and Norwegian Populations – The SAMINOR 2 Questionnaire Survey". Following the 2003–2004 SAMINOR 1 Survey, this study was conducted in 2012 by the Centre for Sámi Health Research, UiT – The Arctic University of Norway [45]. All residents aged 18–69 years in 25 municipalities and districts with mixed Sámi and Norwegian settlements in Central and Northern Norway received the invitation. The response rate was 27%, resulting in a sample of 11,600 participants (68.7% from Finnmark, 18.0% from Troms, 7.8% from Nordland, and 5.5% from Trøndelag districts). To solve our research questions, we needed a study sample including only users and potential users of mental health services. Thus, we excluded respondents who reported no past-year mental health problems, substance use, addictive behaviours, or mental health-service utilisation or satisfaction score and did not answer questions regarding R/S. The present study subsample of The SAMINOR 2 Questionnaire Survey comprised 2,364 participants (Figure 1), with 55.3% female and 28.6% Sámi.

Instruments and variables

Outcome variables: mental health-service utilisation and satisfaction

The questionnaire tapped the respondents' past-year use of mental health services: "During the past 12 months, have you been examined or treated for mental health problems at a psychiatric hospital, district psychiatric center, private specialist, or none?" The respondents could mark separately for the different categories. We summarised the positive answers and set a dichotomous past-year utilisation variable (yes vs. no). Users of mental health services, including previous years, could answer the question, "All in all, how satisfied are you with the care and treatment you received?" The respondents checked off on a Likert scale from 0 ("least satisfied") to 10 ("most satisfied"). We dichotomised the answers in a variable of mental health-service

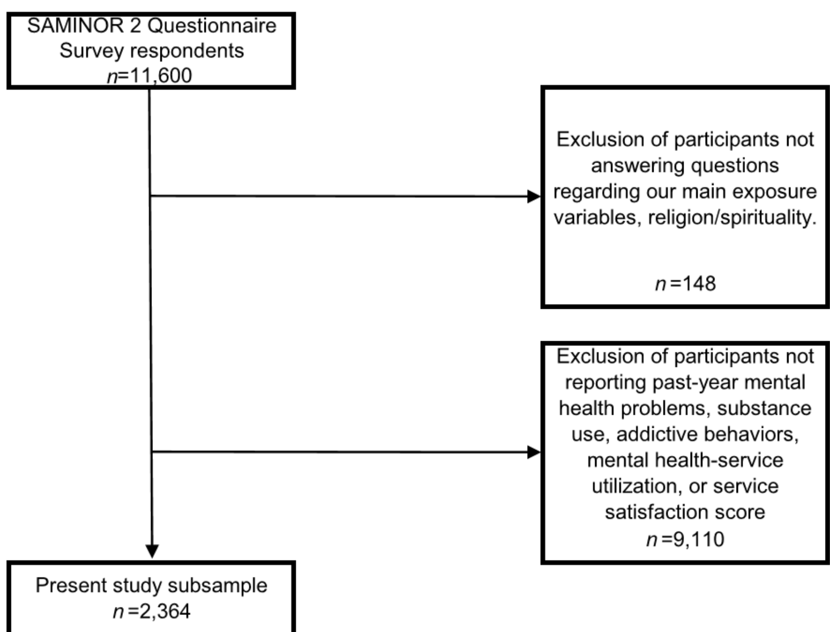

Figure 1. Flow chart of inclusion.

satisfaction: "least satisfaction" (0–5) or "moderate to large satisfaction" (6–10).

Independent variables: religious/spiritual factors

We used the two measures of general R/S, which are appropriate to a religiously homogeneous population dominated by traditional Lutheranism [5,46,47].

The view of life and the importance of religious beliefs comprised four categories [19] "I am a believer/confessing or personally Christian" ("religious"); "I believe there is a god, but religion is not so important in my everyday life" ("less devoted believer"); "Unsure"; "I do not believe there is any god" ("non-believer").

Religious attendance rate during the past 6 months at (a) a church, (b) congregation house, or (c) other religious building was reported separately as "more than 3 times a month", "1–3 times a month", "1–6 times", or "never". The total participation rate in all three building categories was pooled and dichotomised as "once or more often during the past 6 months" or "not during the past 6 months".

Due to the historical importance of Laestadianism as an R/S factor in the Sámi areas, information about the affiliation to a Laestadian congregation or Laestadian family background (a parent or grandparent having such affiliation) was available [5]. However, the number of Laestadians included in our sample ($n = 76$) was low. Significance test of Laestadian affiliation and Laestadian family background ($n = 489$) revealed no significant association between these factors and our outcome variables in the bivariate and multivariable analyses. Thus, we did not include these variables in the presented models.

Control variables: past-year mental health problems and sociodemographic factors

To analyse mental health-service utilisation, we included only respondents revealing current mental health problems, substance use, or addictive behaviours. We defined mental health problems based on reports of at least one of the following difficulties: *past-year* suicide attempt, suicide ideation, or (non-suicidal) self-injury; or *past-month* anxiety and depression symptoms measured by a score above the clinical cut-off level of 1.85 on the Hopkins Symptom Checklist–10 (HSCL–10). This checklist is a short instrument consisting of two subscales, anxiety (5 items) and depression (5 items), giving a total score (from 0 to 4) measuring overall psychological distress and predicting mental disorder [48]. To allow for other mental health problems not revealed or covered by our questions, the numbers include all persons receiving mental health services for the past 12 months (extending the sample by 179 individuals). We defined substance use and addictive behaviours by reports of at least one of the following difficulties: *past-year* use of hashish and other illegal drugs, periodic drinking pattern, drinking more than three times a week, or problematic gambling behaviour (need to gamble with increasing amounts of money, lying to intimates about gambling activities, or returning to gamble after losing money) or *past-month* alcohol intoxication more than twice.

We included the following control variables in our analyses: sex, age, educational level (1–9 years; 10–12 years; 13–15 years; >15 years), total household gross income (NOK <301,000; NOK 301,000–750,000; NOK > 750,000; indicating socioeconomic status), municipality, and ethnicity. We based our ethnic categories (subjective criteria [49] on the participants' report of their ethnic self-ascription and personal ethnic background (Norwegian, Sámi, Kven, and "other" [any combination was possible]). Our final ethnic categories were "Sámi" (Sámi self-ascription or background, including 16.2% bi-ethnic Kvens) and "non-Sámi" (mainly ethnic Norwegians in addition to 4.1% Kvens) [49]. Sámi-speaking patients may be less satisfied with health services [15]. However, significance tests of Sámi as the home language ($n = 336$) showed no significant association between home language and the outcome variables in our bivariate and multivariable analyses. Therefore, we did not include Sámi home language in the presented models.

Statistical analyses

Using Stata 17 and a 5% significance level, we applied chi-squared tests to estimate the unadjusted total effect of the different R/S categories on mental health-service utilisation and satisfaction. Mixed-effect logistic regression models were used to measure the direct impact of R/S on service utilisation and satisfaction when adjusted for sociodemographic factors. For the regression models, the outcome variables were mental health-service utilisation and satisfaction, respectively. The model included the following low-level fixed variables: Religious attendance, religious importance, sex, age, ethnicity, educational level, and household income level. Municipality was added to the models as a high-level random group variable, including the effect of assumed, unmeasured local differences. We also made corresponding fixed-effect logistic regression analyses excluding municipality from the models. As these models did not change the main findings, we do not present these results. Finally, we tested for

interaction effects on mental health-service utilisation and satisfaction between the sociodemographic and R/S factors by including each R/S–sociodemographic factor interaction term in turn in the logistic regression models.

Ethical considerations

The Norwegian Regional Committees for Medical and Health Research Ethics approved this study (reference code 2006/1766/REK nord). The study is based on participant consent and follows the Declaration of Helsinki. The project adheres to the Ethical Guidelines for Sámi Health Research, adopted by the Sámi Parliament in 2019.

Results

Sample description

The overall sample prevalence of past-year mental health-service utilisation among persons reporting mental health problems, substance use, or addictive behaviours was 21.8% ($n = 488$), being almost twice as high in females (27.4%) than males (14.7%) and higher in the youngest age group (18–39 years: 25.1%) than in the oldest (55–69 years: 15.8%, Table 1). Of the total sample, 79.2% reported large to moderate satisfaction with mental health services, with significantly more females (82.2%) than males (73.7%) reporting satisfaction. Mental health-service utilisation and satisfaction did not differ significantly between Sámi and non-Sámi. Anxiety and depression symptoms (reported by 50% of the total sample), problematic drinking behaviour

Table 1. Sample description and bivariate analyses of mental health-service utilisation and satisfaction – subsample of The SAMINOR 2 Questionnaire Survey.

	Sample description		Past-year mental health-service utilization among persons with mental health problems[a] or substance use/addictive behaviors[b]			Lifetime mental health-service satisfaction[c]		
	n	%	*n*	%	χ^2	*n*	%	χ^2
Total sample	2,364	100,0	488	21.8	–	521	79.2	–
Religious/spiritual indicators								
Religious attendance rated								
Not during the past 6 months	831	35.5	181	22.4	0.6	173	74.9	3.5
Once or more often during the past 6 months	1,509	64.5	297	21.0		340	81.2	
Religious importance and view of life								
I do not believe there is any god	511	21.8	92	**18.5**	25.9***	96	77.4	1.0
Unsure	449	19.2	98	23.1		98	77.8	
I believe there is a god, but religion is not so important	995	42.5	183	**19.4**		205	79.8	
Religious (I am a believer/confessing Christian)	386	16.5	112	**31.4**		117	81.8	
Sociodemographic factors								
Sex								
Male	1,058	44.8	148	**14.7**	52.4***	171	**73.7**	6.5*
Female	1,306	55.3	340	**27.4**		350	**82.2**	
Age								
18–39 years	879	37.2	213	**25.1**	19.6***	207	78.4	1.4
40–54 years	808	34.2	175	23.0		182	77.8	
55–69 years	677	28.6	100	**15.8**		132	82.5	
Ethnicitye								
Non-Sámi	1,678	71.4	342	21.5	0.2	362	78.5	0.7
Sámi	672	28.6	143	22.4		157	81.4	
Educational level (years)								
1° or lower 2° school (1–9)	376	16.1	70	19.2	5.3	71	75.5	7.0
Upper 2° school (10–12)	621	26.6	119	20.6		136	76.0	
College or university (13–15)	657	28.1	132	20.9		131	77.1	
University (>15)	682	29.2	159	24.7		174	85.3	
Total household income (gross income)								
Low (NOK <301,000 NOK)	555	24.2	144	**27.6**	22.3***	140	**70.7**	13.6**
Intermediate (NOK 301,000–750,000)	1,163	50.7	239	21.8		262	81.1	
High (NOK >750,000)	574	25.0	88	**15.8**		101	**87.1**	

Notes: n=number of observations. Bold values are cells with adjusted residuals of *p*-value ≤0.05.
[a]*Past year* suicide attempts or ideation or self-injury; or *past month* anxiety and depression symptoms. To allow for other mental health problems not covered by our questions, the numbers include all persons receiving mental health services past 12 months.
[b]*Past year* use of hashish or illegal drugs, periodic drinking pattern, problematic gambling behaviour, or drinking 4 times or more per week; or *past month* alcohol intoxication 3 times or more.
[c]Large to moderate vs. least satisfaction. Rating includes lifetime use of mental services.
[d]At a church, congregation house, or religious building.
[e]Ethnic self-ascription. The non-Sámi group comprises mostly ethnic Norwegians and 4.1% Kvens. The Sámi group includes 16.2% biethnic Kvens.
*$p \leq 0.05$.
**$p < 0.01$.
***$p<0.001$.

Table 2. Sample description by types of mental health problems, substance use, and addictive behaviours ($n = 2,364$) – subsample of The SAMINOR 2 Questionnaire Survey.

	Ethnicity					Religious attendance					Religious importance and view of life									
	Non-Sámi $n = 1,678$		Sámi $n = 672$			Not during the past 6 months $n = 831$		Once or more often during the past 6 months $n = 1,509$			I do not believe there is any god $n = 511$		Unsure $n = 449$		I believe there is a god, but religion is not so important $n = 995$		Religious (I am a believer/ confessing Christian) $n = 386$			
Mental health problems, substance use, and addictive behaviors	*n*	%	*n*	%	χ^2	*n*	%	*n*	%	χ^2	*n*	%	*n*	%	*n*	%	*n*	%	χ^2	
Anxiety and depression symptoms[a]	826	49.2	357	53.1	2.9	420	50.5	753	49.9	0.1	235	46.0	221	49.2	513	51.6	206	53.4	6.1	
Problematic drinking behavior[b]	621	37.0	221	32.9	3.5	336	**40.4**	507	**33.6**	10.9***	223	**43.6**	172	38.3	349	35.1	94	**24.4**	37.1***	
Suicidal behavior or self-injury[c]	229	13.7	96	14.3	0.2	144	**17.3**	176	**11.7**	14.6***	89	**17.4**	63	14.0	117	**11.8**	56	14.5	9.2*	
Problematic gambling behavior[d]	92	5.5	51	7.6	3.7	53	6.4	87	5.8	0.4	36	7.1	22	4.9	57	5.7	26	6.7	2.4	
Drug use[e]	96	5.7	42	6.3	0.2	72	**8.7**	66	**4.4**	17.8***	65	**12.7**	23	5.1	36	3.6	12	**3.1**	58.9***	

Note: n=number of observations. Bold values are cells with adjusted residuals of p-value ≤0.05. Multiple mental health problems are possible; thus, the table adds up to more than 100%.
[a]Hopkins Symptom Checklist−10 score above cut-off level (1.85) past 4 weeks (vs. below cut-off or missing answer), predicting mental disorder.
[b]*Past-year* periodic drinking pattern or drinking 4 times or more per week; or *past month* alcohol intoxication 3 times or more (vs. non-problematic drinking behaviour or missing answer).
[c]*Past-year* suicide attempts or ideation, or self-injury (vs. no past-year reports or missing answer.).
[d]*Past-year* need to gamble with increasing amounts of money, lying to intimates about gambling activities, or returning to gamble after losing money (vs. non-problematic gambling behaviour or missing answer).
[e]*Past-year* use of hashish or illegal drugs (vs. no past-year reports or missing answer).
*$p \leq 0.05$.
**$p < 0.01$.
***$p < 0.001$.

(prevalence 36%), and suicidal behaviour or self-injury (prevalence 14%) were the most frequent mental health problems in the sample, independent of the R/S category (Table 2). Compared with religious attendees and believers, we found more suicidal behaviour or self-injury, problematic drinking behaviour, and substance use among the non-attendees and non-believers. No significant differences were noted in the prevalence of anxiety and depressive symptoms or problematic gambling behaviour between the R/S categories. Furthermore, we found no significant ethnic differences in the distribution of mental health problems, substance use, or addictive behaviours (Table 2).

Bivariate analyses and logistic regression models for past-year mental health-service utilisation and satisfaction in multivariable-adjusted models: religious/spiritual findings

In the bivariate tests, mental health-service utilisation was most frequent among the religiously self-ascribed respondents and least frequent among non-believers (Table 1). However, after a post hoc stratification on religious attendance, this difference was insignificant in the non-attending group (not tabulated). Also, religious self-ascription was only significantly associated with service use in the oldest age groups (not tabulated). Religious self-ascription remained significantly associated with more frequent use of mental health services in the adjusted model, compared with all other categories. However, following our bivariate findings, we found an interaction effect on service use between religious self-ascription and age (OR = 1.03 per year, 95% CI 1.00–1.05, not tabulated). Adding this interaction term in the model completely removed the association between religious self-ascription and the use of mental health services. Also, a post hoc Bonferroni test of the oldest age group revealed that the mean HSCL−10 score, i.e. the level of mental distress, among the religiously self-ascribed (1.92) was significantly higher than among the non-believers (1.58, $p < 0.001$), unsure (1.58, $p < 0.001$), and the not-so-devoted believers (1.92, $p = 0.016$, $F = 8.44$, not tabulated). There were no significant differences in HSCL−10 scores across religious importance and view of life in the other age groups.

Table 3. Odds ratios for mental health-service utilisation and satisfaction in multivariable-adjusted models – subsample of The SAMINOR 2 Questionnaire Survey.

	Past-year mental health-service utilization among persons with mental health problems[a] or substance use/addictive behaviors[b] (n=2,213)	Lifetime mental health-service satisfaction[c] (n=614)
	OR (95% CI)	OR (95% CI)
Religious/spiritual indicators		
Religious attendance rate[d]		
Not during the past 6 months	1.00	1.00
Once or more often during the past 6 months	**0.77**(0.60–0.97)*	1.38(0.87–2.19)
Religious importance and view of life		
I do not believe there is any god	1.00	1.00
Unsure	1.34(0.96–1.89)	0.83(0.44–1.59)
I believe there is a god, but religion is not so important	1.05(0.77–1.44)	1.01(0.55–1.86)
Religious (I am a believer/ confessing Christian)	**1.97**(1.38–2.83)***	1.04(0.51–2.14)
Sociodemographic factors		
Sex		
Male	1.00	1.00
Female	**1.99**(1.58–2.51)***	**1.58**(1.03–2.41)*
Age (year)	**0.99**(0.98–0.99)**	1.00(0.99–1.02)
Ethnicity[e]		
Non-Sámi	1.00	1.00
Sámi	0.93(0.72–1.21)	1.14(0.70–1.85)
Educational level (years)		
1° or lower 2° school (1–9)	1.00	1.00
Upper 2° school (10–12)	1.03(0.72–1.47)	0.90(0.47–1.72)
College or university (13–15)	1.10(0.77–1.59)	0.96(0.49–1.89)
University (>15)	**1.47**(1.03–2.10)*	1.37(0.68–2.76)
Total household income (gross income)		
Low (NOK <301,000)	1.00	1.00
Middle (NOK 301,000–750,000)	**0.70**(0.54–0.91)**	**1.64**(1.04–2.58)*
High (NOK >750,000)	**0.51**(0.37–0.70)***	**2.47**(1.25–4.87)**

Notes: Mixed-effect logistic regression-models including municipality as a random effect (not shown in the table) and age (year) as a continuous variable. *n*=number of observations. OR=odds ratio (95% confidence interval). Bold values are ORs significant at 0.05 level.
[a]*Past year* suicide attempts or ideation or self-injury; or *past month* anxiety and depression symptoms. To allow for other mental health problems not covered by our questions, the numbers include all persons receiving mental health services past 12 months.
[b]*Past year* use of hashish or illegal drugs, periodic drinking pattern, problematic gambling behaviour, or drinking 4 times or more per week; or *past month* alcohol intoxication 3 times or more.
[c]Large to moderate vs. least satisfaction. Rating includes all previous use of mental services.
[d]At a church, congregation house, or religious building.
[e]Ethnic self-ascription. The non-Sámi group comprises mostly ethnic Norwegians and 4.1% Kvens. The Sámi group includes 16.2% biethnic Kvens.
*$p \leq 0.05$.
**$p < 0.01$.
***$p < 0.001$.

In the adjusted models, religious attendance was associated with less frequent use of mental health services, compared with no attendance (OR = 0.77 [95% CI 0.60–0.97], Table 3). However, a post hoc Bonferroni test revealed that the mean HSCL–10 score among the religious attendees (1.83) was lower than among the non-attendees (1.90, $p = 0.017$, $F = 5.66$, not tabulated).

Our R/S factors were not significantly related to lifetime mental health-service satisfaction. Furthermore, we found no significant ethnic or gender differences in the association between the R/S factors and mental health-service utilisation and satisfaction or other R/S–sociodemographic factor interaction effects.

Logistic regression models for past-year mental health-service utilisation and satisfaction in multivariable-adjusted models: sociodemographic findings

In the adjusted model, female gender (OR = 1.99 [95% CI 1.58–2.51]) and younger age (OR = 0.99 [95% CI 0.98–0.99] per year) were significantly associated with frequent use of mental health services (Table 3). University-level education significantly predicted mental health-service utilisation (OR = 1.47 [95% CI 1.03–2.10], compared with the primary education level). High and middle household income levels were associated with less frequent use of mental health services

(OR = 0.70 [95% CI 0.54–0.91] and 0.51 [95% CI 0.37–0.70], respectively) compared with the low-income level.

Female gender (OR = 1.58 [95% CI 1.03–2.41]) and household income were significantly associated with lifetime mental health-service satisfaction. The odds ratios in the high- and middle-income groups were 1.64 (95% CI 1.04–2.58) and 2.47 (95% CI 1.25–4.87), respectively, compared with the low-income group.

We found no significant interaction effects between the sociodemographic factors.

Discussion

This study examined the importance of R/S factors for mental health-service utilisation and satisfaction among adult individuals reporting past-year mental health problems, substance use, or addictive behaviours in Sámi-Norwegian areas. We used quantitative data from the SAMINOR 2 Study and mixed-effect logistic regression models controlling for R/S and sociodemographic factors. Religious attendance was associated with infrequent use of mental health services in the past year across gender and ethnic categories, a finding possibly related to the lower level of psychological distress among religious attendees. We found an overall positive effect of religious self-ascription on mental health-service utilisation. However, a positive interaction effect on service use between religious self-ascription and age explained this correlation. This finding may be partly related to the higher level of mental distress among the religiously self-ascribed in the oldest age group. Additionally, religious attendance and belief were associated with less frequent past-year suicidal behaviour or self-injury, problematic drinking behaviour, and illicit substance use. We found no significant total or direct effect of R/S on lifetime mental health-service satisfaction. High socioeconomic status was related to less frequent service use, but greater service satisfaction. Finally, we found no ethnic differences in mental health-service utilisation or satisfaction.

Association between religious/spiritual factors and past-year mental health-service utilisation

In the adjusted model, we found a negative association between religious attendance and mental health-service utilisation across ethnic categories. This result may be partly due to lower need for mental health services because of the lower level of psychological distress among religious attendees, including less alcohol and illicit substance use, and suicidal behaviour [50]. These findings were partly published previously [5,47]. Also, the negative association may be related to the use of R/S methods of handling mental health problems, e.g. through traditional healing [18], a coping strategy integrated into the Sámi and the Northern Norwegian culture [16], and other positive religious coping [35]. However, we have no information on the use of these methods in our sample. A religious fellowship may represent a social and psychological support system buffering mental distress [5,47] and influencing professional mental healthcare use in this sample, similar to the effect of the Church among African Americans [31]. In Sámi-Norwegian areas, religious family networks actively contribute to the patient's healing process [51]. Lukachko et al. [42], studying a sample of 3,570 African American adults, found that religious attendance had a marginal inverse relationship with the use of mental health services, but not among subjects having a past-year presence of any diagnosable anxiety, mood, or substance disorder. Their findings suggest that religious African Americans have fewer mental health problems and less need for mental healthcare. Harris and colleagues [52] conducted a longitudinal study on a large national American sample comprising 64,450 individuals reporting emotional distress. They found that religious attendance was not related to outpatient mental healthcare use among persons experiencing moderate distress. However, among individuals in serious distress, religious attendance was positively associated with service utilisation, and a greater attendance rate predicted more service use. The religious support network likely encourages the use of professional mental healthcare for the severe mentally ill. Our sample is small, and is not stratified on the degree of mental distress. While our data lack direct information on general attitudes towards mental health services that could explain the decreased service use among religious attendees, our analyses did not reveal any significant relationship (positive or negative) between religious attendance and mental health-service satisfaction.

We found a positive interaction effect on mental health-service utilisation between religious self-ascription and age, resulting in higher service use among the religiously self-ascribed in the oldest age groups that was not observed in non-attendees. This observation may be partly related to the higher level of mental distress among the religiously self-ascribed in the oldest age group. Kiærbech et al. [5], also studying the cross-sectional SAMINOR 2 data, found that religious belief was associated with lifetime exposure to violence, but did not specify the origins and types of violence, and could not explain how the violence exposure was related to the believers. The same study also found religious belief to be associated with both Sámi

self-ascription and Sámi family background without Sámi self-ascription. We did not adjust for the latter category in our models. Although most studies finding poorer mental health among Sámi do not differentiate between these Sámi categories [6–10], we would expect both groups to be at risk for violence exposure and poorer mental health, especially in the age group that grew up during Norwegianization (until about 1980) [3].

In their large, longitudinal study, Harris and colleagues [52] also found R/S importance associated with outpatient mental healthcare use among individuals experiencing serious distress, but not in persons with moderate distress. Furthermore, past-year *increased* R/S importance predicted more service use among persons with serious distress, but not among those with moderate distress. As their models did not simultaneously adjust for religious attendance and R/S importance, the findings could relate to the religious support network's function in encouraging the use of professional mental healthcare for the most mentally ill. In another study of 13,038 American adolescents by Xie et al. [40], which did not differentiate between persons with severe and moderate distress, R/S importance was associated with less service use. In addition, a high level of subjective religiosity was associated with less positive attitudes towards mental health treatment in a small sample of African American church attendees [32]. For religious individuals with moderate psychological problems, a church leader might be more available for consultation than a mental health professional [41] and easier to talk to than to a non-believing psychologist [31]. Our analyses did not reveal any significant relationship between R/S importance and view of life and mental health-service satisfaction. However, we must note that the sample is small.

R/S is a complex phenomenon with multidimensional and multi-stratificational characteristics having disparate roles and impacts in different populations and R/S groups [29]. Consequently, the social and psychological aspects of R/S may have disparate functions in the individual's life [53,54]. Additionally, the role of religious attendance in two persons' lives may differ, even if they attend religious services equally frequently [55]. Changes in non-R/S factors impacting religious attendance (e.g. health conditions, job, family, and relationships with other members) may lead to compensating engagement in noninstitutional forms of R/S [56]. Our cross-sectional study does not account for these factors. However, it is reasonable to believe that older age groups have poorer physical health, possibly impacting participation in R/S social activities and leading to a compensating use of mental health services in age groups already underrepresented as service users.

Association between sociodemographic factors and past-year mental health-service utilisation and satisfaction

The effects of gender, age, and socioeconomic status on the use of mental health services are well known from several international studies [57]. High income is associated with a low risk of mental health problems [58]. However, in our sample, high household income (indicating high socioeconomic status) was connected to high satisfaction with mental health service, though these groups had the lowest use of such services. Furthermore, university-level education, which is still related to high income, was associated with *more* frequent use of mental health services and a non-significant tendency towards high service satisfaction. These findings may indicate that people of low socioeconomic status have the lowest confidence in (and may have the worst experiences with) such services. This group had the highest need for mental health services. In contrast, high-income patients may be better at communicating their problems and claiming their rights as patients or may be taken more seriously by mental health professionals.

In line with studies of other ethnic and Indigenous minorities [25,26,30], we expected Sámi ethnicity to affect mental health-service utilisation and satisfaction in our sample. However, our bivariate and adjusted models revealed neither a total nor a direct impact of ethnicity. This result follows the study of mental health services in Finnmark, which found no relationship between ethnicity and dropout rates or patients' perception of therapeutic alliance [14]. Sámi-speaking patients were less satisfied with municipal health services than Norwegian-speaking patients in the 2003–2004 SAMINOR 1 Study [15]. We found no ethnic differences regarding mental health-services utilisation or satisfaction in our sample from the SAMINOR 2 Study and no significant effect of Sámi language use. Although the Sámi have poorer mental health, the findings suggest that they are well integrated into Norwegian society and have access to mental healthcare comparable to the majority population [11]. Socioeconomic equality and the heightened Sámi cultural competence in mental health services in recent years, including improvements in government awareness of ethnic inequalities, may have contributed to this situation [14]. The establishment of the Sámi Norwegian

National Advisory Unit on Mental Health and Substance Use (SANKS) in 2002 is part of this development. SANKS is a psychiatric health service that provides culturally sensitive mental assessment and treatment for Sámi inhabitants in Norway.

Finally, highly educated people, who are typically atheists [5], are not equally distributed in the area, and we would observed clusters of religious individuals. Many districts are also located far from professional mental health services. However, our multilevel model, which included municipality as a random effect, accounted for these geographical differences.

Strengths and limitations

The low response rate (27%) may have caused selection bias, raising the question of the external validity and generalisability of the study [45]. Nevertheless, SAMINOR 2 is the most extensive population-based study of mixed Sámi-Norwegian areas. This study adds essential knowledge to the limited research field of R/S and mental health-service utilisation and satisfaction, particularly in the Arctic region. However, the questions included in the study do not address specific psychiatric diagnoses and provide only proxy measures of disorders related to mental health, substance use, and addictive behaviours. Furthermore, a cross-sectional study design is unsuited to determining causal relationships. Persons dissuaded from using professional mental health services may not admit this preference on the questionnaire, thus representing a possible response bias. The focus on Lutheranism and Pietism, especially their organisational dimensions, overlooks the assessment of less organised R/S, the use of traditional healing, and non-Christian R/S, e.g. so-called Sámi shamanism. However, the latter is a 21st century modern phenomenon of predominantly urban contexts of southern Norway [59]. Finally, R/S is a complex multilevel-multidimensional phenomenon with disparate impacts and roles in different populations and R/S groups [29]. Thus, our findings may not be generalisable to other contexts.

Implications for practice and further research

To religious attendees and members of an R/S fellowship in Sámi-Norwegian areas, R/S coping methods and social networks may represent preventive and therapeutic resources for mental distress. Decision makers and mental health professionals may consider this knowledge to improve mental healthcare services for this group. However, further research is needed, and we recommend larger samples that include more Laestadians and Sámi language users. Future studies should also address the use of traditional healing and social networks, general attitudes towards mental health services, Sámi family background, and the level of mental distress. In addition, qualitative methods could provide more insight into the issues and guide the planning of new quantitative studies.

Conclusion

In our sample, religious attendance is associated with infrequent use of mental health services across genders and ethnic categories, possibly due to religious attendees experiencing fewer mental health problems. This indicate that the R/S fellowship may buffer mental distress and represent a psychologically supportive alternative to professional services. R/S was not related to mental health-service satisfaction. Higher mental health-service utilisation among the religiously self-ascribed in the oldest age groups may be due to their higher level of mental distress related to factors not adjusted for in our models.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

The Nordland Hospital Trust financed the production of this article. The project was previously supported by Finnmark Hospital Trust under grant number 2015/2236-2 and by SANKS under grant numbers 06/2017, 12/2017, and 06/2019.

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Appendices

Questionnaire—Norwegian

Helse- og levekårs-undersøkelse

1. Jeg samtykker i å delta i undersøkelsen i henhold til informasjon gitt i informasjonsskrivet ☐ Ja

Egen helse

2. Hvordan er helsen din nå? (Sett bare ett kryss)

☐ Dårlig ☐ Ikke helt god ☐ God ☐ Svært god

3. Har du, eller har du noen gang hatt?

	Ja	Nei	Alder ved start
Diabetes (sukkersyke)	☐	☐	
Høyt blodtrykk	☐	☐	
Angina pectoris (hjertekrampe)	☐	☐	
Hjerteinfarkt	☐	☐	
Psykiske plager som du har søkt hjelp for	☐	☐	
Kronisk bronkitt, emfysem, KOLS	☐	☐	
Astma	☐	☐	
Eksem	☐	☐	
Psoriasis	☐	☐	
Multippel sklerose (MS)	☐	☐	
Bechterews sykdom	☐	☐	

4. Har du i løpet av det siste året vært plaget med smerter og/eller stivhet i muskler og ledd som har vart i minst 3 måneder sammenhengende? ☐ Ja ☐ Nei

Hvis ja, angi grad av plager fra de ulike deler av kroppen i tabellen nedenunder (ett kryss pr linje)

	Ikke plaget	En del plaget	Sterkt plaget
Nakke, skuldre	☐	☐	☐
Armer, hender	☐	☐	☐
Øvre del av ryggen	☐	☐	☐
Korsryggen	☐	☐	☐
Hofter, ben, føtter	☐	☐	☐
Hode	☐	☐	☐
Brystregionen	☐	☐	☐
Mageregionen	☐	☐	☐
Underliv	☐	☐	☐
Andre steder	☐	☐	☐

5. Hvor ofte har du i løpet av de siste 4 uker brukt følgende medisiner? (sett ett kryss pr linje)

	Ikke brukt siste 4 uker	Sjeldnere enn hver uke	Hver uke men ikke daglig	Daglig
Sovemedisin	☐	☐	☐	☐
Beroligende medisin	☐	☐	☐	☐
Medisin mot depresjon	☐	☐	☐	☐

6. Hvilke utsagn passer best på din helsetilstand i dag?

Gange

☐ Jeg har ingen problemer med å gå omkring
☐ Jeg har litt problemer med å gå omkring
☐ Jeg er sengeliggende

Personlig stell

☐ Jeg har ingen problemer med personlig stell
☐ Jeg har litt problemer med å vaske meg eller kle meg
☐ Jeg er ute av stand til å vaske meg

Vanlige gjøremål (f.eks. arbeid, studier, husarbeid, familie- eller fritidsaktiviteter)

☐ Jeg har ingen problemer med å utføre mine vanlige gjøremål
☐ Jeg har litt problemer med å utføre mine vanlige gjøremål
☐ Jeg er ute av stand til å utføre mine vanlige gjøremål

Smerte og ubehag

☐ Jeg har verken smerte eller ubehag
☐ Jeg har moderat smerte eller ubehag
☐ Jeg har sterk smerte eller ubehag

Angst og depresjon

☐ Jeg er verken engstelig eller deprimert
☐ Jeg er noe engstelig eller deprimert
☐ Jeg er svært engstelig eller deprimert

7. Hvor mye veier du? (i hele kg)

8. Hvor høy er du? (i hele cm)

9. Vi ber deg angi din fysiske aktivitet etter en skala fra svært lite til svært mye. Skalaen nedenfor går fra 1–10. Med fysisk aktivitet mener vi både arbeid i hjemmet og i yrkeslivet, samt trening og annen fysisk aktivitet som turgåing o.l. Sett kryss i ruten som best angir ditt nivå av fysisk aktivitet.

	1	2	3	4	5	6	7	8	9	10	
Svært lite	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Svært mye

Familie og språkbakgrunn

I Nord-Norge bor det folk med ulik etnisk bakgrunn. Det vil si at de snakker ulike språk og har forskjellige kulturer. Eksempler på etnisk bakgrunn, eller etnisk gruppe er norsk, samisk og kvensk.

10. Hvilket hjemmespråk har/hadde du, dine foreldre og besteforeldre? (Sett ett eller flere kryss)

	Norsk	Samisk	Kvensk	Annet, beskriv:	
Morfar	☐	☐	☐	☐	....
Mormor	☐	☐	☐	☐	....
Farfar	☐	☐	☐	☐	....
Farmor	☐	☐	☐	☐	....
Far	☐	☐	☐	☐	....
Mor	☐	☐	☐	☐	....
Jeg selv	☐	☐	☐	☐	....

11. Hva er din, din fars og din mors etniske bakgrunn?
(Sett ett eller flere kryss)

	Norsk	Samisk	Kvensk	Annet, beskriv:	
Min etniske bakgrunn er	☐	☐	☐	☐	....
Min fars etniske bakgrunn er	☐	☐	☐	☐	....
Min mors etniske bakgrunn er	☐	☐	☐	☐	....

12. Hva regner du deg selv som? (Sett ett eller flere kryss)

Norsk	Samisk	Kvensk	Annet, beskriv:	
☐	☐	☐	☐	....

13. Hvordan vil du vurdere dine ferdigheter til å forstå, snakke, lese eller skrive samisk?

	Svært bra	Nokså bra	Med anstrengelse	Noen få ord	Ikke i det hele tatt
Forstå	☐	☐	☐	☐	☐
Snakke	☐	☐	☐	☐	☐
Lese	☐	☐	☐	☐	☐
Skrive	☐	☐	☐	☐	☐

Arbeid, trygd og økonomi

14. Hvor stor er familiens/husstandens bruttoinntekt per år?

☐ Under kr 150 000 kr.
☐ Kr 150 000–300 000
☐ Kr 301 000–450 000
☐ Kr 451 000–600 000
☐ Kr 601 000–750 000
☐ Kr 751 000–900 000
☐ Over 900 000

15. Hvor mange personer bor det i din husstand? Antall personer .... ☐☐

16. Hvor mange års skolegang har du gjennomført?
(Ta med alle år du har gått på skole eller studert) .... ☐☐

17. Bodde du på internat (statsinternat kommunalt eller privat) da du gikk på grunnskolen? .... ☐ Ja ☐ Nei

18. Hva har vært dine viktigste inntektskilder siste året?
(Sett ett eller flere kryss)

☐ Lønnsarbeid:
  ☐ Heltid ☐ Deltid ☐ Sesong
☐ Selvstendig næring:
  ☐ Heltid ☐ Deltid ☐ Sesong
☐ Alderspensjon/AFP
☐ Kontantstønad/overgangsstønad/foreldrepenger
☐ Dagpenger
☐ Sykepenger
☐ Arbeidsavklaringspenger
☐ Uførepensjon
☐ Stønad til livsopphold (sosial stønad)
☐ Støtte fra ektefelle/foreldre/søsken/barn
☐ Lån/studielån og stipend
☐ Annet (Oppsparte midler/arv/gevinst osv)

19. Mener du at du står i fare for å miste ditt nåværende arbeid eller inntekt de nærmeste 2 årene? .... ☐ Ja ☐ Nei

20. Kunne du tenke deg å flytte fra din nåværende bosteds-kommune dersom du fikk tilbud om arbeid et annet sted?

☐ Ja ☐ Kun deler av året ☐ Nei ☐ Vet ikke

21. Dersom du er i lønnet arbeid hvordan trives du i din nåværende jobb/næring?

☐ Svært godt ☐ Godt ☐ Dårlig ☐ Veldig dårlig

22. På bakgrunn av egen helse og erfaringene fra arbeidslivet, hvor sannsynlig tror du det er at du fortsetter i lønnet arbeid/næring fram til:

	Svært sannsynlig	Sannsynlig	Mindre sannsynlig	Svært lite sannsynlig
62 års alder	☐	☐	☐	☐
67 års alder	☐	☐	☐	☐
70 års alder	☐	☐	☐	☐
Eldre enn 70 år	☐	☐	☐	☐

23. Dersom du er selvstendig næringsdrivende, hvilke type næring jobber du i? (Sett ett eller flere kryss)

- ☐ Reindrift
- ☐ Jordbruk
- ☐ Forretningsdrift
- ☐ Fiske
- ☐ Skogbruk
- ☐ Annet

Psykisk helse

24. Under finner du en liste over ulike problemer. Har du opplevd noe av dette de siste 4 ukene? (Sett ett kryss for hver plage)

	Ikke plaget	Litt plaget	Ganske mye	Veldig mye
Plutselig frykt uten grunn	☐	☐	☐	☐
Følt deg redd eller engstelig	☐	☐	☐	☐
Matthet eller svimmelhet	☐	☐	☐	☐
Følt deg anspent eller oppjaget	☐	☐	☐	☐
Lett for å klandre deg selv	☐	☐	☐	☐
Søvnproblemer	☐	☐	☐	☐
Nedtrykt, tungsindig	☐	☐	☐	☐
Følelse av å være unyttig, lite verd	☐	☐	☐	☐
Følelse av at alt er et slit	☐	☐	☐	☐
Følelse av håpløshet mht. framtida	☐	☐	☐	☐

25. Spørsmålene handler om hvordan du har følt deg og hvordan du har hatt det den siste uken. For hvert spørsmål, velg det svaralternativet som best beskriver hvordan du har hatt det. Hvor ofte i løpet av den siste uken har du: (Vennligst kryss av i boksen som er nærmest det utsagnet som best beskriver deg.)

	Hele tiden	Nesten hele tiden	Mye av tiden	En del av tiden	Litt av tiden	Ikke i det hele tatt
Følt meg glad og i godt humør	☐	☐	☐	☐	☐	☐
Følt meg rolig og avslappet	☐	☐	☐	☐	☐	☐
Følt meg aktiv og sterk	☐	☐	☐	☐	☐	☐
Følt meg opplagt og uthvilt	☐	☐	☐	☐	☐	☐
Følt at mitt daglige liv har vært fylt av ting som interesserer meg	☐	☐	☐	☐	☐	☐

26. Har du i løpet av de siste 12 månedene opplevd at ubehagelige minner har trengt seg på og forstyrret deg uten at du har kunnet gjøre noe med det?

☐ Nei ☐ Ja, men sjelden ☐ Av og til ☐ Ofte

27. Har du i løpet av de siste 12 månedene bevisst unngått situasjoner for å slippe ubehagelige minner eller følelser, på en slik måte at det har hindret deg i å gjøre det du vil?

☐ Nei ☐ Ja, men sjelden ☐ Av og til ☐ Ofte

28. Har du i løpet av de siste 12 måneder ikke vært i stand til å reagere følelsesmessig i situasjoner der de fleste andre reagerer?

☐ Nei ☐ Ja, men sjelden ☐ Av og til ☐ Ofte

29. Angi hvor godt følgende påstander beskriver deg og familien din

	Stemmer dårlig				Stemmer helt
Jeg stoler fullt ut på mine vurderinger og avgjørelser	☐	☐	☐	☐	☐
Jeg trives best sammen med andre	☐	☐	☐	☐	☐
Jeg trives svært godt i familien min	☐	☐	☐	☐	☐
Troen på meg selv får meg gjennom vanskelige perioder	☐	☐	☐	☐	☐
Jeg knytter lett nye vennskap	☐	☐	☐	☐	☐
Det er godt samhold i familien min	☐	☐	☐	☐	☐
I motgang klarer jeg å finne noe bra å vokse på	☐	☐	☐	☐	☐
Jeg er flink til å få kontakt med nye folk	☐	☐	☐	☐	☐
Familien min ser positivt på fremtiden selv i vanskelige perioder	☐	☐	☐	☐	☐
Jeg klarer å akseptere hendelser i livet som er umulig å forandre	☐	☐	☐	☐	☐
Jeg synes det er enkelt å finne på noe bra å snakke om	☐	☐	☐	☐	☐
I familien vår er vi lojal mot hverandre	☐	☐	☐	☐	☐

Tobakk og rusmidler

30. Røyker du, eller har du tidligere røykt?

☐ Ja, daglig ☐ Ja, tidligere ☐ Ja, av og til ☐ Nei, aldri

Hvor mange sigaretter røyker du vanligvis daglig? ☐☐

Alder i år

Hvor gammel var du da du begynte å røyke daglig? ☐☐

31. Bruker du, eller har du tidligere brukt snus?

☐ Ja, daglig ☐ Ja, tidligere ☐ Ja, av og til ☐ Nei, aldri

Til deg som snuser daglig: Hvor mange porsjoner bruker du hver dag? ☐☐

Til deg som snuser av og til: Hvor mange porsjoner bruker du vanligvis pr uke? ☐☐

Alder i år

Hvis ja, hvor gammel var du da du begynte å snuse daglig? ☐☐

32. Omtrent hvor ofte har du i løpet av det siste året drukket alkohol? (Lettøl og alkoholfritt øl regnes ikke med)

- ☐ Aldri drukket alkohol
- ☐ Har ikke drukket alkohol siste året
- ☐ Noen få ganger siste året
- ☐ Omtrent en gang i måneden
- ☐ 2–3 ganger pr måned
- ☐ Ca. 1 gang i uka
- ☐ 2–3 ganger i uka
- ☐ 4–7 ganger i uka

33. Har du drukket alkohol i løpet av de siste 4 uker? ☐ Ja ☐ Nei

Hvis ja, har du drukket så mye at du har kjent deg sterkt beruset (full)?

☐ Nei ☐ Ja, 1–2 ganger ☐ Ja, 3 ganger eller mer

34. Vil du karakterisere ditt alkoholbruk eller drikkemønster som periodisk (drikker ofte og mye i perioder, for så å ha lengre perioder uten alkoholinntak)?
(sett ett eller flere kryss)

☐ Ja, siste 12 måneder ☐ Ja, tidligere ☐ Nei

35. Har du noen gang brukt narkotika?
(sett ett eller flere kryss)

	Ja, siste året	Ja, tidligere	Nei
Hasj/marihuana (cannabis)	☐	☐	☐
Andre narkotiske stoffer for eksempel LSD, amfetamin, ecstasy, kokain, heroin, GHB, o.l.	☐	☐	☐

Religion og livssyn

36. Er du, dine foreldre eller dine besteforeldre knyttet til noen av de følgende livssynssamfunn: (sett ett eller flere kryss)

	Meg selv	Mor	Far	Besteforeldre
Statskirka	☐	☐	☐	☐
Læstadiansk forsamling	☐	☐	☐	☐
Annen religiøs forsamling/fellesskap	☐	☐	☐	☐
hvilket:				
Ikke-religiøst livssynssamfunn	☐	☐	☐	☐
hvilket:				
Ikke medlem av noe livssynssamfunn	☐	☐	☐	☐

37. Hvordan stiller du deg til religion?

- ☐ Jeg er troende/bekjennende kristen (personlig kristen)
- ☐ Jeg tror det finnes en Gud, men religion betyr ikke så mye for meg i det daglige
- ☐ Usikker
- ☐ Jeg tror ikke det finnes noen Gud

38. Hvor ofte har du i løpet av de siste 6 måneder vært på/i:
(Sett ett kryss pr linje)

	Mer enn 3g/mnd	1–3 g/mnd	1–6 g/siste 6 mnd	Aldri
Kirke	☐	☐	☐	☐
Forsamlings-/menighetshus	☐	☐	☐	☐
Humanetisk tilstelning	☐	☐	☐	☐
Annen religiøs bygning	☐	☐	☐	☐

Selvopplevd diskriminering

Diskriminering forekommer når en person eller gruppe av mennesker blir behandlet mindre fordelaktig enn andre på bakgrunn av f.eks. etnisk opprinnelse, religion, tro, funksjonshemning, alder eller seksuell legning.

39. Har du opplevd å bli diskriminert?

☐ Ja, de to siste årene ☐ Ja, før ☐ Nei ☐ Vet ikke

Dersom du svarte ja, på forrige spørsmål, besvar spørsmål 40–47. Hvis du har svart nei, går du videre til spørsmål 48.

40. Dersom du har vært utsatt for diskriminering, hvor ofte skjedde det?

☐ Svært ofte ☐ Noen ganger ☐ En sjelden gang

41. Hvorfor tror du at du ble diskriminert? Skyldes diskrimineringen: (Sett ett eller flere kryss)

- ☐ Funksjonshemning
- ☐ Lærevansker
- ☐ Religion eller tro
- ☐ Etnisk bakgrunn
- ☐ Alder
- ☐ Andre årsaker, spesifiser:
- ☐ Seksuell legning
- ☐ Kjønn
- ☐ Nasjonalitet
- ☐ Geografisk tilhørighet
- ☐ Sykdom
- ☐ Vet ikke

....

42. Kan du angi hvor diskrimineringen foregikk? (Sett ett eller flere kryss)

- ☐ På Internett
- ☐ I skolen/utdanning
- ☐ I arbeidslivet
- ☐ I forbindelse med jobbsøkning
- ☐ I frivillig arbeid/organisasjoner
- ☐ I møtet med det offentlige
- ☐ I familie/slekt
- ☐ Da du skulle leie/kjøpe bolig
- ☐ Da du skulle skaffe banklån
- ☐ I forbindelse med å få medisinsk behandling
- ☐ På butikken eller ved restaurantbesøk
- ☐ I lokalsamfunnet
- ☐ Annet sted, spesifiser: ....

43. Kan du angi hvem som diskriminerte deg?
(Sett ett eller flere kryss)

- ☐ Offentlig ansatt
- ☐ Ukjente
- ☐ Arbeidskollegaer
- ☐ En eller flere fra samme etniske gruppe som deg selv.
- ☐ En eller flere fra annen etnisk gruppe enn deg selv.
- ☐ Medelever/studenter
- ☐ Lærere/ansatte
- ☐ Andre

44. Gjorde du noe aktivt for å få slutt på diskrimineringen? ☐ Ja ☐ Nei

45. Har du noen gang tatt kontakt med Likestillings- og diskrimineringsombudet for råd eller hjelp angående diskriminering?

☐ Ja ☐ Nei ☐ Husker ikke

46. Hvor mye berørte diskrimineringen deg?

☐ Ikke i det hele tatt ☐ Litt ☐ Noe ☐ Mye

47. Har du opplevd at du har blitt diskriminert fordi du er same?

☐ Ja ☐ Nei ☐ Vet ikke ☐ Er ikke same

Vold og overgrep

48. Har du opplevd at noen systematisk og over lengre tid har forsøkt å kue, fornedre eller ydmyke deg? (Sett ett eller flere kryss)

☐ Nei, aldri ☐ Ja, som barn (under 18 år)
☐ Ja, som voksen (18 år eller over) ☐ Ja, de siste 12 mnd

Hvis ja, av hvem?

☐ Fremmed person ☐ Samlivspartner
☐ Familie, slektning ☐ Andre kjente

49. Er du blitt utsatt for fysiske overgrep/mishandling? (Sett ett eller flere kryss)

☐ Nei, aldri ☐ Ja, som barn (under 18 år)
☐ Ja, som voksen (18 år eller over) ☐ Ja, de siste 12 mnd

Hvis ja, av hvem?

☐ Fremmed person ☐ Samlivspartner
☐ Familie, slektning ☐ Andre kjente

50. Er du blitt utsatt for seksuelle overgrep? (Sett ett eller flere kryss)

☐ Nei, aldri ☐ Ja, som barn (under 18 år)
☐ Ja, som voksen (18 år eller over) ☐ Ja, de siste 12 mnd

Hvis ja, av hvem?

☐ Fremmed person ☐ Samlivspartner
☐ Familie, slektning ☐ Andre kjente

51. Hvis du har vært utsatt for noen form for overgrep, har du betrodd deg til noen? (Sett ett eller flere kryss)

☐ Nei ☐ Noen i familien ☐ Venner ☐ Fagfolk

Tannhelse

52. Hvordan vurderer du tannhelsen din

☐ Dårlig ☐ Ikke helt god ☐ God ☐ Svært god

53. Har du tannprotese/gebiss? ☐ Ja ☐ Nei

54. Bruker du selv noen av følgende hjelpemidler – og i tilfelle hvor ofte?

	Regelmessig/ daglig	Uregelmessig/ noen ganger i uka	Uregelmessig/ noen ganger i mnd.	Sjeldnere/ aldri
Tannbørste	☐	☐	☐	☐
Fluortannkrem	☐	☐	☐	☐
Tanntråd	☐	☐	☐	☐
Tannstikkere	☐	☐	☐	☐
Fluortabletter	☐	☐	☐	☐
Skyllevæske	☐	☐	☐	☐
Protesebørste	☐	☐	☐	☐

55. Når var du sist hos tannlege eller tannpleier?

☐ Mindre enn ett år siden ☐ 1–2 år siden
☐ 3–5 år siden ☐ Mer enn 5 år siden

56. Hvis det er mer enn 2 år siden, hva er da grunnen ?
(Sett ett eller flere kryss)

- ☐ Jeg har ikke blitt innkalt
- ☐ Det er lang ventetid hos tannlegen
- ☐ Jeg har ikke hatt tid
- ☐ Økonomiske årsaker
- ☐ Jeg har ikke hatt behov for tannbehandling
- ☐ Jeg er redd eller engstelig for å gå til tannlege
- ☐ Andre årsaker:

____

57. Hvordan bruker du tannhelsetjenesten? (Sett ett eller flere kryss)

☐ Blir regelmessig innkalt av tannlege eller tannpleier

☐ Melder meg regelmessig for undersøkelse

☐ Melder meg når jeg har vondt eller har mistet en fylling

☐ Bruker ikke å gå til tannlege så ofte

58. Har du i løpet av de to siste årene fått en eller flere av disse diagnosene hos tannlege ?

	Ja	Nei	Vet ikke
Alvorlig tannkjøttsbetennelse	☐	☐	☐
Mild tannkjøttsbetennelse	☐	☐	☐
Munntørrhet	☐	☐	☐
Hull (karies) i en eller flere tenner	☐	☐	☐
Andre diagnoser	☐	☐	☐

59. Er du fornøyd med tennene dine eller protesene? Angi svaret på en skala der 1 er svært misfornøyd og 5 er svært fornøyd

	1	2	3	4	5	
Svært misfornøyd	☐	☐	☐	☐	☐	Svært fornøyd

60. Hvor ofte pusset du tennene dine som 10-åring?

☐ En gang om dagen eller mer

☐ Av og til

☐ Sjelden eller aldri

61. Hvor ofte kontrollerte foreldrene eller dine foresatte at du hadde pusset tennene dine, da du var i 10-årsalderen?

☐ Ofte (omtrent daglig) ☐ Av og til ☐ Aldri

62. Om du har barn under 6 år boende hos deg, hvor ofte hjelper du til med tannpuss eller kontrollerer at barna har pusset tennene sine?

☐ Ofte (omtrent daglig) ☐ Av og til ☐ Aldri

63. Om du har barn som er mellom 6–12 år boende hos deg; hvor ofte hjelper du til med tannpuss eller kontrollerer at barna har pusset tennene sine?

☐ Ofte (omtrent daglig) ☐ Av og til ☐ Aldri

64. Dersom du har barn i aldergruppen 0–12 år boende hjemme hos deg, har dere da praktisert faste regler for spising av sjokolade og andre søtsaker for barna?

☐ Ja ☐ Nei

65. Hvor fornøyd er du med tannhelsetjenesten i din kommune?

svært misfornøyd ☐ ☐ ☐ ☐ ☐ ☐ svært fornøyd ☐ Vet ikke

Selvmord og selvmordsatferd

66. Har du mistet noen som har stått deg nær i selvmord? ☐ Ja ☐ Nei

67. Har du tenkt på å ta livet ditt?

☐ Ja, det siste året ☐ Ja, tidligere ☐ Nei, aldri

68. Har du forsøkt å ta ditt eget liv?

☐ Ja, det siste året ☐ Ja, tidligere ☐ Nei, aldri

69. Har du skadet deg selv med vilje?

☐ Ja, det siste året ☐ Ja, tidligere ☐ Nei, aldri

Dersom du har forsøkt å ta livet ditt, kan du svare på spørsmålene som følger. Hvis du har svart nei på dette spørsmålet, kan du gå videre til spørsmål nr 76.

70. På hvilken måte forsøkte du å ta ditt eget liv?
(Sett ett eller flere kryss)

☐ Henging ☐ Skytevåpen

☐ Skarp gjenstand ☐ Overdose piller/medikamenter

☐ Annen måte

71. Hva var motivet for å forsøke å ta ditt eget liv?

Et klart ønske om å dø	☐ Ja	☐ Nei
Situasjonen føltes uutholdelig	☐ Ja	☐ Nei
Jeg ønsket hjelp fra noen	☐ Ja	☐ Nei

72. Var du beruset/rusa da du forsøkte å ta ditt eget liv? ☐ Ja ☐ Nei

73. Hvor gammel var du første gang du forsøkte å ta ditt eget liv? ☐☐

74. Hvor mange ganger har du forsøkt å ta ditt eget liv? ☐☐

75. Fortalte du til andre om selvmordsforsøket/ene?
(Sett ett eller flere kryss)

☐ Nei ☐ Noen i familien ☐ Venner ☐ Fagfolk

Spilleatferd

76. Har du noen gang følt behov for å spille for mer og mer penger? (Sett ett eller flere kryss)

☐ Ja, siste året ☐ Ja, tidligere ☐ Nei

77. Har du noen gang løyet for mennesker som er viktige for deg, om hvor mye du spiller? (Sett ett eller flere kryss)

☐ Ja, siste året ☐ Ja, tidligere ☐ Nei

78. Har du noen gang hatt perioder da du, etter å ha tapt penger på spill en dag, har vendt tilbake en annen dag for å vinne de tilbake? (Sett ett eller flere kryss)

☐ Ja, siste året ☐ Ja, tidligere
☐ Nei ☐ Vet ikke/husker ikke

79. Har du i løpet av siste året spilt online rollespill?

☐ Ja, daglig ☐ Ja, ukentlig
☐ Ja, månedlig eller sjeldnere ☐ Nei

Erfaringer og bruk av helsetjenester

80. Den legen du vanligvis bruker er det

☐ Din fastlege ☐ Annen lege

81. Hvor lenge har du hatt din nåværende fastlege?

☐ Mindre enn 6 mnd ☐ 6 til 11 måneder
☐ 12 til 24 mnd ☐ Mer enn 2 år

82. Har du i løpet av de siste 12 mnd kontaktet fastlegen din for hjelp eller råd til deg selv? ☐ Ja ☐ Nei

Hvis ja, opplevde du at du fikk den hjelpa du ba om?

☐ Aldri ☐ Av og til ☐ Vanligvis ☐ Alltid

83. Hvor fornøyd eller misfornøyd er du med følgende sider ved fastlegetjenesten?

	Meget fornøyd	Fornøyd	Misfornøyd	Meget misfornøyd	Vet ikke
Fastlegens tilgjengelighet på telefon	☐	☐	☐	☐	☐
Ventetid for å få time hos fastlege	☐	☐	☐	☐	☐
Tid hos fastlegen	☐	☐	☐	☐	☐
Fastlegens forståelse for dine problem	☐	☐	☐	☐	☐
Fastlegens informasjon om dine helseplager, undersøkelse og behandlingsopplegg	☐	☐	☐	☐	☐
Totalt sett, hvor fornøyd eller misfornøyd er du med den kommunale helsetjenesten?	☐	☐	☐	☐	☐

Med spesialisthelsetjenesten menes det sykehus, distriktspsykiatrisk senter (DPS), spesialistlegesenter eller enkeltspesialist

84. Har du i løpet av de siste 12 måneder vært til undersøkelse eller behandling for *fysiske plager* hos

☐ Sykehus ☐ Spesialistlegesenter
☐ Privatpraktiserende spesialist ☐ Ingen av delene

85. Har du i løpet av de siste 12 måneder vært til undersøkelse eller behandling for *psykiske plager* hos

☐ Psykiatrisk sykehus ☐ Distriktspsykiatrisk senter
☐ Privatpraktiserende spesialist ☐ Ingen av delene

86. Dersom du har vært til behandling hos spesialist for fysiske eller psykiske plager, svar på følgende spørsmål Svar på en skala fra 0 til 10 (0 = i liten grad 10 = i stor grad)

Fikk du anledning til å fortelle det du følte var viktig om din tilstand?

	0	1	2	3	4	5	6	7	8	9	10	Ikke aktuelt
For fysiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
For psykiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Snakket legene/behandlerne til deg slik at du forstod dem?

	0	1	2	3	4	5	6	7	8	9	10	Ikke aktuelt
For fysiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
For psykiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Føler du at du fikk være med å bestemme over din behandling?

	0	1	2	3	4	5	6	7	8	9	10	Ikke aktuelt
For fysiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
For psykiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Er du blitt bedre av behandlingen?

	0	1	2	3	4	5	6	7	8	9	10	Ikke aktuelt
For fysiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
For psykiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Alt i alt, har du tillit til sykehuset eller spesialisten du var hos?

	0	1	2	3	4	5	6	7	8	9	10	Ikke aktuelt
For fysiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
For psykiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Alt i alt, hvor tilfreds er du med pleien og behandlingen du eventuelt fikk?

	0	1	2	3	4	5	6	7	8	9	10	Ikke aktuelt
For fysiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
For psykiske plager	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Erfaringer med henvisning

87. Har du i løpet av de siste 12 måneder ønsket å bli henvist til spesialist, men ikke blitt det?

For fysiske plager

- ☐ Nei, aldri
- ☐ Ja, en gang
- ☐ Ja, flere ganger
- ☐ Ikke aktuelt

For psykiske plager

- ☐ Nei, aldri
- ☐ Ja, en gang
- ☐ Ja, flere ganger
- ☐ Ikke aktuelt

88. Har du i løpet av de siste 12 måneder ønsket å bli henvist til fysioterapeut, kiropraktor eller liknende, men ikke blitt det?

- ☐ Nei, aldri
- ☐ Ja, en gang
- ☐ Ja, flere ganger
- ☐ Ikke aktuelt

89. Dersom du ble henvist, hvor lenge ventet du på time?

Antall uker ☐☐

90. Har du bedt om fritt sykehusvalg ved henvisning til spesialistbehandling?

- ☐ Ja
- ☐ Nei
- ☐ Ikke aktuelt

Språk ved legebesøk

91. Sist du var hos fastlegen, hvilket språk snakket du og legen sammen på?

	Norsk	Samisk	Annet, beskriv:
Jeg snakket	☐	☐	☐ ....
Legen snakket	☐	☐	☐ ....

92. Sist du var på sykehus/hos spesialist, hvilket språk snakket du og legen sammen på?

	Norsk	Samisk	Annet, beskriv:
Jeg snakket	☐	☐	☐ ....
Legen snakket	☐	☐	☐ ....

93. Hvilket språk ønsker du først og fremst å snakke med helsepersonell på? (sett ett eller flere kryss)

Norsk	Samisk	Annet, beskriv:
☐	☐	☐ ....

Bruk av tolk

94. Hvis du har svart «samisk», men ikke fikk tilbud om samisk-talende lege ved siste legebesøk, ble det da tilbudt tolk?

Hos fastlegen:

- ☐ Ja
- ☐ Nei
- ☐ Ønsker ikke å bruke tolk
- ☐ Ikke aktuelt

På sykehus/hos spesialist:

- ☐ Ja
- ☐ Nei
- ☐ Ønsker ikke å bruke tolk
- ☐ Ikke aktuelt

95. Dersom samisktalende tolk ble brukt ved siste legebesøk, hvem fungerte da som tolk?

Hos fastlegen:

- ☐ Offentlig ansatt tolk
- ☐ Familie
- ☐ En ansatt på legekontoret
- ☐ Annet

På sykehus/hos spesialist:

- ☐ Offentlig ansatt tolk
- ☐ Familie
- ☐ Annen sykehusansatt
- ☐ Annet

96. Hvis du noen gang har vært til legeundersøkelse/behandling der det ble brukt samisktalende tolk, hvor fornøyd er du med kommunikasjonen/samtalen mellom deg og legen/behandleren?

Hos fastlegen:

- ☐ Meget fornøyd
- ☐ Fornøyd
- ☐ Misfornøyd
- ☐ Meget misfornøyd
- ☐ Vet ikke

På sykehus/hos spesialist:

- ☐ Meget fornøyd
- ☐ Fornøyd
- ☐ Misfornøyd
- ☐ Meget misfornøyd
- ☐ Vet ikke

97. Har du noen gang opplevd at du ikke har fått norsk/samisk tolkehjelp selv om du ba om det?

- ☐ Ja, det har hendt at jeg har bedt om tolk, men ikke fått det.
- ☐ Nei, jeg har alltid fått tolk hvis jeg har bedt om det
- ☐ Har aldri spurt om tolk

Takk for at du deltok i undersøkelsen!

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-110901 – NORSK

Questionnaire—Northern Sámi

Dearvvašvuođa ja eallindiliiskkadeapmi

ROMSSA UNIVERSITEHTA

1. Mun mieđan searvat jearahallamii daid dieđuid vuođul mat leat addon diehtojuohkinčállagis ☐ Jo

Iežat dearvvašvuohta

2. Mo lea du dearvvašvuohta dál? (Bija duššse ovtta ruossa)

☐ Heittot ☐ Ii áibbas buorre ☐ Buorre ☐ Hui buorre

3. Lea go dus, dahje lea go dus goassige leamaš?

	Jo	Ii	Man boaris ledjet go álggii
Diabetes (sohkardávda)	☐	☐	
Alla varradeaddu	☐	☐	
Angina pectoris (váibmogeasáhat)	☐	☐	
Váibmodohppehat	☐	☐	
Psykalaš váttisvuođat maidda leat bivdán veahki	☐	☐	
Bissovaš broŋkihtta, emfysema, KOLS	☐	☐	
Ástmá	☐	☐	
Eksema	☐	☐	
Soriasis	☐	☐	
Multippel sklerose (MS)	☐	☐	
Bechterew dávda	☐	☐	

4. Leat go maŋimuš jagis unnimusat 3 mánu giksašuvvan bákčasiiguin ja/dahje ahte deahkit ja láđđasat leamaš stiivon? ☐ Jo ☐ In

Jus leat, almmut tabellii man olu leat giksašuvvan daid iešguđetge lahtuin. (Okta ruossa juohke linjái)

	In giksašuvvan	Veahá giksašuvvan	Olu giksašuvvan
Niskkiin, olggiiguin	☐	☐	☐
Gieđaiguin	☐	☐	☐
Hárduin	☐	☐	☐
Čilggiin	☐	☐	☐
Spirraliiguin, julggiiguin	☐	☐	☐
Oivviin	☐	☐	☐
Rattiin	☐	☐	☐
Čovjjiin	☐	☐	☐
Vuolledábiin	☐	☐	☐
Eará sajiin	☐	☐	☐

5. Man dávjá leat maŋimuš 4 vahkus geavahan čuovvovaš dálkasiid? (Bija ovtta ruossa juohke linjái)

	In leat geavahan maŋimuš 4 vahkus	Hárvvit go juohke vahku	Juohke vahku muhto in beaivvá-laččat	Beaivvá-laččat
Oađđindálkasa	☐	☐	☐	☐
Ráfáidahttindálkasa	☐	☐	☐	☐
Dálkasa lossamiela vuostá	☐	☐	☐	☐

6. Guđemuš cealkámuš heive buoremusat du dearvvašvuođadillái odne?

Vázzin

☐ Mus eai leat váttisvuođat vázzit
☐ Mus leat veahá váttisvuođat vázzit
☐ Mun in sáhte eará go seaŋggas veallát

Iežat dikšun

☐ Mus eai leat váttisvuođat dikšut iežan
☐ Mus leat veahá váttisvuođat basademiin dahje gárvodemiin
☐ Mun in nagot ieš basadit

Dábálaš doaimmat (omd. bargu, oahppu, viessobarggut, bearaš- dahje astoáigedoaimmat)

☐ Mus eai leat váttisvuođat doaimmahit dábálaš doaimmaid
☐ Mus leat veahá váttisvuođat doaimmahit dábálaš doaimmaid
☐ Mun in nagot iežan dábálaš doaimmaid doaimmahit

Bákčasat ja unohasvuohta

☐ Mus eai leat bákčasat eai ge unohasvuođat
☐ Mus leat veahá bákčasat dahje unohasvuođat
☐ Mus leat garra bákčasat dahje unohasvuođat

Ballu ja lossamiella

☐ Mus ii leat ballu ii ge lossamiella
☐ Mus lea veahá ballu dahje lossamiella
☐ Mus lea hui ballu dahje lossamiella

7. Man ollu deattát don? (olles kiloid)

8. Man allat leat don? (olles cm)

9. Bivdit du almmuhit man aktiiva don leat rumašlaš doaimmaiguin skálai mas nuppi geažis lea hui unnán ja nuppis hui ollu. Skála lea 1–10 rádjai. Rumašlaš doaimmaiguin oaivvildat sihke ruovttudoaimmaid ja bargguid bargodilis, ja lášmmohallama ja eará doaimmaid mat gáibidit lihkadeami, nu go tuvrra vázzit jna. Bija ruossa dan ruktái mii buoremusat čilge man aktiiva don leat.

	1	2	3	4	5	6	7	8	9	10	
Hui unnán	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Hui ollu

Bearaš ja gielladuogáš

Davvi-Norggas ásset olbmot geain lea iešguđet etnalaš duogáš. Dat mearkkaša ahte sii hállet iešguđetlágan gielaid ja sis leat iešguđetlágan kultuvrrat. Ovdamearkkat etnalaš duogážiin, dahje etnalaš joavkkuin leat dážat, sápmelaččat ja kvenat.

10. Makkár giela hálat/hállet don, du váhnemat ja áhkut ja ádját ruovttugiellan? (Bija ovtta dahje máŋga ruossa)

	Dárogiela	Sámegiela	Kvenagiela	Eará, čilge:
Áddjá (eatni áhčči)	☐	☐	☐	☐ ....
Áhkku (eatni eadni)	☐	☐	☐	☐ ....
Áddjá (áhči áhčči)	☐	☐	☐	☐ ....
Áhkku (áhči eadni)	☐	☐	☐	☐ ....
Áhčči	☐	☐	☐	☐ ....
Eadni	☐	☐	☐	☐ ....
Mun ieš	☐	☐	☐	☐ ....

11. Mii lea du, áhččát ja eadnát etnalaš duogáš? (Bija ovtta dahje máŋga ruossa)

	Dáža	Sápmelaš	Kvena	Eará, čilge:
Mu etnalaš duogáš lea	☐	☐	☐	☐ ....
Áhččán etnalaš duogáš lea	☐	☐	☐	☐ ....
Eadnán etnalaš duogáš lea	☐	☐	☐	☐ ....

12. Manin don logat iežat? (Bija ovtta dahje máŋga ruossa)

Dážan	Sápmelažžan	Kvenan	Eará, čilge:
☐	☐	☐	☐ ....

13. Mo don árvvoštalat iežat gelbbolašvuođa áddet, hállat, lohkat dahje čállit sámegiela?

	Hui bures	Oalle bures	Veahá ražastemiin	Moadde sáni	In obanassiige
Ádden	☐	☐	☐	☐	☐
Hálan	☐	☐	☐	☐	☐
Logan	☐	☐	☐	☐	☐
Čálán	☐	☐	☐	☐	☐

Bargu, oadju ja ekonomiija

14. Man stuorra bruttosisaboahtu lea bearrašis/bearašgottis jahkásaččat?

☐ Vuollel 150 000 ru.
☐ 150 000–300 000 ru.
☐ 301 000–450 000 ru.
☐ 451 000–600 000 ru.
☐ 601 000–750 000 ru.
☐ 751 000–900 000 ru.
☐ Badjel 900 000 ru.

15. Gallis ásset du bearášgottis? Galle olbmo .... ☐☐

16. Galle skuvlajagi leat don čađahan? (Rehkenastte buot jagiid maid leat skuvlla vázzán dahje studeren) .... ☐☐

17. Ásset go internáhtas (stáhtainternáhtas, gieldda dahje priváhta) go vázzet vuođđoskuvlla? .... ☐ Jo ☐ In

18. Mat leat leamaš deháleamos gáldut du sisabohttui maŋimuš jagi? (Bija ovtta dahje máŋga ruossa)

☐ Bálkábargu:
- ☐ Ollesáiggi ☐ Oasseáiggi ☐ Áigodatbargu

☐ Iešealáhusdoalli:
- ☐ Ollesáiggi ☐ Oasseáiggi ☐ Áigodatbargu

☐ Ealáhatruhta/AFP
☐ Reaidaruhtadoarjja/nuppástusdoarjja/váhnenruđat
☐ Beaiveruđat
☐ Buohcanruđat
☐ Bargočielggadanruđat
☐ Lámisvuođapenšuvdna
☐ Doarjja birgenláhkái (sosiálaveahkki)
☐ Doarjja beallelaččas/váhnemiin/oappáin/vieljain/mánáin
☐ Loatna/studieloatna ja stipeanda
☐ Eará (sestojuvvon ruđat/árbi/vuoitu jna)

19. Oaivvildat go ahte soaittát massit iežat dálá barggu dahje sisaboađu čuovvovaš guovtti jagis? .... ☐ Jo ☐ In

20. Sáhtášit go fárret dan gielddas gos dál ásat jus oččošit bargofálaldaga muhttin eará sajis?

☐ Jo ☐ Dušše osiid jagis ☐ In ☐ In dieđe

21. Jus leat bálkábarggus, mo loavttát dan barggus/ealáhusas mas leat dál?

☐ Hui bures ☐ Bures ☐ Heittogit ☐ Hui heittogit

22. Du dearvvašvuođa ja bargovásáhusaid vuođul, man jáhkehahtti lea ahte don joatkkát bálkábarggus/ealáhusas dassá leat:

	Hui jáhkehahtti	Jáhkehahtti	Unnán jáhkehahtti	Hui unnán jáhkehahtti
Sullii 62 jagi	☐	☐	☐	☐
Sullii 67 jagi	☐	☐	☐	☐
Sullii 70 jagi	☐	☐	☐	☐
Boarrásat go 70 jagi	☐	☐	☐	☐

23. Jus leat iešealáhusdoalli, makkár ealáhusas leat don? (Bija ovtta dahje máŋga ruossa)

- ☐ Boazodoalus
- ☐ Eanandoalus
- ☐ Gávpedoaimmas
- ☐ Guolásteamis
- ☐ Vuovdedoalus
- ☐ Eará ealáhusas

Psykalaš dearvvašvuohta

24. Dás vuolábealde lea listu mas leat iešguđetlágan váttisvuođat. Leat go vásihan maidige dáin dan maŋimuš 4 vahkus? (Bija ovtta ruossa juohke giksái)

	In leat giksa-šuvvan	Veahá giksa-šuvvan	Viehka sakka giksa-šuvvan	Hirbmadit giksa-šuvvan
Fáhkkestaga ballu masa ii leat sivva	☐	☐	☐	☐
Dovdan balu dahje leamaš árgi	☐	☐	☐	☐
Skurvvas dahje oaivejorgásii	☐	☐	☐	☐
Dovdan leat čavgen dahje huššas	☐	☐	☐	☐
Leamaš jođán sivahit iežat	☐	☐	☐	☐
Oađđinváttisvuođat	☐	☐	☐	☐
Skurtnjas, lossamielalaš	☐	☐	☐	☐
Dovdan ávkkeheapmin, ahte dus lea unnán árvu	☐	☐	☐	☐
Dovdan ahte buot lea rahčamuš	☐	☐	☐	☐
Dovdan eahpedoaivvu boahtteáigi ektui	☐	☐	☐	☐

25. Jearaldagat leat dan birra makkár dovddut ja mo dus lea leamaš dan maŋimuš vahku. Juohke jearaldahkii, vállje dan vástádusa mii čilge buoremusat mo dus lea leamaš. Man dávjá leat don dan maŋimuš vahkus: (Bidjal ruossa dan ruktái mii buoremusat čilge du)

	Ovttat ládje	Measta ovttat ládje	Stuorra oasi áiggis	Muhttin oasi áiggis	Veahá áiggis	In oba-nassiige
Dovdan ahte lean movttet ja buori mielas	☐	☐	☐	☐	☐	☐
Dovdan ahte lean jaskat ja lotkat	☐	☐	☐	☐	☐	☐
Dovdan ahte lean doaimmalaš ja gievra	☐	☐	☐	☐	☐	☐
Dovdan ahte lean vuoŋis ja vuoiŋŋastan	☐	☐	☐	☐	☐	☐
Dovdan ahte mu árgabeaivvis leat áššit main mun beroštan	☐	☐	☐	☐	☐	☐

26. Leat go maŋimuš 12 mánus vásihan ahte unohis muittut leat muosehuhttán ja bieguhan du, it ge leat sáhttán dáhkat dáinna maidige?

☐ In ☐ Jo, muhto hárve ☐ Muhttomin ☐ Dávjá

27. Leat go maŋimuš 12 mánus mieleavttus garván dilálašvuođaid garvin dihte unohis muittuid dahje dovdduid, nu ahte dat leat hehtten du dáhkat dan maid hálidat?

☐ In ☐ Jo, muhto hárve ☐ Muhttomin ☐ Dávjá

28. Leat go maŋimuš 12 mánus dovdan ahte it nagodan reageret dilálašvuođain goas eatnašat reagerejit dovdduiguin?

☐ In ☐ Jo, muhto hárve ☐ Muhttomin ☐ Dávjá

29. Almmut man bures čuovvovaš cealkagat govvidit du ja du bearraša

	Ii doala deaivása				Doallá deaivása
Mun luohttán ollásit iežan meroštallamiidda ja mearrádusaide	☐	☐	☐	☐	☐
Mun loavttán buoremusat go lean searválagaid earáiguin	☐	☐	☐	☐	☐
Mun loavttán hui bures iežan bearrašis	☐	☐	☐	☐	☐
Mu jáhkku alccen veahkeha mu váttis áigodagaid čađa	☐	☐	☐	☐	☐
Mun oaččun álkit ustibiid	☐	☐	☐	☐	☐
Lea buorre oktavuohta mu bearrašis	☐	☐	☐	☐	☐
Vuostegiehtageavadis nagodan gávdnat buriid áššiid mat loktejit mu	☐	☐	☐	☐	☐
Lean čeahppi oažžut oktavuođa ođđa olbmuiguin	☐	☐	☐	☐	☐
Mu bearrašis lea positiiva oaidnu boahtteáiggi ektui maiddái váttis áigodagain	☐	☐	☐	☐	☐
Mun nagodan dohkkehit dáhpáhusaid eallimis maid lea veadjemeahttun rievdadit	☐	☐	☐	☐	☐
Mu mielas lea álki hutkat juoidá buori man birra sáhttá hállat	☐	☐	☐	☐	☐
Min bearrašis leat mii oskkáldasat guhtet guoibmáseamet	☐	☐	☐	☐	☐

Duhpát ja gárrenmirkkut

30. Borgguhat go, dahje leat go ovdal borgguhan?

- ☐ Jo, beaivválaččat
- ☐ Jo, muhttomin
- ☐ Jo, ovdal
- ☐ In, in goassige

Galle sigareahta borgguhat dábálaččat beaivái? ☐☐

Man boaris ledjet go borgguhišgohtet beaivválaččat? Ahki ☐☐

31. Snuvsset go, dahje leat go ovdal snuvssen?

- ☐ Jo, beaivválaččat
- ☐ Jo, muhttomin
- ☐ Jo, ovdal
- ☐ In, in goassige

Jus snuvsset beaivválaččat: Galle snuvssa-bihttá geavahat beaivái? ☐☐

Jus snuvsset muhttomin: Galle snuvssa-bihttá geavahat dábálaččat juohke vahku? ☐☐

Jus snuvsset, man boaris ledjet go snuvssegohtet beaivválaččat? Ahki ☐☐

32. Sullii man gallii leat maŋimuš jagis juhkan alkohola?
(Geahppavuolla ja alkoholahis vuolla ii lohkko)

- [ ] In leat goassige juhkan alkohola
- [ ] In leat juhkan alkohola maŋimuš jagis
- [ ] Moddii dan maŋimuš jagis
- [ ] Sullii oktii mánus
- [ ] 2–3 geardde mánus
- [ ] Sullii 1 vahkus
- [ ] 2–3 geardde vahkus
- [ ] 4–7 geardde vahkus

33. Leat go juhkan alkohola dan maŋimuš 4 vahkus? ☐ Jo ☐ In

Jus leat, leat go juhkan nu ollu ahte dovdet ahte ledjet sakka gárihuvvan?
☐ In ☐ Jo, 1–2 geardde ☐ Jo, 3 geardde dahje dávjjit

34. Sáhtát go gohčodit iežat alkoholageavaheami dahje juhkanminstara birrajohtulassan (jugat dávjá ja ollu muhttin áiggi, ja de lea guhkit áigi goas it juga alkohola)?
(Bija ovtta dahje máŋga ruossa)

☐ Jo, maŋimuš 12 mánus ☐ Jo, ovdal ☐ In

35. Leat go goassige geavahan narkotihka? (Bija ovtta dahje máŋga ruossa)

	Jo, maŋimuš jagis	Jo, ovdal	In
Hasj/marihuana (cannabis)	☐	☐	☐
Eará narkotihkalaš gárrenmirkkuid, omd. dihte LSD, amfetamiinna, ecstasy, kokaiinna, heroiinna, GHB, ja sullasaš	☐	☐	☐

Osku ja eallinoaidnu

36. Leat go don, du váhnemat dahje áhkut ja ádját čadnon ovttage dáin čuovvovaš eallinoaidnuservodagaide: (Bija ovtta dahje máŋga ruossa)

	Mun ieš	Eadni	Áhčči	Áhkut ja ádját
Stáhtagirku	☐	☐	☐	☐
Lestadiánalaš searvegoddi	☐	☐	☐	☐
Eará vuoiŋŋalaš searvegoddi/searvevuohta	☐	☐	☐	☐
makkár:				
Eahpe-vuoiŋŋalaš eallinoaidnoservodat	☐	☐	☐	☐
makkár:				
Ii miellahttun makkárge eallinoaidnoservodagas	☐	☐	☐	☐

37. Makkár oktavuohta lea dus oskui?

- [ ] Mun lean oskkolaš/dovddastan risttalašvuhtii (persovnnalaččat risttalaš)
- [ ] Mun jáhkán ahte gávdno Ipmil, muhto oskkus ii leat nu stuorra mearkkašupmi mu árgabeaivvis
- [ ] Eahpesihkkar
- [ ] Mun in jáhke ahte gávdno Ipmil

38. Man dávjá leat dan maŋimuš 6 mánus leamaš:
(Bija ovtta ruossa juohke linjái)

	Dávjjit go 3 mánus	1–3 mánus	1–6 háve maŋimuš 6 mánus	In oktiige
Girkus	☐	☐	☐	☐
Čoakkalmas-/searvegoddevisttis	☐	☐	☐	☐
Humánaehtalaš doaluin	☐	☐	☐	☐
Eará vuoiŋŋalaš visttis	☐	☐	☐	☐

Vásihuvvon vealaheapmi

Lea vealaheapmi go olmmoš dahje olmmošjoavku meannuduvvo fuonit go earát ovdamearkka dihte sin etnalaš duogáža, religiuvnna, osku, doaibmahehttehusa, agi dahje seksuálálaš beroštumi dihte.

39. Leat go vásihan vealahuvvot?
☐ Jo, maŋimuš guovtti jagis ☐ Jo, ovdal ☐ In ☐ In dieđe

Jus vástidit jo ovddit jearaldahkii, vástit jearaldagaid 40–47.
Jus leat vástidan in, manat viidásat 48. jearaldahkii.

40. Jus leat vásihan vealahuvvot, man dávjá dáhpáhuvai?
☐ Hui dávjá ☐ Duollet dálle ☐ Hárve

41. Manne jáhkát ahte don vealahuvvojit? Mii lei sivvan vealaheapmái: (Bija ovtta dahje máŋga ruossa)

- [ ] Doaibmahehttehus
- [ ] Oahppováttisvuođat
- [ ] Religiuvdna dahje osku
- [ ] Etnalaš duogáš
- [ ] Ahki
- [ ] Eará sivat, čilge:
- [ ] Seksuála beroštupmi
- [ ] Sohkabealli
- [ ] Našunalitehta
- [ ] Geográfalaš gullevašvuohta
- [ ] Buozalmasvuohta
- [ ] In dieđe

42. Sáhtát go muitalit gos vealaheapmi dáhpáhuvai? (Bija ovtta dahje máŋga ruossa)

- [ ] Interneahtas
- [ ] Skuvllas/oahpu oktavuođas
- [ ] Bargodilis
- [ ] Bargoohcama oktavuođas
- [ ] Eaktodáhtolaš barggus/organisašuvnnas
- [ ] Deaivvadettiin almmolaš ásahusain
- [ ] Bearrašis/fulkkiid searvvis
- [ ] Go áigot láigohit/oastit viesu
- [ ] Go áigot háhkat báŋkoloana
- [ ] Medisiinnalaš dálkkodeami oktavuođas
- [ ] Buvddas dahje boradanbáikkis
- [ ] Báikkálaš servodagas
- [ ] Eará sajis, čilge:

43. Sáhtát go muitalit gii du vealahii? (Bija ovtta dahje máŋga ruossa)

☐ Almmolaš bargi
☐ Amas olmmoš
☐ Bargoustibat
☐ Okta dahje máŋgasat geain lea seamma etnalaš duogáš go dus
☐ Okta dahje máŋgasat geain lea eará etnalaš duogáš go dus
☐ Skuvlaoabbá/-vielja/studeanttat
☐ Oahpaheaddjit/bargit
☐ Earát

44. Dahket go maidige aktiivvalaččat heaittihit vealaheami? ☐ Jo ☐ In

45. Leat go goassige váldán oktavuođa Dásseárvu- ja vealaheamiáittardeddjiin oažžun dihte ráđiid dahje veahki vealaheami ektui?

☐ Jo ☐ In ☐ In muitte

46. Čuozai go vealaheapmi dutnje?

☐ Ii obanassiige ☐ Veahá ☐ Muhttin muddui ☐ Sakka

47. Leat go vásihan vealahuvvot go leat sápmelaš?

☐ Jo ☐ In ☐ In dieđe ☐ In leat sápmelaš

Veahkaválddálašvuohta

48. Leat go vásihan ahte muhttin lea guhkit áiggi badjel systemáhtalaččat geahččalan duolbmat, fuotnut dahje gudnehuhttit du? (Bija ovtta dahje máŋga ruossa)

☐ In, in goassige
☐ Jo, mánnán (vuollel 18 jagi)
☐ Jo, rávisolmmožin (18 jagi dahje boarrásat)
☐ Jo, maŋimuš 12 mánus

Jus jo, gii?

☐ Amas olmmoš
☐ Guoibmi/beallelaš
☐ Bearašlahttu, fuolki
☐ Eará oahpesolmmoš

49. Leat go vásihan rumašlaš veahkaválddálašvuođa/ doaruheami? (Bija ovtta dahje máŋga ruossa)

☐ In, in goassige
☐ Jo, mánnán (vuollel 18 jagi)
☐ Jo, rávisolmmožin (18 jagi dahje boarrásat)
☐ Jo, maŋimuš 12 mánus

Jus jo, gii dán dagai?

☐ Amas olmmoš
☐ Guoibmi/beallelaš
☐ Bearašlahttu, fuolki
☐ Eará oahpesolmmoš

50. Leat go vásihan seksualálaš veahkaválddálašvuođa? (Bija ovtta dahje máŋga ruossa)

☐ In, in goassige
☐ Jo, mánnán (vuollel 18 jagi)
☐ Jo, rávisolmmožin (18 jagi dahje boarrásat)
☐ Jo, maŋimuš 12 mánus

Jus jo, gii dán dagai?

☐ Amas olmmoš
☐ Guoibmi/beallelaš
☐ Bearašlahttu, fuolki
☐ Eará oahpesolmmoš

51. Jus leat vásihan makkárge veahkaválddálašvuođa, leat go muitalan dan geasage? (Bija ovtta dahje máŋga ruossa)

☐ In
☐ Soapmásii bearrašis
☐ Ustibiidda
☐ Fágaolbmuide

Bátnedearvvašvuohta

52. Mo don árvvoštalat iežat bátnedearvvašvuođa?

☐ Heittot ☐ Ii áibbas buorre ☐ Buorre ☐ Hui buorre

53. Leat go dus luovosbánit? ☐ Jo ☐ Eai

54. Geavahat go ieš muhttin dáid čuovvovaš veahkeneavvuin – ja jus dagat, man dávjá?

	Áiggis áigái/ beaivvá-laččat	Duollet dálle/ moddii vahkus	Duollet dálle/ moddii mánus	Hárvvibut/ in goassige
Bátnegustta	☐	☐	☐	☐
Fluorbátnegeallasa	☐	☐	☐	☐
Bátnesoallunsuona	☐	☐	☐	☐
Bátnesoloniid	☐	☐	☐	☐
Fluor-tableahtaid	☐	☐	☐	☐
Njálbmedoidinčázi	☐	☐	☐	☐
Bátnegustta heivehuvvon luovosbániide	☐	☐	☐	☐

55. Goas maŋimuš ledjet bátnedoaktára dahje bátnedivššára luhtte?

☐ Vuollel jagi áigi
☐ 1–2 jagi áigi
☐ 3–5 jagi áigi
☐ Badjel 5 jagi áigi

56. Jus lea badjel 2 jagi áigi, mii dasa lea sivvan? (Bija ovtta dahje máŋga ruossa)

☐ In leat gohččojuvvon
☐ Lea guhkes vuordináigi beassat bátnedoaktára lusa
☐ In leat ástan
☐ Ekonomalaš sivat
☐ Mus ii leat leamaš dárbu bátnedikšui
☐ Mun balan dahje lean árgi vuolgit bátnedoaktára lusa
☐ Eará sivat:

____

57. Mo don geavahat bátnedearvvašvuođabálvalusa?
(Bija ovtta dahje máŋga ruossa)

- ☐ Bátnedoavttir dahje bátnedivššár gohčču mu áiggis áigái boahtit
- ☐ Dieđihan áiggis áigái iskkadeapmái
- ☐ Diŋgon diimmu go leat bákčasat dahje go lean láhppán bátnedeavdaga
- ☐ In láve mannat bátnedoaktára lusa nu dávjá

58. Leat go dan maŋimuš guovtti jagis ožžon ovtta dahje eanet dáin diagnosain bátnedoaktáris?

	Jo	In	In dieđe
Duođalaš infekšuvdna bátnealŋŋain	☐	☐	☐
Infekšuvdna bátnealŋŋain mii ii lean nu duođalaš	☐	☐	☐
Njálbmi goikan	☐	☐	☐
Ráigi ovtta dahje máŋgga bánis (karies)	☐	☐	☐
Eará diagnosaid	☐	☐	☐

59. Leat go duhtavaš iežat bániiguin dahje luovosbániiguin? Almmut vástádusa skálai mas 1 lea hui duhtameahttun ja 5 lea hui duhtavaš

	1	2	3	4	5	
Hui duhtameahttun	☐	☐	☐	☐	☐	Hui duhtavaš

60. Man dávjá bussejit bániid 10-jahkásažžan?

- ☐ Oktii beaivái dahje dávjjit
- ☐ Duollet dálle
- ☐ Hárve dahje in goassige

61. Man dávjá iske du váhnemat dahje ovddasteaddjit ahte ledjet bussen bániid, go ledjet 10-jahkásaš?

☐ Dávjá (birrasii beaivválaččat) ☐ Duollet dálle ☐ Eai goassige

62. Jus dus leat mánát vuollel 6 jagi geat ásset du luhtte, man dávjá veahkehat don sin bániid busset dahje iskkat leat go sii bussen bániid?

☐ Dávjá (birrasii beaivválaččat) ☐ Duollet dálle ☐ In goassige

63. Jus dus leat mánát gaskal 6–12 jagi geat ásset du luhtte, man dávjá veahkehat don sin bániid busset dahje iskkat leat go sii bussen bániid?

☐ Dávjá (birrasii beaivválaččat) ☐ Duollet dálle ☐ In goassige

64. Jus dus leat mánát gaskal 0–12 jagi geat ásset du luhtte, leat go dis dihto njuolggadusat goas mánát ožžot borrat šukuláda ja eará sohkarnjálgáid?

☐ Jo ☐ Eai

65. Man duhtavaš leat bátnedearvvašvuođabálvalusain du gielddas?

Hui duhtameahttun ☐ ☐ ☐ ☐ ☐ ☐ ☐ Hui duhtavaš ☐ In dieđe

Iešsorbmen ja iešsorbmenláhtenvuohki

66. Leat go goassige massán lagašolbmo iešsorbmema geažil? ☐ Jo ☐ In

67. Leat go smiehttan iežat sorbmet?

☐ Jo, maŋimuš jagis ☐ Jo, ovdal ☐ In, in goassige

68. Leat go geahččalan iežat sorbmet?

☐ Jo, maŋimuš jagis ☐ Jo, ovdal ☐ In, in goassige

69. Leat go mielaeavttus hávvádan iežat?

☐ Jo, maŋimuš jagis ☐ Jo, ovdal ☐ In, in goassige

Jus leat geahččalan iežat sorbmet, sáhtát vástidit čuovvovaš jearaldagaid. Jus leat vástidan ii jearaldahkii, sáhtát mannat viidásat 76. jearaldahkii.

70. Mo geahččalit iežat sorbmet?
(Bija ovtta dahje máŋga ruossa)

- ☐ Harcen
- ☐ Bastilis dávviriin
- ☐ Eará láhkai
- ☐ Báhčinvearju
- ☐ Váldán badjelmeare tableahtaid/dálkasiid

71. Mii lei ággan go geahččalit iežat sorbmet?

Čielga dáhttu jápmit	☐ Jo	☐ Ii
Dilli orui leamen veadjemeahttun	☐ Jo	☐ Ii
Mun hálidin veahki soapmásis	☐ Jo	☐ Ii

72. Ledjet go juhkan/gárihuvvan go geahččalit sorbmet iežat? ☐ Jo ☐ In

73. Man boaris ledjet vuosttaš háve go geahččalit sorbmet iežat? ☐☐

74. Gallii leat geahččalan sorbmet iežat? ☐☐

75. Muitalit go earáide ahte leat geahččalan sorbmet iežat?
(Bija ovtta dahje máŋga ruossa)

- ☐ In
- ☐ Ustibiidda
- ☐ Soapmásii bearrašis
- ☐ Fágaolbmuide

Speallanláhtenvuohki

76. Leat go goassige dovdan dárbbu speallat eanet ahte eanet ruđaid ovddas? (Bija ovtta dahje máŋga ruossa)

☐ Jo, maŋimuš jagis ☐ Jo, ovdal ☐ In

77. Leat go goassige gielistan iežat lagašolbmuide man ollu don spealat? (Bija ovtta dahje máŋga ruossa)

☐ Jo, maŋimuš jagis ☐ Jo, ovdal ☐ In

78. Leat go dus goassige leamaš áigodagat goas, go leat massán ruđaid ovtta beaivvi, leat máhccan ruovttuluotta muhttin eará beaivvi vuoitin dihte daid ruovttuluotta?
(Bija ovtta dahje máŋga ruossa)

☐ Jo, maŋimuš jagis ☐ Jo, ovdal
☐ Eai ☐ In dieđe/in muitte

79. Leat go maŋimuš jagi speallen rollaspealu interneahtas?

☐ Jo, beaivválaččat ☐ Jo, vahkkosaččat
☐ Jo, mánnosaččat dahje hárvvibut ☐ In

Dearvvašvuođabálvalusaid geavaheapmi ja vásáhusat daiguin

80. Dat doavttir maid dábálaččat geavahat lea

☐ Du fástadoavttir ☐ Eará doavttir

81. Man guhká lea dus leamaš dat fástadoavttir mii dus dál lea?

☐ Vuollel 6 mánu ☐ Gaskal 6–11 mánu
☐ Gaskal 12–24 mánu ☐ Guhkit 2 jagi

82. Leat go dan maŋimuš 12 mánus váldán oktavuođa fástadoaktáriin oažžun dihte veahki dahje ráđiid alccet? ☐ Jo ☐ In

Jus leat, vásihit go ahte oažžot dan veahki maid bivdet?

☐ In goassige ☐ Muhttomin ☐ Dábálaččat ☐ Álo

83. Man duhtavaš dahje duhtameahttun leat čuovvovaš osiin fástadoavtterbálvalusain?

	Hui duhtavaš	Duhtavaš	Duhtameahttun	Hui duhtameahttun	In dieđe
Man álki fástadoaktára lea fidnet ságaide telefuvnna bokte	☐	☐	☐	☐	☐
Vuordináigi beassat fástadoaktára lusa	☐	☐	☐	☐	☐
Áigi fástadoaktára luhtte	☐	☐	☐	☐	☐
Man bures fástadoavttir ádde du váttisvuođaid	☐	☐	☐	☐	☐
Fástadoaktára dieđut du dearvvašvuođaváttisvuođaid, iskkadeami ja dálkkodanvugiid ektui	☐	☐	☐	☐	☐
Ollislaččat, man duhtavaš dahje duhtameahttun leat don gieldda dearvvašvuođabálvalusain?	☐	☐	☐	☐	☐

Spesialistadearvvašvuođabálvalusain oaivvilduvvo, buohcciviessu, guovllupsykiatriija guovddáš (DPS), spesialisttadoavtterguovddáš dahje ovttaskas spesialista.

84. Leat go maŋimuš 12 mánus leamaš iskkadeamis dahje dálkkodeamis *rumašlaš váttisvuođaid* geažil

☐ Buohcciviesus ☐ Spesialistadoavtterguovddážis
☐ Priváhta spesialistta luhtte ☐ In guđege sajis

85. Leat go maŋimuš 12 mánus leamaš iskkadeamis dahje dálkkodeamis *psykalaš váttisvuođaid* geažil

☐ Psykiátralaš buohcciviesus ☐ Guovllupsykiatriija guovddážis
☐ Priváhta spesialistta luhtte ☐ In guđege sajis

86. Jus leat leamaš spesialistta luhtte rumašlaš dahje psykalaš váttuid dálkkodeami dihte, vástit čuovvovaš jearaldagaid.
Vástit 0–10 rádjái skálas (0 = hui unnán 10= hui ollu)

Oážžot go vejolašvuođa muitalit dan mii du mielas lei dehálaš du dilálašvuođa ektui?

	0	1	2	3	4	5	6	7	8	9	10	Ii guoskevaš
Rumašlaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Hálle go doaktárat/divššárat dutnje nu ahte don áddejit sin?

	0	1	2	3	4	5	6	7	8	9	10	Ii guoskevaš
Rumašlaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Besset go iežat mielas leat searvvis mearridit iežat dálkkodeami?

	0	1	2	3	4	5	6	7	8	9	10	Ii guoskevaš
Rumašlaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dagahii go dálkkodeapmi ahte buorránit?

	0	1	2	3	4	5	6	7	8	9	10	Ii guoskevaš
Rumašlaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ollislaččat, lea go dus luohttámuš buohccivissui dahje spesialistii gean luhtte fitnet?

	0	1	2	3	4	5	6	7	8	9	10	Ii guoskevaš
Rumašlaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ollislaččat, man duhtavaš leat don divššuin ja dálkkodemiin maid oažžot?

	0	1	2	3	4	5	6	7	8	9	10	Ii guoskevaš
Rumašlaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalaš váttuid oktavuođas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Vásáhusat čujuhemiin

87. Leat go maŋimuš 12 mánus hálidan čujuhuvvot spesialistta lusa, muhto it leat čujuhuvvon?

Rumašlaš váttuid oktavuođas

☐ In, in goassige ☐ Jo, oktii
☐ Jo, máŋgii ☐ Ii guoskevaš

Psykalaš váttuid oktavuođas

☐ In, in goassige ☐ Jo, oktii
☐ Jo, máŋgii ☐ Ii guoskevaš

88. Leat go maŋimuš 12 mánus hálidan čujuhuvvot fysioterapevtta, kiropraktora dahje sullasačča lusa, muhto it leat čujuhuvvon?

☐ In, in goassige ☐ Jo, oktii
☐ Jo, máŋgii ☐ Ii guoskevaš

89. Jus čujuhuvvojit, man guhká vurdet diimmu?

Galle vahku ☐☐

90. Leat go sihtan friddja buohcciviessoválljema go leat čujuhuvvon spesialistadálkkodeapmái?

☐ Jo ☐ In ☐ Ii guoskevaš

Giella doaktára luhtte

91. Maŋimuš go ledjet fástadoaktára luhtte, makkár giela hálaide doai doaktáriin?

	Dárogiela	Sámegiela	Eará,	čilge:
Mun hállen	☐	☐	☐	....
Doavttir hálai	☐	☐	☐	....

92. Maŋimuš go ledjet buohcciviesus/spesialistta luhtte, makkár giela hálaide doai doaktáriin?

	Dárogiela	Sámegiela	Eará,	čilge:
Mun hállen	☐	☐	☐	....
Doavttir hálai	☐	☐	☐	....

93. Makkár giela hálašit miellasepmosit dearvvašvuođabargiiguin? (Bija ovtta dahje máŋga ruossa)

Dárogiela	Sámegiela	Eará,	čilge:
☐	☐	☐	....

Dulkka atnin

94. Jus vástidit «sámegiela», muhto ii fállojuvvon sámegielat doavttir maŋimuš go ledjet doaktára luhtte, ožžot go dulkafálaldaga?

Fástadoaktára luhtte:

☐ Jo ☐ In
☐ In hálit geavahit dulkka ☐ Ii guoskevaš

Buohcciviesus/spesialistta luhtte:

☐ Jo ☐ In
☐ In hálit geavahit dulkka ☐ Ii guoskevaš

95. Jus geavahuvvui sámegielat dulka maŋimuš go ledjet doaktára luhtte, gii doaimmai dulkan?

Fástadoaktára luhtte:

☐ Almmolaš bálkáhuvvon dulka ☐ Bearašlahttu
☐ Doavtterkantuvrra bargi ☐ Eará

Buohcciviesus/spesialistta luhtte:

☐ Almmolaš bálkáhuvvon dulka ☐ Bearašlahttu
☐ Eará bargi buohcciviesus ☐ Eará

96. Jus goassige leat leamaš doavtteriskkadeamis/dálkkodeamis gos lei sámegielat dulka, man duhtavaš leat don du ja doaktára/divššára gulahallamiin/ságastallamiin?

Fástadoaktára luhtte:

☐ Hui duhtavaš ☐ Duhtavaš
☐ Duhtameahttun ☐ Hui duhtameahttun
☐ In dieđe

Buohcciviesus/spesialistta luhtte:

☐ Hui duhtavaš ☐ Duhtavaš
☐ Duhtameahttun ☐ Hui duhtameahttun
☐ In dieđe

97. Leat go goassige vásihan ahte it leat ožžon dárogielat/sámegielat dulkaveahki vaikke leat bivdán dan?

☐ Jo, lea dáhpáhuvvan ahte lean bivdán dulkka in ge leat ožžon
☐ Ii, lean álo ožžon dulkka jus lean bivdán dan
☐ In leat goassige bivdán dulkka

Giitu go servet jearahallamii!

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-110901 – NORDSAMISK

Questionnaire—Lule Sámi

Varresvuoda- ja iellemdile guoradallam

1. Mån guorrasav oassálasstet guoradallamij daj diedoj milta ma li diehtojuohkemtjállagin ☐ Guorrasav

Ietjat varresvuohta

2. Gåktu le duv varresvuohta dálla? (Bieja avtav ruossav)

☐ Nievrre ☐ Ij la ållo buorak ☐ Buorak ☐ Huj buorak

3. Le gus dujna, jali le gus dujna goassak læhkám?

	Le	Ij la	Man vuoras lidji gå oadtjo
Diabetes (såhkårvihke)	☐	☐	
Alla varradæddo	☐	☐	
Angina pectoris (tsåhkegæsádahka)	☐	☐	
Tsåhkehávve	☐	☐	
Psykalaš vájve masi la viehkev åhtsåm	☐	☐	
Bisse bronkihtta, emfysema, KOLS	☐	☐	
Ástmá	☐	☐	
Eksebma	☐	☐	
Soriasis	☐	☐	
Multippel sklerose (MS)	☐	☐	
Bechterews dávda	☐	☐	

4. Le gus <u>maŋemus jage</u> vájvástuvvam báktjasij ja/jali viednam diehkoj ja gálvam lahtasij <u>binnemusát gålmå máno</u> avtat rajes? ☐ Lev ☐ Iv la

Jus le, tjále tabellaj vuollelin makta le vájvástuvvam
(Bieja avtav ruossav juohkka linjáj)

	Iv la vájvástuvvam	Vehik vájvástuvvam	Huj vájvástuvvam
Nisske, oalge	☐	☐	☐
Gieda	☐	☐	☐
Hárddo	☐	☐	☐
Svirrala	☐	☐	☐
Nårråsa, juolge	☐	☐	☐
Oajvve	☐	☐	☐
Radde	☐	☐	☐
Tjoajvve	☐	☐	☐
Vuollevájmmo	☐	☐	☐
Ietjá sajijn	☐	☐	☐

5. Man álu le <u>maŋemus 4 vahkon</u> bårråm tjuovvovasj dálkkasijt? (Bieja avtav ruossav juohkka linjáj)

	Iv la bårråm maŋemus 4 vahkon	Vuorjábut gå juohkka vahko	Juohkka vahko, valla ij bæjválattjat	Bæjvá-lattjat
Oademdálkkasav	☐	☐	☐	☐
Ráfájduhttemdálkkasav	☐	☐	☐	☐
Dálkkasav låssåmiela vuosstij	☐	☐	☐	☐

6. Makkár javllamusá hiehpi buoremusát duv varresvuoda dilláj uddni?

Vádtsem

☐ Mujna ij la gássjelisvuohta vádtset
☐ Mujna le vehik gássjelisvuohta vádtset
☐ Mån iv máhte ietján gå seŋgan vellahit

Ietjat sujtto

☐ Mujna ij la gássjelisvuohta ietjam sujttit
☐ Mujna le vehik gássjelisvuohta basádimijn ja gárvvunimijn
☐ Mån iv ietjam basádit máhte

Dábálasj dåjma (d.d. barggo, låhkåm, sijddabarggo, familljа- jali asstoájggedåjma)

☐ Mujna ij la gássjelisvuohta dábálasj dåjmajt doajmmat
☐ Mujna le vehik gássjelisvuohta dábálasj dåjmajt doajmmat
☐ Mån iv nagá ietjam dábálasj dåjmajt doajmmat

Báktjasa ja unugisvuohta

☐ Mujna ælla báktjasa jalik unugisvuoda
☐ Mujna le vehik báktjasa ja unugisvuoda
☐ Mujna le garra báktjasa jali unugisvuoda

Ballo ja låssåmiella

☐ Mujna ij la ballo ij ga låssåmiella
☐ Mujna le vehik ballo jali låssåmiella
☐ Mujna le huj ballo jali huj låssåmiella

7. Man ålov viehkki dån? (ålles kilojt)

8. Man allak le dån? (ålles cm)

9. Gåhttjop duv almodit ietjat rubbmelasj dåjmadimev skálan huj binnás gitta huj ålluj. Skála dánna vuollelin le 1–10 rádjáj. Rubbmelasj dåjmadime li sihke sijddadåjma ja bargo bargodilen, ja aj låsjmudallama ja ietjá rubbmelasj dåjmadimev duola degu vádtsem jnv Bieja ruossav dan ruktuj mij buoremusát tjielggi man rubbmelasj dåjmalasj dån le.

	1	2	3	4	5	6	7	8	9	10	
Huj binná	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Huj ållo

Famillja ja gielladuogásj

Nuortta-Vuonan årru ulmutja gejn le moattelágásj tjerdalasj duogátja. Dat merkaj sij hålli geŋga gielajt ja sijájn le geŋga kultuvra. Åvddåmærkkan tjerdalasj duogátjij, jali tjerdalasj juohkusij li dádtja, sábmelattja ja guojna.

10. Makkár gielav håla. Makkár gielav hålli/hållin duv æjgáda ja áhko ja ádjá sijdan? (Bieja avtav jali moadda ruossa)

	Dáro-gielav	Sáme-gielav	Guojna-gielav	Ietjá gielajt,	tjielggi:
Áddjá (iedne áhttje)	☐	☐	☐	☐	
Áhkko (iedne ieddne)	☐	☐	☐	☐	
Áddjá (áhtje áhttje)	☐	☐	☐	☐	
Áhkko (áhtje ieddne)	☐	☐	☐	☐	
Áhttje	☐	☐	☐	☐	
Ieddne	☐	☐	☐	☐	
Mån iesj	☐	☐	☐	☐	

11. Mij le duv, duv áhtje, duv iedne tjerdalasj duogásj?
(Bieja avtav jali moadda ruossa)

	Dádtja	Sábme	Guojnna	Ietjá,	tjielggi:
Muv tjerdalasj duogásj le	☐	☐	☐	☐	
Muv áhtje tjerdalasj duogásj le	☐	☐	☐	☐	
Muv iedne tjerdalasj duogásj le	☐	☐	☐	☐	

12. Manen ietjat aná? (Bieja avtav jali moadda ruossa)

Dádtjan	Sábmen	Guojnnan	Ietján,	tjielggi:
☐	☐	☐	☐	

13. Gåktu dån árvustalá ietjat tjehpudagáv dádjadit, hållat, låhkåt jali tjállet sámegielav?

	Huj buoragit	Vehik buoragit	Vehik rahtjamijn	Soames bágov	Iv åvvånis
Dádjadav	☐	☐	☐	☐	☐
Hålav	☐	☐	☐	☐	☐
Lågåv	☐	☐	☐	☐	☐
Tjáláv	☐	☐	☐	☐	☐

Barggo, oadjo ja økonomija

14. Man stuorra bruttosisboahto le familjan/goaden jahkásattjat?

☐ Vuollela 150 000 kr ☐ 150 000–300 000 kr
☐ 301 000–450 000 kr ☐ 451 000–600 000 kr
☐ 601 000–750 000 kr ☐ 751 000–900 000 kr
☐ Badjel 900 000 kr

15. Man galles årru dan vieson gånnå dån åro? Galla ulmutja ☐☐

16. Galla skåvllåjage le dån tjádadam? (Lågå gájkka jagijt majt la skåvlån vádtsám jali studerim) ☐☐

17. Årru gus internáhtan (stáhtainternáhtan, suohkana jali priváhta) gå vuodoskåvlåv vádtsi? ☐ Lev ☐ Iv la

18. Ma li læhkám ájnnasamos gáldo duv sisbåhtuj maŋemus jage? (Bieja avtav jali moadda ruossa)

☐ Bálkkábarggo:
- ☐ Ållessájggáj ☐ Oasseájggáj ☐ Jáhpebarggo

☐ Iesjrádálasj æládus:
- ☐ Ållessájggáj ☐ Oasseájggáj ☐ Jáhpebarggo

☐ Boarrásijpensjåvnnå/AFP
☐ Ruhtadoarjja/gasskamuddodoarjja/æjgátrudá
☐ Biejvverudá
☐ Skihppijrudá
☐ Barggotjielggidamrudá
☐ Fábmálisvuodapensjåvnnå
☐ Doarjja viessombierggimij (sosiállaviehkke)
☐ Doarjja gállasjguojmes/æjgádijs/oarbbenijs/mánásj
☐ Lådna/studielådna ja stipenda
☐ Ietján (siesstemrudá/árbbe/vidniga jnv.)

19. Árvvala gus dujna le máhttelisvuohta bargov majt dálla barga masset, jali ietjat sisboadov tjuodtjelij guovten jagen? ☐ Árvvalav ☐ Iv

20. Lidji gus jåhttåt das suohkanis gånnå dalla åro jus lidji barggofálaldagáv oadtjot ietjá sajen?

☐ Lidjiv ☐ Dåssju oasev jages
☐ Iv lim ☐ Iv diede

21. Jus le bálkkábargon gåktu soaptso dan bargon/æládusán gånnå le dálla?

☐ Huj buoragit ☐ Buoragit ☐ Nievret ☐ Huj nievret

22. Duv varresvuoda ja barggoåtsådallamij milta le gus jåhkedahtte bálkkábargon/æládusán joarká gitta dasik dævddá:

	Huj jáhke-dahtte	Jáhke-dahtte	Binnebut jáhkedahtte	Huj binnáv jáhkedahtte
Sulá 62 jage	☐	☐	☐	☐
Sulá 67 jage	☐	☐	☐	☐
Sulá 70 jage	☐	☐	☐	☐
Vuorrasap gå 70 jage	☐	☐	☐	☐

23. Jus le dujna iesjrádálasj æládus, makkár æládus le dujna?
(Bieja avtav jali moadda ruossa)

- ☐ Boatsojæládus
- ☐ Guolástus
- ☐ Ednambarggo
- ☐ Miehttseæládus
- ☐ Oasestibme
- ☐ Ietjá

Psykalasj varresvuohta

24. Vuollelin gávna listav duojna dájna gássjelisvuodajn. Le gus násedam majdik dájs dáj nielje maŋemus vahkon?
(Bieja avtav ruossav juohkka vájvváj)

	Iv le vájvás-tuvvam	Vehik vájvást-uvvam	Viehka vájvás-tuvvam	Sælldát vájvás-tuvvam
Hæhkka balo sivá dagi	☐	☐	☐	☐
Dåbddåm balov jali læhkám goavgas	☐	☐	☐	☐
Njuotsas jali dajnas	☐	☐	☐	☐
Dåbddåm ietjat niejdedum ja juolodibmen	☐	☐	☐	☐
Iesjlájttem	☐	☐	☐	☐
Nahkárahtes ijá	☐	☐	☐	☐
Håjen ja nievresluondok	☐	☐	☐	☐
Dåbddåm ietjat åvkedibmen, dåbddåm dujna le binná árvvo	☐	☐	☐	☐
Dåbddåm dåssju rahtjamusáv	☐	☐	☐	☐
Dårvodisvuodav dåbddåt boahtteájge gáktuj	☐	☐	☐	☐

25. Gatjálvisá le dan birra makkár dåbdå ja gåktu dujna le læhkám dan maŋemus vahko. Juohkka gatjálvisán, vállji dav vásstádusáv mij buoremusát tjielggi gåktu dujna le læhkám. Man álu le dån dan maŋemus vahko: (Bieja ruossav dan ruktuj mij lagámusát tjielggi duv dilev)

	Avtat rajes	Vargga avtat rajes	Stuorra oasev ájges	Muhtem oasev ájges	Vehik oasev ájges	Iv åvvånis
Dåbddåm ietjam åvon ja buorre mielan	☐	☐	☐	☐	☐	☐
Dåbddåm ietjam jasska ja loajttot	☐	☐	☐	☐	☐	☐
Dåbddåm ietjam dåjmalattjan ja gievrran	☐	☐	☐	☐	☐	☐
Dåbddåm ietjam vieddje ja vuojŋastam	☐	☐	☐	☐	☐	☐
Dåbddåm muv árggabiejven le åssje majt mån berustav	☐	☐	☐	☐	☐	☐

26. Le gus maŋemus 12 mánon násedam unugis mujtojt ma li nággim ja ráfeduhttám duv, ja maj ij le læhkám máhttelisvuohta majdik dahkat?

☐ Iv la ☐ Lev, valla vuorjját ☐ Muhttijn ☐ Álu

27. Le gus dån maŋemus 12 mánon mielalattjat garvvám dilijt unugis mujtoj jali dåbdåj diehti nav vaj da li hieredam duv dahkamis dav majt hálijdi?

☐ Iv la ☐ Lev, valla vuorjját ☐ Muhttijn ☐ Álu

28. Le gus dån maŋemus 12 mánon dåbddåm ij la nahkam reagerit dilijn gånnå ienemusá iehtjádijs reagerijin dåbdåj?

☐ Iv la ☐ Lev, valla vuorjját ☐ Muhttijn ☐ Álu

29. Almmuda man buoragit tjuovvovasj tjuottjodus gåvvi duv ja duv familjav

	Ij hieba				Hiehpá buoragit
Luohtedav ållåsijt dajda merustallamijda ja mærrádusájda majt vålldiv	☐	☐	☐	☐	☐
Mån soaptsov buoremusát gå lav aktan iehtjádij	☐	☐	☐	☐	☐
Mån soaptsov huj buoragit ietjam familja siegen	☐	☐	☐	☐	☐
Muv jáhkko allasim viehket muv gassjelis ájgij tjadá	☐	☐	☐	☐	☐
Mån álkket rádnajt oattjov	☐	☐	☐	☐	☐
Muv familjan le buorre aktijvuohta	☐	☐	☐	☐	☐
Vuosstemannamijn nagáv gávnnat buorre åssijt ma låggŋiji muv	☐	☐	☐	☐	☐
Lev tjiehppe åttjutjit aktijvuodav amás ulmutjij	☐	☐	☐	☐	☐
Muv familjan le positijvalasj vuojnno boahtteájggáj, gassjelis ájgij adjáj	☐	☐	☐	☐	☐
Mån nagáv dåhkkidit dáhpádusájt iellemin majt ij máhte rievddat	☐	☐	☐	☐	☐
Muv mielas le álkke gávnnat juojddáv buorev man birra máhttá sáhkadit	☐	☐	☐	☐	☐
Muv familjan lip åskeldisá guhtik guojmmásimme	☐	☐	☐	☐	☐

Dubáhkka ja gárevsælgga

30. Suovasta gus, jali le gus suovastam åvddål?

- ☐ Lev bæjválattjat
- ☐ Lev åvddål
- ☐ Lev muhttijn
- ☐ Iv, iv goassak

Galla sigárehta suovasta dábálattjat bæjvváj? ☐☐

Áldar

Man vuoras lidji gå álggi suovastit bæjválattjat? ☐☐

31. Snuksi gus, jali le gus åvddål snuksim?

- ☐ Lev bæjválattjat
- ☐ Lev åvddål
- ☐ Lev muhttijn
- ☐ Iv, iv goassak

Dunji guhti snuksi bæjválattjat: Galli snuksi bæjvváj? ☐☐

Dunji guhti snuksi duoloj dálloj: Galli snuksi dábálattjat juohkka vahko? ☐☐

Áldar

Jus lev, man vuoras lidji gå álggi snuksit bæjválattjat? ☐☐

32. Sulá galli le maŋemus jage alkoholav juhkam? (Giehppisvuola ja alkoholadis vuola ij lågåduvá)

- ☐ Iv le goassak juhkam alkoholav
- ☐ Iv le juhkam alkoholav maŋemus jage
- ☐ Soames bále dan maŋemus jage
- ☐ Sulá akti mánnuj
- ☐ 2–3 mánnuj
- ☐ Sulá 1 vahkkuj
- ☐ 2–3 vahkkuj
- ☐ 4–7 vahkkuj

33. Le gus juhkam alkoholav dáj maŋemus 4 vahkon? ☐ Lev ☐ Iv la

Jus le, le gus juhkam nav ålov vaj dåbddåm la ietjat gárramin?

☐ Iv la ☐ Lev, akti – guokti ☐ Lev, gålmmi jali ienep

34. Máhtá gus gåhttjot ietjat alkoholjuhkamav jali juhkamvuogev ájggegasskasattjan (jugá álu ja ednagav soames ájge, ja de le guhka ájgge goassa i jugá alkoholav)?
(Bieja avtav jali moadda ruossa)

☐ Máhtáv, maŋemus 12 máno ☐ Máhtáv, åvddål ☐ Iv

35. Le gus dujna goassak narkotihkajn dahkamus læhkám?
(Bieja avtav jali moadda ruossa)

	Lev, maŋemus jage	Lev, åvddål	Iv la
Hasj/marihuana (cannabis)	☐	☐	☐
Ietjá narkotihkalasj gárevselga, duola degu LSD, amfetamijnna, ecstasy, kokaijnna, heroijnna, GHB, jnv.	☐	☐	☐

Åssku ja iellemvuojnno

36. Le gus dån, duv æjgáda jali duv áhko ja ádjá tjanádum aktasik dájda tjuovvovasj iellemvuojnnosiebrijda:
(Bieja avtav jali moadda ruossa)

	Mån iesj	Ieddne	Áhttje	Áhko ja ádjá
Stáhtagirkko	☐	☐	☐	☐
Laestadiánálasj tjoaggulvis	☐	☐	☐	☐
Ietjá vuojŋŋalasj tjoaggulvis/aktisasjvuohta	☐	☐	☐	☐
makkár:				
Vuojŋŋalasjiellemvuojnodis sebrudahkaj	☐	☐	☐	☐
makkár:				
Ij lav sebrulasj makkárik iellemvuojnnosebrudagán	☐	☐	☐	☐

37. Makkár aktijvuohta le dujna åsskuj?

- ☐ Mån lav jáhkulasj/dåbdåstav risstalasjvuohtaj (persåvnålasj ristagis)
- ☐ Mån jáhkáv Jubmel gávnnu, valla jáhkos ij le nav stuorra berustibme bæjválattjat
- ☐ Juorrulav
- ☐ Mån iv jáhke Jubmel gávnnu

38. Man álu le daj maŋemus 6 mánon læhkám:
(Bieja avtav ruossav juohkka linjáj)

	Ienep gå gålmmi mánnuj	1–3 mánnuj	1–6 maŋemus 6 mánnuj	Iv goassak
Girkkon	☐	☐	☐	☐
Tjoaggulvis-/biednadåben	☐	☐	☐	☐
Humánehtalasj tjåhkanimen	☐	☐	☐	☐
Ietja vuojŋŋalasj dåben	☐	☐	☐	☐

Badjelgæhttjalimev vásedam

Badjelgæhttjam le gå ulmusj jali juogos ulmutjijs aneduvvi nievrebun gå iehtjáda. Sivvan máhttá liehket sijá tjerdalasj duogásj, åssko, jáhkko, doajmmahieredisvuohta, áldar jali seksuálalasj berustime.

39. Le gus vásedam badjelgæhttjamav?

☐ Lev, maŋemus guokta jage ☐ Lev, åvddål
☐ Iv la ☐ Iv diede

Jus vásstedi lev åvdep gatjálvissaj, vássteda gatjálvisájt 40–47. Jus le vásstedam iv, maná vijddábut 48. gatjálvissaj.

40. Jus le vásedam badjelgæhttjamav, man álu dáhpáduváj?

☐ Huj álu ☐ Duolluj dalloj ☐ Vuorjját

41. Mannen jáhká dån badjelgehtjaduvvi ? Mij lij sivvan badjelgæhttjamij: (Bieja avtav jali moadda ruossa)

- ☐ Doajmmahieredisvuohta
- ☐ Seksuálalasj berustime
- ☐ Oahppamgåssjelisvuoda
- ☐ Sjiervve
- ☐ Åssku jali jáhkko
- ☐ Tjerdalasjvuohta
- ☐ Tjerdalasj duogásj
- ☐ Geográfalasj gulluvasjvuohta
- ☐ Áldar
- ☐ Skihpudahka
- ☐ Ietjá sivá, tjielggi: ....
- ☐ Iv diede

42. Máhtá gus subtsastit gånnå badjelgæhttjam dáhpáduváj?
(Bieja avtav jali moadda ruossa)

- ☐ Internehtan
- ☐ Skåvlån/åhpadusán
- ☐ Bargon
- ☐ Barggoåhtsåma aktijvuodan
- ☐ Luojvojbargon/organisásjåvnån
- ☐ Almulasjvuoda æjvvalimen
- ☐ Berrahij/familja aktijvuodan
- ☐ Gå ájggu lájggit/oasstit viesov
- ☐ Gå ájggu háhkuhit báŋŋkaluojkav
- ☐ Medisijnalasj dálkudime aktijvuodan
- ☐ Oassásin jali bårådimbájken
- ☐ Bájkálasj sebrudagán
- ☐ Ietjá sajen, tjielggi: ....

43. Máhtá gus subtsastit guhti duv badjelvgehtjaj?
(Bieja avtav jali moadda ruossa)

- ☐ Almulasj bargge
- ☐ Amás ulmutja
- ☐ Bargorádna
- ☐ Akta jali moattes gejn le sæmmi tjerdalasj duogásj gå dujna.
- ☐ Akta jali moattes gejn le ietjá tjerdalasj duogásj gå dujna.
- ☐ Guojmmeoahppe/studenta
- ☐ Åhpadiddje/bargge
- ☐ Iehtjáda

44. Dahki gus majdik vájmmelisát hiejtedittjat badjelgæhttjamav? ☐ Dahkiv ☐ Ittjiv

45. Le gus goassak válldám aktijvuodav dássádusoahttsijn åttjutjit rádev ja viehkev badjelgæhttjama gáktuj?

☐ Lev ☐ Iv la ☐ Iv mujte

46. Guoskadaláj gus badjelgæhttjam dunji?

☐ Ij åvvånis ☐ Vehik ☐ Muhtemærráj ☐ Ednagav

47. Le gus vásedam badjelgæhttjamav dan diehti gå la sábme?

☐ Lev ☐ Iv la ☐ Iv diede ☐ Iv la sábme

Vahágahttem ja vierredahko

48. Le gus vásedam soames guhkes ájgev ja systemmáhtalattjat le gæhttjalam niejddet, hæssodit jali njuoradit duv? (Bieja avtav jali moadda ruossa)

- ☐ Iv, iv goassak
- ☐ Lev, ållessjattugin (18 jage jali vuorrasabbo)
- ☐ Lev, mánnán (vuollel 18 jage)
- ☐ Lev, maŋemus 12 mánon

Jus le, gæssta?

- ☐ Amás ulmutjis
- ☐ Berrahis, fuolkes
- ☐ Guojmes
- ☐ Ietjá oahppásis

49. Le gus vásedam rubbmelasj vierredagov/dierredimev?
(Bieja avtav jali moadda ruossa)

- ☐ Iv, iv goassak
- ☐ Lev, ållessjattugin (18 jage jali vuorrasabbo)
- ☐ Lev, mánnán (vuollel 18 jage)
- ☐ Lev, maŋemus 12 mánon

Jus le, gæssta?

- ☐ Amás ulmutjis
- ☐ Berrahis, fuolkes
- ☐ Guojmes
- ☐ Ietjá oahppásis

50. Le gus vásedam seksuálalasj råhtsatjimev? (Bieja avtav jali moadda ruossa)

- ☐ Iv, iv goassak
- ☐ Lev, ållessjattugin (18 jage jali vuorrasabbo)
- ☐ Lev, mánnán (vuollel 18 jage)
- ☐ Lev, maŋemus 12 mánon

Jus le, gæssta?

- ☐ Amás ulmutjis
- ☐ Berrahis, fuolkes
- ☐ Guojmes
- ☐ Ietjá oahppásis

51. Jus le vásedam makkárik vierredagov, le gus soabmásij dáv subtsastam? (Bieja avtav jali moadda ruossa)

- ☐ Iv la
- ☐ Rádnajda
- ☐ Soames berrahij
- ☐ Fáhkaulmutjijda

Bádnevarresvuohta

52. Gåktu le duv bádnevarresvuohta ietjat mielas?

☐ Nievrre ☐ Ij la rat buorre ☐ Buorre ☐ Huj buorre

53. Le gus dujna luovasbáne? ☐ Le ☐ Ælla

54. Åvkástalá gus dån iesj muhtemav dájs tjuovvovasj viehkkenævojs – ja jus, man álu?

	Bæjválattjat	Duolla dálla/ moaddi vahkon	Duolla dálla/ moaddi mánon	Vuorjjábut/ ij goassak
Bádneskuorun	☐	☐	☐	☐
Fluorbádnegella	☐	☐	☐	☐
Bádnesuodna	☐	☐	☐	☐
Bádnesåluna	☐	☐	☐	☐
Fluor-tablehta	☐	☐	☐	☐
Njálmedåjddemtjáhtje	☐	☐	☐	☐
Bádneskuorun hiebadum luovasbánijda	☐	☐	☐	☐

55. Goassa maŋemus lidji bádnedåktåra jali bádnesujttára lunna?

- ☐ Binnep gå jahke das åvddål
- ☐ 1–2 jage ájgge
- ☐ 3–5 jage ájgge
- ☐ Badjel 5 jage ájgge

56. Jus le badjel guovte jage ájgge, mij dasi le sivvan?
(Bieja avtav jali moadda ruossa)

- ☐ Iv le gåhtjoduvvam
- ☐ Guhka vuorddemájgge le bessat bádnedåktåra lusi
- ☐ Iv la asstam
- ☐ Økonomalasj sivát
- ☐ Mujna ij la læhkám dárbbo bádnesujttimij
- ☐ Mån baláv jali gåvav vuolggemis bádnedåktåra lusi
- ☐ Ietjá sivá:

____

57. Gåktu dån ávkki bádnevarresvuodadievnastusáv? (Bieja avtav jali moadda ruossa)

- ☐ Bádnedåktår jali bádnesujttár gåhttju muv duolloj dálloj boahtet
- ☐ Diededav juovnnát bánijt gehtjadittjat
- ☐ Diŋŋguv tijmav gå li báktjasa, jali gå lav bádnedevdadisáv lahppám
- ☐ Iv nav álu bádnedåktåra lusi maná

58. Le gus daj maŋemus guovten jagen oadtjum avtav jali ienebuv dajs diagnosajs bádnedåktåris?

	Lev	Iv la	Iv diede
Alvos bádneoadtjevuolssje	☐	☐	☐
Bádneoadtjevuolssje mij ij la nav alvos	☐	☐	☐
Njálmme gåjkkåm	☐	☐	☐
Rájgge avtan jali moatten bánen (karies)	☐	☐	☐
Ietjá diagnosajt	☐	☐	☐

59. Le gus dudálasj ietjat bánij jali ietjat luovasbánij? Almoda vásstádusáv skálaj gånnå 1 le huj duhtamahtes ja 5 le huj dudálasj

Huj duhtamahtes 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Huj dudálasj

60. Man álu bánijt skuorru 10-jagágin?

- ☐ Akti bæjvváj jali ienebut
- ☐ Duolloj dálloj
- ☐ Vuorjját jali ij goassak

61. Man álu dárkestin duv æjgáda jali åvdåsvásstediddje jus dån lidji bánijt skuorrum, gå lidji 10-jagák?

☐ Dájvváj (birrasij bæjválattjat) ☐ Duolloj dálloj ☐ Ij goassak

62. Jus dujna li máná nuorabu gå 6 jagága gudi duv lunna årru, man dájvváj viehkeda dån sijáv bánijt skuorrot jali dárkesta gus jus sij le bánijt skuorrum?

☐ Dájvváj (birrasij bæjválattjat) ☐ Duolloj dálloj ☐ Ij goassak

63. Jus dujna li máná 6–12 jage gaskan gudi duv lunna årru, man dájvváj viehkeda dån sijáv bánijt skuorrot jali dárkesta gus jus sij li bánijt skuorrum?

☐ Dájvváj (birrasij bæjválattjat) ☐ Duolloj dálloj ☐ Ij goassak

64. Jus li máná gudi li 0–12 jage gasskan gudi duv lunna årru, le gus diján læhkám njuolgadusá goassa máná oadtju sjokoládav ja ietja hálmugijt bårråt?

☐ Le ☐ Ælla

65. Man dudálasj le dån bádnevarresvuodadievnastusájn ietjat suohkanin?

Huj dudálasj ☐ ☐ ☐ ☐ ☐ ☐ Huj duhtamahtes ☐ Iv diede

Iesjsårmmim ja iesjsårmmimdåhpádus

66. Le gus massám soabmásav lagámusájs iesjsårmmima baktu? ☐ Lev ☐ Iv la

67. Le gus ájádallam ietjat sårmmit?

☐ Lev, maŋemus jagen ☐ Lev, åvddåla ☐ Iv, iv goassak

68. Le gus gæhttjalam ietjat sårmmit?

☐ Lev, maŋemus jagen ☐ Lev, åvddåla ☐ Iv, iv goassak

69. Le gus mielanækton vahágahttám ietjat?

☐ Lev, maŋemus jagen ☐ Lev, åvddåla ☐ Iv, iv goassak

Jus le gæhttjalam ietjat sårmmit, máhtá vásstedit tjuovvovasj gatjálvisájt. Jus le vásstedam iv gatjálvissaj, máhtá mannat vijddábut 76. gatjálvissaj.

70. Gåktu gæhttjali ietjat sårmmit? (Bieja avtav jali moadda ruossa)

- ☐ Hartsastimijn
- ☐ Vuohtjemværjoj
- ☐ Basstelis dávverijn
- ☐ Badjelmierre tablehtajs/dálkkasijs
- ☐ Ietjá láhkáj

71. Mij lij sivvan gå gæhttjali ietjat sårmmit?

Tjielga hállo jábmet	☐ Lej	☐ Ij lim
Dille lij gierddamahtes	☐ Lej	☐ Ij lim
Mån hálijdiv viehkev soabmásis	☐ Lej	☐ Ij lim

72. Lidji gus juhkam/gárramin gå gæhttjali ietjat sårmmit? ☐ Lidjiv ☐ Iv lim

73. Man vuoras lidji gå vuostasj bále gæhttjali ietjat sårmmit? ☐☐

74. Man galli le gæhttjalam ietjat sårmmit? ☐☐

75. Subtsasti gus iehtjádijda dån lidji gæhttjalam ietjat sårmmit? (Bieja avtav jali moadda ruossa)

- ☐ Iv la
- ☐ Soames berrahij
- ☐ Rádnajda
- ☐ Fáhkaulmutjijda

Speallamdábe

76. Le gus goassak dåbddåm dárbov spellat ienep ja ienep rudáj åvdås? (Bieja avtav jali moadda ruossa)

☐ Lev, maŋemus jagen ☐ Lev, åvddål ☐ Iv la

77. Le gus goassak gielestam sidjij gudi li ájnnasa dunji, man ålov dån spela? (Bieja avtav jali moadda ruossa)

☐ Lev, maŋemus jagen ☐ Lev, åvddål ☐ Iv la

78. Le gus dujna goassak læhkám ájggegasska goassa le massám rudájt avta biejve, le máhtsám ruoptus muhtem ietjá biejve vuojtátjit ruopptot dajt rudájt majt le massám? (Bieja avtav jali moadda ruossa)

☐ Lev, maŋemus jage ☐ Lev, åvddål

☐ Iv la ☐ Iv diede/iv mujte

79. Le gus maŋemus jage spellam rollaspelav internehtan?

☐ Lev, bæjválattjat ☐ Lev, vahkutjattjat

☐ Lev, mánutjattjat jali vuorjját ☐ Iv la

Varresvuodadievnastusáj ávkástallam ja åtsådallama

80. Dat doktår gev dábálattjat ávkástalá le

☐ Duv stuovesdoktår ☐ Ietjá doktår

81. Man guhkev le dujna læhkám dat stuovesdoktår gut dujna dálla le?

☐ Vuollel 6 mánu ☐ Gaskal 6–11 mánu

☐ Gaskal 12–24 mánu ☐ Guhkebuv gå 2 jage

82. Le gus dáj maŋemus 12 máno vålldam aktijvuodav stuovesdoktårijn åttjutjit viehkev jali rádijt allasit? ☐ Lev ☐ Iv la

Jus le, vásedi gus oadtjot dav viehkev majt sihti?

☐ Iv goassak ☐ Muhttijn ☐ Dábálattjat ☐ Agev

83. Man dudálasj jali duhtamahtes le tjuovvovasj åsij stuovesdoktårdievnastusájn?

	Huj dudálasj	Dudálasj	Duhtamahtes	Huj duhtamahtes	Iv diede
Man åledahtte le stuovesdoktår telefåvnå baktu	☐	☐	☐	☐	☐
Vuorddemájgge bessat stuovesdoktåra lusi	☐	☐	☐	☐	☐
Ájgge stuovesdoktåra lunna	☐	☐	☐	☐	☐
Man buoragit stuovesdoktår dádjat duv gåssjelisvuodajt	☐	☐	☐	☐	☐
Stuovesdoktåra diedo duv varresvuodagåssjelisvuodaj, guoradallamij ja dálkudimvuogij hárráj	☐	☐	☐	☐	☐
Ålles láhkáj, man dudálasj jali duhtamahtes le dån suohkana varresvuodadievnastusájn?	☐	☐	☐	☐	☐

Sierratjiehpij varresvuodadievnastusájn (spesialhelsetjenesten) árvvaluvvá, skihppijviesso, guovllopsykiatrija guovdásj (DPS), sierratjiehpij doktårguovdásj jali ájnegis sierratjiehpe.

84. Le gus maŋemus 12 mánon læhkám guoradallamin jali dálkudimen *rubbmelasj gåssjelisvuodaj* diehti

☐ Skihppijvieson ☐ Sierratjiehpij doktårguovdátjin

☐ Priváhta sierratjiehpe lunna ☐ Iv makkárik sajen

85. Le gus maŋemus 12 mánon læhkám guoradallamin jali dálkodimen *psykalasj gåssjelisvuodaj* diehti

☐ Psykiatralasj skihppijvieson ☐ Guovllopsykiatrija guovdátjin

☐ Priváhta sierratjiehpe lunna ☐ Iv makkárik sajen

86. Jus le læhkám sierratjiehpe (spesialista) lunna rubbmelasj jali psykalasj gåssjelisvuodaj dálkodime diehti, vássteda tjuovvovasj gatjálvisájt Vássteda 0–10 rádjáj skálán (0 = huj unnán 10 = huj ållo)

Oadtju gus máhttelisvuodav subtsastit dav mij duv mielas lej ájnas duv dile gáktuj?

	0	1	2	3	4	5	6	7	8	9	10	Ij guoske-vasj
Rubbmelasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Hållin gus doktåra/dálkudiddje dunji nav vaj dån dádjadi suv/sijáv?

	0	1	2	3	4	5	6	7	8	9	10	Ij guoske-vasj
Rubbmelasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Bessi gus ietjat mielas siegen liehket mierredimen ietjat dálkudimev?

	0	1	2	3	4	5	6	7	8	9	10	Ij guoske-vasj
Rubbmelasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dagáj gus dálkkudibme nav vaj buorráni?

	0	1	2	3	4	5	6	7	8	9	10	Ij guoske-vasj
Rubbmelasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ålles láhkáj, le gus dujna luohtádus skihppijviessuj jali sierratjæhppáj gen lunna lidji?

	0	1	2	3	4	5	6	7	8	9	10	Ij guoske-vasj
Rubbmelasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ålles láhkáj, man dudálasj le sujtujn ja dálkudimijn majt oattjo?

	0	1	2	3	4	5	6	7	8	9	10	Ij guoske-vasj
Rubbmelasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykalasj gåssjelis-vuoda aktijvuodan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Vásádusá rájaduvvamijn

87. Le gus maŋemus 12 mánon hálijdam rájaduvvat sierratjiehpij lusi, valla illa rájaduvvam?

Rubbmelasj gássjelisvuoda aktijvuodan

- ☐ Iv, iv goassak
- ☐ Lev, akti
- ☐ Lev, moaddi
- ☐ Ij guoskadalá

Psykalasj gássjelisvuoda aktijvuodan

- ☐ Iv, iv goassak
- ☐ Lev, akti
- ☐ Lev, moaddi
- ☐ Ij guoskadalá

88. Le gus maŋemus 12 mánon hálijdam rájaduvvat fysioterápevta, kiropráktora jali sulásattja lusi, valla ij la rájaduvvam?

- ☐ Iv, iv goassak
- ☐ Lev, akti
- ☐ Lev, moaddi
- ☐ Ij guoskadalá

89. Jus rájaduvvi, man guhkev vuorddi tijmav?

Galla vahko ☐☐

90. Le gus sihtam friddja skihppijviesoválljimav gå le rájaduvvam sierratjiehpijdálkudibmáj?

- ☐ Lev
- ☐ Iv la
- ☐ Ij guoskadalá

Giella doktåra lunna

91. Maŋemus gå lidji stuovesdoktåra lunna, makkár gielav hållabihtte dåj doktårijn?

	Dárogielav	Sámegielav	Iehtjá gielav,	tjielggi:
Mån hålliv	☐	☐	☐	....
Doktår hálaj	☐	☐	☐	....

92. Maŋemus gå lidji skihppijvieson/spesialista lunna, makkár gielav hålajda dåj doktårijn?

	Dárogielav	Sámegielav	Iehtjá gielav,	tjielggi:
Mån hålliv	☐	☐	☐	....
Doktår hálaj	☐	☐	☐	....

93. Makkár gielav hálijda ienemusát hållat varresvuodabarggij? (Bieja avtav jali moadda ruossa)

Dárogielav	Sámegielav	Iehtjá gielav,	tjielggi:
☐	☐	☐	....

Dålkåv adnem

94. Jus le vásstedam «sámegielav», valla ittjij fáladuvá sámegielak doktår maŋemus gå lidji doktåra lunna, fáladuváj gus de dålkkå?

Stuovesdoktåra lunna:

- ☐ Fáladuváj
- ☐ Ittjij
- ☐ Iv hálijdam adnet dålkåv
- ☐ Ij guoskadalá

Skihppijvieson/sierratjiehpe lunna:

- ☐ Fáladuváj
- ☐ Ittjij
- ☐ Iv hálijdam adnet dålkåv
- ☐ Ij guoskadalá

95. Jus lij sámegielak dålkkå maŋemus gå lidji doktåra lunna, guhti dåjmaj dålkkån?

Stuovesdoktåra lunna:

- ☐ Almulasj bálkkiduvvam dålkkå
- ☐ Beraj
- ☐ Doktårkontåvrå bargge
- ☐ Iehtjáda

Skihppijvieson/sierratjiehpe lunna:

- ☐ Almulasj bálkkiduvvam dålkkå
- ☐ Beraj
- ☐ Iehtjá bargge skihppijviesos
- ☐ Iehtjáda

96. Le gus goassak læhkám doktårguoradallamin/dálkudimen gånnå lij sámegielak dålkkå, man dudálasj lidji dån, duv ja doktåra/dálkudiddje, ságastallamijn?

Stuovesdoktåra lunna:

- ☐ Huj dudálasj
- ☐ Dudálasj
- ☐ Duhtamahtes
- ☐ Huj duhtamahtes
- ☐ Iv diede

Skihppijvieson/sierratjiehpe lunna:

- ☐ Huj dudálasj
- ☐ Dudálasj
- ☐ Duhtamahtes
- ☐ Huj duhtamahtes
- ☐ Iv diede

97. Le gus goassak vásedam ij le oadtjum dárogielak/sámegielak dålkåviehkev vájku le ádnum?

- ☐ Lev vásedam dålkåv lev ádnum, valla iv la oadtjum
- ☐ Iv la, agev lev dålkåv oadtjum jus lev ádnum
- ☐ Iv la goassak dålkåv ádnum

Gijtto gå oassálassti guoradallamij!

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-110901 – LULESAMISK

Questionnaire—Southern Sámi

Healsoe- jïh jieledegoerehtimmie

1. Manne luhpehtem meatan årrodh goerehtimmesne dej bïevnesi tsegkie mah leah bïevneseprievesne vadteme ☐ Jaavoe

Jïjtse healsoe

2. Guktie dov healsoe daelie? (Bïejh ajve aktem kroessem)

☐ Nåake ☐ Ij dan hijven ☐ Hijven ☐ Joekoen hijven

3. Datne åtnah, jallh datne naan aejkien åtneme?

	Jaavoe	Ijje	Aaltere gosse eelki
Sohkerjaamedh-gæbja	☐	☐	
Jolle vïrretrygke	☐	☐	
Angina pectoris (vaajmoe-geasadimmie)	☐	☐	
Vaajmoe-domhpenasse	☐	☐	
Psykiske vaejvieh mej åvteste datne viehkiem ohtseme	☐	☐	
Kronihken bronkidte, emfyseme, KOLS	☐	☐	
Aastma	☐	☐	
Ekseeme	☐	☐	
Psoriasise	☐	☐	
Multippel sklerose (MS)	☐	☐	
Bechterews skïemtjelasse	☐	☐	

4. Datne dan minngemes jaepien bååktjege åtneme jïh/jallh gæhtjoes orreme åedtjine jïh lïhtsine mah unnemes 3 askh vaaseme iktemierien? ☐ Jaavoe ☐ Ijje

Jis jaavoe, vuesehth guktie dah baektjiedimmieh orreme kråahpen ovmessie bieline goeresne vuelielisnie

(akte kroesse fïerhtene linjesne)

	Im njåvtasovvh	Ånnetji njåvtasovvem	Tjarki njåvtasovvem
Tjovrese, åelkieh	☐	☐	☐
Gïeth	☐	☐	☐
Rudtjen bijjiebielie	☐	☐	☐
Gaatna	☐	☐	☐
Nyhtelh, juelkieh	☐	☐	☐
Åejjie	☐	☐	☐
Mïelkebielie	☐	☐	☐
Tjåejjiebielie	☐	☐	☐
Tsuepie	☐	☐	☐
Jeatjah lehkesne	☐	☐	☐

5. Man daamtaj datne dej minngemes 4 våhkoej daejtie bådtjide nåhtadamme? (bïejh aktem kroessem fïerhten linjese)

	Im nåhtadamme dej minngemes 4 våhkoej	Sveekebe goh fïerhten våhkoen	Fïerhten våhkoen, men ij biejjieladtje	Biejjieladtje
Åeremebådtja	☐	☐	☐	☐
Bådtja mij jaskele	☐	☐	☐	☐
Bådtja depresjovnen vööste	☐	☐	☐	☐

6. Mah lahtesh bööremeslaakan dov healsoetsiehkiem buerkestieh daan biejjien?

Vaedtseme

☐ Im dåeriesmoerh utnieh bïjre jarkan vaedtsedh
☐ Såemies dåeriesmoerh åtnam bïjre jarkan vaedtsedh
☐ Manne seangkosne gællan

Persovneles flæjjadimmie

☐ Im dåeriesmoerh utnieh jïjtjemem flæjjadidh
☐ Såemies dåeriesmoerh åtnam bïssedidh jallh gåårvedidh
☐ Im buektehth bïssedidh

Siejhme darjomesh (v.g. barkoe, studijh, gåetiebarkoe, fuelhkie jallh eejehtallemedarjomh)

☐ Im dåeriesmoerh utnieh mov sïejhme darjomesh darjodh
☐ Såemies dåeriesmoerh åtnam mov sïejhme darjomesh darjodh
☐ Im buektehth mov sïejhme darjomesh darjodh

Baektjiedimmie jïh vaejvie

☐ Mov vallah baektjiedimmie jallh vaejvie
☐ Mov gaskemedtien baektjiedimmie jallh vaejvie
☐ Mov tjarke baektjiedimmie jallh vaejvie

Asve jïh depresjovne

☐ Im asvem jallh depresjovnem utnieh
☐ Manne ohtje asvem jallh depresjovnem åtnam
☐ Mov tjarke asve jallh depresjovne

7. Man leevles datne? (ellies kg)

8. Man guhkies datne? (ellies cm)

9. Mijjieh datnem gihtjebe dov fysiske darjomh vuesiehtidh akten skaalan mietie, gaajh vaenie fysiske darjomistie gaajh jïjnjh darjomidie. Skaala lea 1–10. Fysiske darjomh leah dovne barkoe gåetesne jïh ålkone, jïh saavreme jïh jeatjah fysiske darjomh goh ålkone vaedtsedh j.pl. Bïejh kroessem dan ruvtese mij bööremes dov daltesem vuesehte dov fysiske darjomistie.

Gaajh vaenie	1	2	3	4	5	6	7	8	9	10	Gaajh jïjnje
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Fuelhkie jïh gïelemaadtoe

Noerhte-Nöörjesne almetjh veasoeh joekehts etnihken maadtojne. Daate sæjhta jiehtedh dah joekehts gïelh soptsestieh jïh joekehts kultuvrh utnieh. Goh etnihken maadtoe jallh etnihken dåehkie lea nöörjen, saemien jïh kveenen.

10. Maam hïejmegïelide datne åtnah/utnih, dov eejhtegh jïh aahkah/aajjah utnieh/utnin? (Bïejh aktem jallh jienebh kroessh)

	Nöörjen	Saemien	Kveenen	Jeatjah, buerkesth:
Tjidtj'-aajja	☐	☐	☐	☐ ....
Tjidtj'-aahka	☐	☐	☐	☐ ....
Aehtj'-aajja	☐	☐	☐	☐ ....
Aehtj'-aahka	☐	☐	☐	☐ ....
Aehtjie	☐	☐	☐	☐ ....
Tjidtjie	☐	☐	☐	☐ ....
Manne	☐	☐	☐	☐ ....

11. Mij dov, dov aehtjien jïh dov tjidtjien etnihken maadtoe?
(Bïejh aktem jallh jienebh kroessh)

	Nöörjen	Saemien	Kveenen	Jeatjah, buerkesth:
Mov etnihken maadtoe lea	☐	☐	☐	☐ ....
Mov aehtjien etnihken maadtoe lea	☐	☐	☐	☐ ....
Mov tjidtjien etnihken maadtoe lea	☐	☐	☐	☐ ....

12. Maam datne aervedh datne leah? (Bïejh aktem jallh jienebh kroessh)

Nöörjen	Saemien	Kveenen	Jeatjah, buerkesth:
☐	☐	☐	☐ ....

13. Guktie datne vienhth datne maahtah guarkedh, soptsestidh, lohkedh jallh saemien tjaeledh?

	Joekoen hijven	Naa hijven	Tjoerem pradtjedh	Naan gille baakoeh	Im mejtegh maehtieh
Guarkedh	☐	☐	☐	☐	☐
Soptsestidh	☐	☐	☐	☐	☐
Lohkedh	☐	☐	☐	☐	☐
Tjaeledh	☐	☐	☐	☐	☐

Barkoe, jielemedåarjoe jïh ekonomije

14. Man stoerre fuelhkien/gåetieguntien bruttobaalhka fïerhten jaepien?

☐ Vuelelen kr 150 000
☐ Kr 150 000–300 000
☐ Kr 301000–450 000
☐ Kr 451 000–600 000
☐ Kr 601 000–750 000
☐ Kr 751 000–900 000
☐ Bijjelen 900 000

15. Man gellie almetjh dov gåetieguntesne årroeh? Man gellie almetjh .... ☐☐

16. Man gellie jaepieh datne skuvlesne tjïrrehtamme? (Vaeltieh meatan gaajhkh jaepieh datne skuvlem vaadtseme jallh lohkeme)........ ☐☐

17. Datne internaatesne (tjïelten, staaten jallh privaate) årroejih gosse maadthskuvlem veedtsih? .... ☐ Jaavoe ☐ Ijje

18. Mestie datne åajvahkommes beetnegh dïenesjamme dan minngemes jaepien? (Bïejh aktem jallh jienebh kroessh)

☐ Baalhkabarkoe:
 ☐ Elliestïjjen ☐ Bielietïjjen ☐ Boelhken
☐ Jïjtjeraarehke jieleme:
 ☐ Elliestïjjen ☐ Bielietïjjen ☐ Boelhken
☐ Aalterepensjovne/AFP
☐ Kontantdåarjoe/overgangsdåarjoe/eejhtegebeetnegh
☐ Biejjiebeetnegh
☐ Skïemtjebeetnegh
☐ Barkoe-avklaringbeetnegh
☐ Uførepensjovne
☐ Dåarjoe jieliemassese (sosijale dåarjoe)
☐ Dåarjoe paarrebieleste/eejhtegijstie/åerpienistie/maanijste
☐ Lööneme/studijelööneme jïh stipende
☐ Jeatjah (spååreme vierhtieh/aerpie/gevinste jnv.)

19. Datne vienhth datne maahtah dov daaletje barkoem jallh baalhkam dassedh dej mubpie 2 jaepiej? .... ☐ Jaavoe ☐ Ijje

20. Datne lih sïjhteme juhtedh dov daaletje årrometjïelteste jis datne faalenassem åadtjoejih barkoen bïjre aktene jeatjah lehkesne?

☐ Jaavoe ☐ Ajve bielieh jaepeste
☐ Ijje ☐ Im daejrieh

21. Dastegh datne baalhkabarkosne, guktie datne tråäjjedh dov daaletje barkosne/jieliemisnie?

☐ Gaajh hijven ☐ Hijven ☐ Nåake ☐ Gaajh nåake

22. Våaroemisnie dov healsoste jïh dååjrehtimmijste barkoejieliedistie, man seapan datne vienhth datne leah baalhkabarkosne/jieliemisnie goske datne:

	Gaajh seapan	Seapan	Ånnetji seapan	Ij dan seapan
62 jaepien båeries	☐	☐	☐	☐
67 jaepien båeries	☐	☐	☐	☐
70 jaepien båeries	☐	☐	☐	☐
Båarasåbpoe goh 70 jaepien båeries	☐	☐	☐	☐

23. Jis datne jïjtjeraarehke jieliemisnie, magkarinie jieliemisnie barkh? (Bïejh aktem jallh jienebh kroessh)

- ☐ Båatsoe
- ☐ Gööleme
- ☐ Jåartaburrie
- ☐ Skåajjeburrie
- ☐ Sïelteburrie
- ☐ Jeatjah

Psykiske healsoe

24. Vuelielisnie aktem læstoem gaavnh ovmessie dåeriesmoerigujmie. Datne maam akt daestie dååjreme dej minngemes 4 våhkoej? (Bïejh aktem kroessem fïereguhten vaajvan)

	Im njåvta-sovvh	Ånnetji njåvta-sovvem	Naa jïjnje	Joekoen jïjnje
Faahketji asvem damteme bielelen fåantoe	☐	☐	☐	☐
Skaabroeh jallh aerkies domteme	☐	☐	☐	☐
Samhtjas jallh svååjpeles	☐	☐	☐	☐
Strååarkan jallh fuehpies domteme	☐	☐	☐	☐
Jïjtjemdh kradtjoehtamme	☐	☐	☐	☐
Dåeriesmoerh åtneme åeredh	☐	☐	☐	☐
Håjnoes, haarmoes	☐	☐	☐	☐
Domteme ovnuhteligs orreme	☐	☐	☐	☐
Domteme gaajhke lea slæjhtoes	☐	☐	☐	☐
Domteme båetijen biejjien nåake	☐	☐	☐	☐

25. Dah gyhtjelassh leah guktie datne damteme jïh guktie datnine orreme dan minngemes våhkoen. Fïereguhten gyhtjelassese edtjh dam vaestiedassem veeljedh mij bööremeslaakan buerkeste guktie datnine orreme. Man daamtaj dan minngemes våhkoen datne: (Bïejh kroessem dan ruvtese mij bööremes buerkeste guktie datnine)

	Ikte-gisth	Mahte ikte-gisth	Mahte abpe tïjjen	Såemies aejkien	Ånnetji	Im gåessie gænnah
Geerjene domteme jïh buerie bievsterisnie	☐	☐	☐	☐	☐	☐
Seadtoes domteme	☐	☐	☐	☐	☐	☐
Eadtjohke jïh veaksehks domteme	☐	☐	☐	☐	☐	☐
Madtjeles jïh liegkes domteme	☐	☐	☐	☐	☐	☐
Domteme mov biejjie-ladtje jieleme dieves orreme destie maam lyjhkem	☐	☐	☐	☐	☐	☐

26. Datne dej minngemes 12 askh dååjreme nååke mojhtesh båateme jïh datnem sturreme bielelen datne buektiehtamme maam akt dejnie darjodh?

- ☐ Ijje
- ☐ Jaavoe, men sveekes
- ☐ Muvhten aejkien
- ☐ Daamtaj

27. Datne dej minngemes 12 askh voerkeslaakan tsiehkieh rïeveme juktie nååke mojhtesh jallh domtesh slyöhpedh, naemhtie guktie dïhte datnem heerredamme darjodh maam sïjhth?

- ☐ Ijje
- ☐ Jaavoe, men sveekes
- ☐ Muvhten aejkien
- ☐ Daamtaj

28. Datne dej minngemes 12 askh ih buektiehtamme domtesigujmie reageradidh dejnie tsiehkine gusnie dah jeanatjommes reageradieh?

- ☐ Ijje
- ☐ Jaavoe, men sveekes
- ☐ Muvhten aejkien
- ☐ Daamtaj

29. Vuesehth man hijven daah jiehtegh datnem jïh dov fuelhkiem buerkiestieh

	Nååkelaakan sjeahta				Eevre sjeahta
Manne mov vuarjasjimmieh jïh sjæjsjalimmieh eevre leajhtedem	☐	☐	☐	☐	☐
Manne bööremeslaakan mubpiejgujmie murredem	☐	☐	☐	☐	☐
Manne mov fuelhkesne joekoen hijven murredem	☐	☐	☐	☐	☐
Ihke manne jïjtsanne jaahkam dle buektehtem geerve boelhki tjïrrh båetedh	☐	☐	☐	☐	☐
Manne aelhkieslaakan orre voelph åadtjoem	☐	☐	☐	☐	☐
Mov fuelhkesne hijven siemesvoete	☐	☐	☐	☐	☐
Trïegkenassesne buektehtem maam akt hijven gaavnedh mesnie maahtam sjïdtedh	☐	☐	☐	☐	☐
Manne væjkele orre almetjigujmie govlehtalledh	☐	☐	☐	☐	☐
Mov fuelhkie dan båetijen bejjan hijvenlaakan vuartesje, aaj geerve boelhkine	☐	☐	☐	☐	☐
Manne åajsoem heannadimmieh jieliedisnie jååhkesjidh mah eah gåaredh jarkelidh	☐	☐	☐	☐	☐
Manne tuhtjem aelhkie maam akt gaavnedh man bïjre hijven soptsestidh	☐	☐	☐	☐	☐
Mov fuelhkesne libie eerlege sinsætnan	☐	☐	☐	☐	☐

Dågkah jïh ruvsevierhtieh

30. Datne rïevhkesth, jallh datne aarebi rïevhkestamme?

- ☐ Jaavoe, biejjeladtje
- ☐ Jaavoe, aarebi
- ☐ Jaavoe, muvhten aejkien
- ☐ Ijje, im gåessie gænnah

Man gellie sigaredth sïejhmemes rïevhkesth? ☐☐

Man båeries

Man båeries lih gosse eelkih rïevhkestidh biejjeladtje? ☐☐

31. Snåhkah, jallh aarebi snåhkeme?

- ☐ Jaavoe, biejjeladtje
- ☐ Jaavoe, aarebi
- ☐ Jaavoe, muvhten aejkien
- ☐ Ijje, im gåessie

Dutnjien mij biejjieladtje snåhka: Man gellie åesieh snåhkah fïerhten biejjien? ☐☐

Dutnjien mij muvhten aejkien snåhka: Man gellie åesieh snåhkah sïejhmemes fïerhten våhkoen? ☐☐

Man båeries

Jis jaavoe, man båeries lih gosse eelkih biejjieladtje snuhkedh? ☐☐

32. Medtie man daamtaj datne dan minngemes jaepien alkohovlem jovkeme? (Viesjiesvoelege jïh voelege namhtah alkohovle eah leah meatan)

- ☐ Im gåessie alkohovlem jovkeme
- ☐ Im alkohovlem jovkeme dan minngemes jaepien
- ☐ Naan gille aejkieh dan minngemes jaepien
- ☐ Ovrehte ikth asken
- ☐ 2–3 aejkieh fïerhten asken
- ☐ Medtie 1 aejkien våhkoen
- ☐ 2–3 aejkieh våhkoen
- ☐ 4–7 aejkieh våhkoen

33. Datne alkohovlem jovkeme dej minngemes 4 våhkoeh? ☐ Jaavoe ☐ Ijje

Jis jaavoe, datne dan jïjnjem jovkeme guktie datne domteme tjarki tjïervesisnie?

- ☐ Ijje
- ☐ Jaavoe, 1–2 aejkieh
- ☐ Jaavoe, 3 aejkieh jallh vielie

34. Datne vienhth dov åtnoe alkohovleste jallh jovkemevuekie goh boelhkine (daamtaj jovkh jïh jïjnjem boelhkine, jïh mænngan guhkebe boelhkh åtnah bielelen alkohovlem jovkedh)? (bïejh aktem jallh jienebh kroessh)

☐ Jaavoe, dej minngemes 12 askh ☐ Jaavoe aarebi ☐ Ijje

35. Datne naan aejkien narkotijkam nåhtadamme? (bïejh aktem jallh jienebh kroessh)

	Jaavoe minngemes jaepien	Jaavoe aarebi	Ijje
Hasj/marihuana (cannabis)	☐	☐	☐
Jeatjah narkotijkah goh LSD, amfetamijne, ecstacy, heroin, Ghb j.pl.	☐	☐	☐

Religijovne jïh jielemevuajnoe

36. Datne, dov eejhtegh jallh dov aahkah/aajjah leah ektiedamme naakenidie daejstie jielemevuajnoekrirrijste: (bïejh aktem jallh jienebh kroessh)

	Manne	Tjidtjie	Aehtjie	Aahkah gon aajjah
Staategærhkoe	☐	☐	☐	☐
Læstadijanen krirrie	☐	☐	☐	☐
Jeatjah religijööse krirrie/ektievoete	☐	☐	☐	☐
Magkeres:				
Ij religijööse jielemevuajnoekrirrie	☐	☐	☐	☐
Magkeres:				
Im leah lihtseginie aktede jielemevuajnoekrirreste	☐	☐	☐	☐

37. Maam datne vienhth religijovnen bïjre?

- ☐ Manne jaehkije/bæjhkoje kristegassje (persovneles kristegassje)
- ☐ Manne vienhtem akte Jupmele gååvnese, men religijovne ij dan stoerre ulmiem utnieh munnjien biejjieladtje
- ☐ Im seekere
- ☐ Im jaehkieh naan Jupmele gååvnese

38. Man daamtaj datne orreme dej minngemes 6 askh: (Bïejh aktem kroessem fïerhten linjese)

	Vielie goh 3 aej./asken	1–3 aej/asken	1–6 aej/minngemes asken	Im gåessie
Gærhkosne	☐	☐	☐	☐
Krirrie-/åålmegegåetesne	☐	☐	☐	☐
Humanetihken gaavnesjimmesne	☐	☐	☐	☐
Jeatjah religijööse gåetesne	☐	☐	☐	☐

Jïjtjedåårjeme sïerredimmie

Sïerredimmie lea gosse akte almetje jallh dåehkie almetjijstie nåakebe gietedimmiem åadtjoeh goh jeatjebh, v.g. sov etnihken maadtoen gaavhtan, jallh religijovne, jaahkoe, funksjovneheaptoe, aaltere jallh seksuelle voete.

39. Datne sïerredimmiem dååjreme?

- ☐ Jaavoe, dej minngmes göökte jaepiej
- ☐ Jaavoe, aarebi
- ☐ Ijje
- ☐ Im daejrieh

Jis jaavoe vaestiedih evtebe gyhtjelassesne, vaestedh gyhtjelassh 40–47. Jis ijje vaestiedamme dle gyhtjelassine 48 aalkah.

40. Jis datne sïerredimmiem dååjreme, man daamtaj daate heannadi?

- ☐ Gaajh daamtaj
- ☐ Såemies aejkien
- ☐ Akten sveekes aejkien

41. Mannasinie datne vienhth datne sïerredimmiem dååjrih? Sïerredimmie lij dannasinie: (Bïejh aktem jallh jienebh kroessh)

- ☐ Funksjovneheaptoe
- ☐ Seksuelle voete
- ☐ Dåeriesmoerh lïeredh
- ☐ Tjoele
- ☐ Religijovne jallh jaahkoe
- ☐ Nasjovnalitete
- ☐ Etnihken maadtoe
- ☐ Geografijen sijjie
- ☐ Aaltere
- ☐ Skïemtjelasse
- ☐ Jeatjah fåantoeh, tjaelieh:
- ☐ Im daejrieh

42. Maahtah vuesiehtidh gusnie sïerredimmie heannadi? (Bïejh aktem jallh jienebh kroessh)

- ☐ Internettesne
- ☐ Skuvlesne/ööhpehtimmesne
- ☐ Barkoejieliedisnie
- ☐ Gosse barkoem syökim
- ☐ Jïjtjevyljehke barkosne/åårganisasjovnine
- ☐ Gosse byögkelesvoetine govlehtallim
- ☐ Fuelhkesne/sliektesne
- ☐ Gosse edtjih leejjedh/åestedh gåetiem
- ☐ Gosse edtjim baanghkelöönemem skååffedh
- ☐ Gosse edtjim medisijnen båehtjierdimmiem åadtjodh
- ☐ Bovresne jallh restaurantesne
- ☐ Voenges siebriedahkesne
- ☐ Jeatjah sijjesne, tjaelieh

43. Maahtah vuesiehtidh gie datnem sïerredi? (Bïejh aktem jallh jienebh kroessh)

- ☐ Byögkeles barkije
- ☐ Ovnohkens almetjh
- ☐ Barkoevoelph
- ☐ Akte jallh jienebh seamma etnihken tjierteste goh jïjtjemdh
- ☐ Akte jallh jienebh jeatjah etnihken tjierteste goh jïjtjemdh
- ☐ Meatanlearohkh/studenth
- ☐ Lohkehtæjjah/barkijh
- ☐ Jeatjebh

44. Datne jïjtje maam akt darjoejih ihke sïerredimmiem nåhkehtidh? ☐ Jaavoe ☐ Ijje

45. Datne naan aejkien govlehtalleme Mïrrestalleme- jïh sïerredimmietjirkijinie juktie raeriem jallh viehkiem åadtjodh sïerredimmien bïjre?

☐ Jaavoe ☐ Ijje ☐ Im mujhtieh

46. Mennie mieresne sïerredimmie datnem gïetedi?

☐ Ij mejtegh gænnah ☐ Ånnetji
☐ Naa jïjnje ☐ Jïjnje

47. Datne sïerredimmiem dååjreme dannasinie datne saemie?

☐ Jaavoe ☐ Ijje ☐ Im daejrieh ☐ Im saemie

Vædtsoesvoete jïh daaresjimmie

48. Datne dååjreme naaken datnem systemen mietie jïh guhkiebasse pryöveme datnem noerhkedh, mïedtelidh jallh haeniehtidh? (Bïejh aktem jallh jienebh kroessh)

- ☐ Ijje, im gåessie gænnah
- ☐ Jaavoe, goh maana (nuerebe goh 18 jaepieh)
- ☐ Jaavoe goh geerve (18 jaepien båeries jallh båarasåbpoe)
- ☐ Jaavoe, dej minngemes 12 askh

Jis jaavoe, giestie?

☐ Ammes almetje ☐ Paarrebielie
☐ Fuelhkie, sliekte ☐ Jeatjah åehpies

49. Datne fysiske daaresjimmieh dååjreme? (Bïejh aktem jallh jienebh kroessh)

- ☐ Ijje, im gåessie gænnah
- ☐ Jaavoe, goh maana (nuerebe goh 18 jaepieh)
- ☐ Jaavoe goh geerve (18 jaepien båeries jallh båarasåbpoe)
- ☐ Jaavoe, dej minngemes 12 askh

Jis jaavoe, giestie?

☐ Ammes almetje ☐ Paarrebielie
☐ Fuelhkie, sliekte ☐ Jeatjah åehpies

50. Datne seksuelle daaresjimmieh dååjreme? (Bïejh aktem jallh jienebh kroessh)

- ☐ Ijje, im gåessie gænnah
- ☐ Jaavoe, goh maana (nuerebe goh 18 jaepieh)
- ☐ Jaavoe goh geerve (18 jaepien båeries jallh båarasåbpoe)
- ☐ Jaavoe, dej minngemes 12 askh

Jis jaavoe, giestie?

☐ Ammes almetje ☐ Paarrebielie
☐ Fuelhkie, sliekte ☐ Jeatjah åehpies

51. Jis datne naan såarhts daaresjimmiem dååjreme, datne dan bïjre naakenidie soptsestamme? (Bïejh aktem jallh jienebh kroessh)

☐ Ijje ☐ Naaken fuelhkesne ☐ Voelph ☐ Faagealmetjh

Baeniehealsoe

52. Guktie dov baeniehealsoem vuarjesjh?

☐ Nåake ☐ Ij dan hijven ☐ Hijven ☐ Joekoen hijven

53. Dov baenieprotese/gebisse? ☐ Jaavoe ☐ Ijje

54. Datne naaken daejstie viehkiedïrregijstie nåhtedh, jïh jis, man daamtaj?

	Iktegisth/ fierhten biejjien	Ij iktegisth/ såemies aejkien	Ij iktegisth/ såemies aejkien asken	Sveekebe/ im gåessie gænnah
Baenieskubpe	☐	☐	☐	☐
Baeniekreeme fluorine	☐	☐	☐	☐
Baenielaejkie	☐	☐	☐	☐
Såålemasse	☐	☐	☐	☐
Fluortabledth	☐	☐	☐	☐
Skuvlemetjaetsie	☐	☐	☐	☐
Proteseskubpe	☐	☐	☐	☐

55. Gåessie lih minngemes aejkien baeniedåakteren luvnie jallh baeniesåjhteren luvnie?

- ☐ Unnebe goh akten jaepien gietjeste
- ☐ 1–2 jaepien gietjeste
- ☐ 3–5 jaepien gietjeste
- ☐ Vielie goh 5 jaepien gietjeste

56. Jis vielie goh 2 jaepien gietjeste, mannasinie? (Bïejh aktem jallh jienebh kroessh)

- ☐ Im manne gohtjedimmiem åådtjeme
- ☐ Tjuara guhkiem vuertedh baeniedåakterasse båetedh
- ☐ Im asteme
- ☐ Ekonomijen gaavhtan
- ☐ Im baeniebåehtjierdimmiem daarpesjamme
- ☐ Manne billem baeniedåakteren luvnie mïnnedh
- ☐ Jeatjah fåantoeh:

____

57. Guktie baeniehealsoeďienesjem nåhtedh? (Bïejh aktem jallh jienebh kroessh)

- ☐ Vihties tïjjen gohtjedimmiem åadtjoem baeniedåakteristie jallh baeniesåjhteristie
- ☐ Jïjtje govlehtallem goerehtæmman båetedh vihties aejkien
- ☐ Baeniedåakterinie govlehtallem gosse baektjede jallh dievhtesem dasseme
- ☐ Im provhkh baeniedåakteren luvnie mïnnedh dan daamtaj

58. Datne dej minngemes göökte jaepiej aktem jallh jienebh daejstie diagnosijste baeniedåakteren luvnie åådtjeme?

	Jaavoe	Ijje	Im daejrieh
Ietjmies gïngse-ovleme	☐	☐	☐
Lijnies gïngse-ovleme	☐	☐	☐
Gejhkie njaelmesne	☐	☐	☐
Raejkie (karijes) aktene jallh jienebinie baenine	☐	☐	☐
Jeatjah diagnosh	☐	☐	☐

59. Datne madtjeles dov baeniejgujmie jallh protesigujmie? Vuesehth vaestiedassem aktene skaalesne gusnie 1 lea joekoen nåjjoeh jïh 5 lea joekoen madtjeles.

Gaajh nåjjoeh ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Gaajh madtjeles

60. Man daamtaj datne dov baenide skubpih gosse lih 10 jaepien båeries?

- ☐ Ikth biejjege jallh vielie
- ☐ Muvhten aejkien
- ☐ Sveekes jallh im gåessie gænnah

61. Man daamtaj dov eejhtegh giehtjedin datne lih baenide skubpeme gosse lih 10 jaepien båeries?

- ☐ Daamtaj (ovrehte biejjieladtje)
- ☐ Muvhten aejkien
- ☐ Eah gåessie gænnah

62. Jis maanah åtnah mah leah nuerebe goh 6 jaepien båeries jïh dov luvnie årroeh, man daamtaj datne viehkehth baenide skubpedh jallh giehtjedh maanah baenide skubpeme?

- ☐ Daamtaj (ovrehte biejjieladtje)
- ☐ Muvhten aejkien
- ☐ Eah gåessie gænnah

63. Jis maanah åtnah mah leah gaskem 6–12 jaepieh jïh dov luvnie årroeh, man daamtaj datne viehkehth baenide skubpedh jallh giehtjedh maanah baenide skubpeme?

- ☐ Daamtaj (ovrehte biejjieladtje)
- ☐ Muvhten aejkien
- ☐ Eah gåessie gænnah

64. Jis maanah aalterisnie 0–12 jaepieh åtnah mah dov luvnie årroeh, dah åadtjoeh sjokolaadem jïh jeatjah sietiesaath byöpmedidh vihties tïjjen?

☐ Jaavoe ☐ Ijje

65. Man madtjeles datne baeniehealsoeďienesjinie dov tjïeltesne?

Gaajh nåjjoeh ☐ ☐ ☐ ☐ ☐ ☐ Gaajh madtjeles ☐ Im daejrieh

Aemielueseme jïh aemielueseme-dåemiedimmie

66. Datne naakenem aemieluesiemisnie dasseme, mij dov lïhke orreme? ☐ Jaavoe ☐ Ijje

67. Datne ussjedamme aemieluesedh?

- ☐ Jaavoe, dan minngemes jaepien
- ☐ Jaavoe, aarebi
- ☐ Ijje, im gåessie

68. Datne voejhkelamme aemieluesedh?

- ☐ Jaavoe, dan minngemes jaepien
- ☐ Jaavoe, aarebi
- ☐ Ijje, im gåessie gænnah

69. Datne jïjtjemdh væljojne irhkeme?

- ☐ Jaavoe, dan minngemes jaepien
- ☐ Jaavoe, aarebi
- ☐ Ijje, im gåessie gænnah

Jis datne voejhkelamme aemieluesedh, maahtah daejtie minngebe gyhtjelasside vaestiedidh. Jis ijje vaestiedamme dan gyhtjelassese, maahtah aelkedh gyhtjelassine nr. 76.

70. Guktie datne pryövih aemieluesedh? (Bïejh aktem jallh jienebh kroessh)

- ☐ Gævnjasjimmie
- ☐ Röövre
- ☐ Besteles aate
- ☐ Fer jïjnjh pïllerh/bådtjah
- ☐ Jeatjahlaakan

71. Mannasinie datne pryövih aemieluesedh?

Sïjhtim amma jaemedh	☐ Jaavoe	☐ Ijje
Mov jielede dan nååke	☐ Jaavoe	☐ Ijje
Viehkiem sïjhtim naakenijstie	☐ Jaavoe	☐ Ijje

72. Mah tjïervesisnie gosse pryövih aemieluesedh? ☐ Jaavoe ☐ Ijje

73. Man båeries lih gosse voestes aejkien pryövih aemieluesedh? ☐☐

74. Man gellie aejkieh pryöveme aemieluesedh? ☐☐

75. Datne aemieluesemepryövemen/i bïjre gïese akt soptsestih? (Bïejh aktem jallh jienebh kroessh)

☐ Ijje ☐ Naaken fuelhkesne ☐ Voelph ☐ Faagealmetjh

Spïelemedåemiedimmie

76. Datne naan aejkien domteme datne daarpesjamme jiene jienebh beetnegi åvteste spealadidh? (Bïejh aktem jallh jienebh kroessh)

☐ Jaavoe, minngemes jaepien ☐ Jaavoe, aarebi ☐ Ijje

77. Datne naan aejkien slaarvestamme almetjidie mah leah vihkeles dutnjien, man jïjnjh beetnegi åvteste datne spealedh? (Bïejh aktem jallh jienebh kroessh)

☐ Jaavoe, minngemes jaepien ☐ Jaavoe, aarebi ☐ Ijje

78. Datne naan aejkien boelhkh åtneme gosse datne, mænngan beetnegh teehpeme spealadimmesne akten biejjien, bååstede båateme akten jeatjah biejjien juktie dejtie bååstede vitnedh? (Bïejh aktem jallh jienebh kroessh)

☐ Jaavoe, minngemes jaepien ☐ Jaavoe, aarebi
☐ Ijje ☐ Im daejrieh/im mujhtieh

79. Datne dan minngemes jaepien online råållespïelem spealadamme?

☐ Jaavoe, biejjieladtje
☐ Jaavoe, fïerhten våhkoen
☐ Jaavoe, fïerhten asken jallh sveekebe
☐ Ijje

Dååjrehtimmieh jïh åtnoe healsoedïenesjijstie

80. Dïhte dåaktere maam sïejhmemes nåhtedh, dïhte

☐ Dov staeriesdåaktere ☐ Jeatjah dåaktere

81. Man guhkiem datne dov daaletje staeriesdåakterem åtneme?

☐ Unnebe goh 6 askh ☐ 6–11 askh
☐ 12–24 askh ☐ Vielie goh 2 jaepieh

82. Datne naan aejkien dej minngemes 12 askh dov staeriesdåakterinie govlehtalleme juktie viehkiem jallh raeriem åadtjodh jïjtsadth? ☐ Jaavoe ☐ Ijje

Jis jaavoe, datne tuhtjh datne dam viehkiem åadtjoejih man mietie gihtjih?

☐ Im gåessie gænnah ☐ Muvhten aejkien
☐ Sïejhmemes ☐ Iktegisth

83. Mennie mieresne datne madtjeles daej aatigujmie staeriesdåakteredïenesjisnie?

	Gaajh madtjeles	Madtjeles	Nåjjoeh	Gaajh nåjjoeh	Im daejrieh
Staeriesdåakterem jaksedh tellefovnesne	☐	☐	☐	☐	☐
Vuertemetïjje juktie tæjmoem åadtjodh staeriesdåakterisnie	☐	☐	☐	☐	☐
Tïjje staeriesdåakterisnie	☐	☐	☐	☐	☐
Staeriesdåaktere dov dåeriesmoerh guarka	☐	☐	☐	☐	☐
Staeriesdåakteren bïevnesh dov healsoevaejviej bïjre, goerehtimmie jïh båehtjiedimmiesoejkesjh	☐	☐	☐	☐	☐
Ållesthlaakan, mennie mieresne datne madtjeles jallh nåjjoeh tjïelten healsoedïenesjinie?	☐	☐	☐	☐	☐

Sjïerehealsoedïenesjinie vienhtebe skïemtjegåetie, distriktepsykiatrijen jarnge (daaroen DPS), sjïeredåakterejarnge jallh sjïeredåaktere.

84. Datne naan aejkien dej <u>minngemes 12 askh</u> goerehtimmesne jallh båehtjierdimmesne orreme *fysiske vaejviej* gaavhtan

☐ Skïemtjegåetesne
☐ Sjïeredåakterejarngesne
☐ Privaatepraksisen sjïeredåakteren luvnie
☐ Im gusnie orreme

85. Datne naan aejkien dej <u>minngemes 12 askh</u> goerehtimmesne jallh båehtjierdimmesne orreme *psykiske vaejviej* gaavhtan

☐ Psykiatrijen skïemtjegåetesne
☐ Distriktepsykiatrijen jarngesne
☐ Privaatepraksisen sjïeredåakteren luvnie
☐ Im gusnie orreme

86. Jis datne båehtjierdimmesne sjïeredåakteren luvnie orreme fysiske jallh psykiske vaejviej gaavhtan, vaestedh daejtie gyhtjelasside Vaestedh aktene skaalesne 0–10 (0 = ånntji 10 = jïjnje)

Nuepiem åadtjoejih soptsestidh maam datne domtih lij vihkeles dov tsiehkien bïjre?

	0	1	2	3	4	5	6	7	8	9	10	Ij sjyöhtehke
Fysiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dah dåakterh/båehtjierdæjjah naemhtie soptsestin guktie datne dejtie guarkajih?

	0	1	2	3	4	5	6	7	8	9	10	Ij sjyöhtehke
Fysiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Datne damth datne åadtjoejih meatan årrodh nænnoestidh dov båehtjierdimmien bïjre?

	0	1	2	3	4	5	6	7	8	9	10	Ij sjyöhtehke
Fysiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Datne buerebe sjïdteme båehtjierdimmeste?

	0	1	2	3	4	5	6	7	8	9	10	Ij sjyöhtehke
Fysiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ållesthlaakan, datne skïemtjegåetiem jallh sjïeredåakterem leajhtedh gusnie datne lih?

	0	1	2	3	4	5	6	7	8	9	10	Ij sjyöhtehke
Fysiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ållesthlaakan, man madtjeles datne sujhteminie jïh båehtjierdimmine datne åadtjoejih?

	0	1	2	3	4	5	6	7	8	9	10	Ij sjyöhtehke
Fysiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psykiske vaejvide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dååjrehtimmieh saehteminie

87. Datne naan aejkien dej minngemes 12 askh sïjhteme sjïeredåakterasse båetedh, men ih åådtjeme?

Fysiske vaejviej åvteste

- ☐ Ijje, im gåessie gænnah
- ☐ Jaavoe, ikth
- ☐ Jaavoe, gellien aejkien
- ☐ Ij sjyöhtehke

Psykiske vaejviej åvteste

- ☐ Ijje, im gåessie
- ☐ Jaavoe, ikth
- ☐ Jaavoe, gellie aejkieh
- ☐ Ij sjyöhtehke

88. Datne naan aejkien dej 12 minngemes askh sïjhteme fysioterapeutese, kiropraktovrasse jallh plearoeh båetedh, men ih åådtjeme?

- ☐ Ijje, im gåessie
- ☐ Jaavoe, ikth
- ☐ Jaavoe, gellie aejkieh
- ☐ Ij sjyöhtehke

89. Jis datne saehtemem åådtjoejih, man guhkiem tjoerih vuertedh goske tæjmoem åådtjoejih?

Man gellie våhkoeh ☐☐

90. Datne frijje skiemtjegåetieveeljemen bïjre bïrreme gosse datnem saehteme sjïerebåehtjierdæmman?

☐ Jaavoe ☐ Ijje ☐ Ij sjyöhtehke

Gïele dåakteren luvnie

91. Minngemes aejkien datne lih staeriesdåakteren luvnie, mennie gïelesne datne jïh dåaktere ektesne soptsestin?

	Nöörjen	Saemien	Jeatjah, buerkesth:
Manne soptsestim	☐	☐	☐ …………
Dåaktere soptsesti	☐	☐	☐ …………

92. Minngemes aejkien datne lih skïemtjegåetesne/ sjïeredåakteren luvnie, mennie gïelesne datne jïh dåaktere ektesne soptsestin?

	Nöörjen	Saemien	Jeatjah, buerkesth:
Manne soptsestim	☐	☐	☐ …………
Dåaktere soptsesti	☐	☐	☐ …………

93. Mennie gïelesne sïjhth uvtemes healsoebarkijigujmie soptestidh? (Bïejh aktem jallh jienebh kroessh)

Nöörjen	Saemien	Jeatjah, buerkesth:
☐	☐	☐ …………

Åtnoe toelhkeste

94. Jis datne vaestiedamme «saemien», men idtjih faalenassem åådtjoeh dåakteren bïjre mij saemiesti minngemes aejkien datne lih dåakteren luvnie, faalehti toelhkem dellie?

Staeriesdåakteren luvnie:

- ☐ Jaavoe
- ☐ Ijje
- ☐ Im sïjhth toelhkem utnedh
- ☐ Ij sjyöhtehke

Skïemtjegåetesne/sjïeredåakteren luvnie:

- ☐ Jaavoe
- ☐ Ijje
- ☐ Im sïjhth toelhkem utnedh
- ☐ Ij sjyöhtehke

95. Jis toelhkem utnih mij saemiesti minngemes aejkien datne lih dåakteren luvnie, gie lij toelhkine dellie?

Staeriesdåakteren luvnie:

- ☐ Byögkeles toelhke
- ☐ Fuelhkie
- ☐ Akte barkije dåakterekontovresne
- ☐ Jeatjah

Skïemtjegåetesne/sjïeredåakteren luvnie:

- ☐ Byögkeles toelhke
- ☐ Fuelhkie
- ☐ Jeatjah barkije skïemtjegåetesne
- ☐ Jeatjah

96. Jis datne <u>naan aejkien</u> goerehtimmesne/båehtjierdimmesne orreme dåakteren luvnie gusnie toelhke mij saemiesti, man hijven datne vienhth soptsestalleme lij dov jïh dåakteren/ båehtjierdæjjan gaskem?

Staeriesdåakteren luvnie:

- ☐ Gaajh madtjeles
- ☐ Madtjeles
- ☐ Nåjjoeh
- ☐ Gaajh nåjjoeh
- ☐ Im daejrieh

Skïemtjegåetesne/sjïeredåakteren luvnie:

- ☐ Gaajh madtjeles
- ☐ Madtjeles
- ☐ Nåjjoeh
- ☐ Gaajh nåjjoeh
- ☐ Im daejrieh

97. Datne <u>naan aejkien</u> dååjreme datne ih nöörjen/saemien toehlhkeviehkiem åådtjeme, jalhts datne dan mietie gihtjih?

- ☐ Jaavoe, nov lea heannadamme manne toelhken mietie gihtjeme, men im dam åådtjeme.
- ☐ Ijje, manne iktegisth toelhkem åådtjeme jis dan mietie gihtjeme
- ☐ Im gåessie gænnah toelhken mietie gihtjeme

Gæjhtoe ihke lih meatan goerehtimmesne!

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-110901 – SØRSAMISK

Questionnaire—English translation

Survey on health and living conditions

1. **I consent to participating in this survey in accordance with the information provided in the information letter** ☐ Yes

Personal health

2. How is your current state of health? (Put one cross only)

☐ Poor ☐ Not so good ☐ Good ☐ Very good

3. Do you have, or have you ever had, any of the following?

	Yes	No	Age at onset
Diabetes	☐	☐	
High blood pressure	☐	☐	
Angina pectoris (stable angina)	☐	☐	
Myocardial infarction (heart attack)	☐	☐	
Psychological problems for which you have sought help	☐	☐	
Chronic bronchitis, emphysema, COPD	☐	☐	
Asthma	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
Multiple sclerosis (MS)	☐	☐	
Bechterew's disease	☐	☐	

4. In the last year, have you suffered from pains and/or stiffness in muscles and joints that have lasted for 3 months or more? ☐ Yes ☐ No

If yes, what was the degree of pain in different parts of your body? (Put one cross per line)

	No pain	Some pain	Strong pain
Neck, shoulders	☐	☐	☐
Arms, hands	☐	☐	☐
Upper back	☐	☐	☐
Lower back	☐	☐	☐
Hips, legs, feet	☐	☐	☐
Head	☐	☐	☐
Chest area	☐	☐	☐
Stomach area	☐	☐	☐
Genitals	☐	☐	☐
Other areas	☐	☐	☐

5. In the last 4 weeks, how often have you used the following medications? (Put one cross per line)

	Not used for the last 4 weeks	Less than every week	Every week, but not daily	Daily
Sleeping pills	☐	☐	☐	☐
Tranquilizers	☐	☐	☐	☐
Antidepressants	☐	☐	☐	☐

6. In each of the following cases, which statement best describes your health condition today?

Walking

☐ I have no problems walking
☐ I have some problems walking
☐ I am bedridden

Personal hygiene

☐ I have no problems with personal hygiene
☐ I have some problems with hygiene and getting dressed
☐ I am not able to clean myself

Usual activities (e.g. work, studies, house chores, family or leisure activities)

☐ I have no problems performing my usual activities
☐ I have some problems performing my usual activities
☐ I am unable to perform my usual activities

Pain and discomfort

☐ I have no pain or discomfort
☐ I have moderate pain or discomfort
☐ I have strong pain or discomfort

Anxiety and depression

☐ I am not anxious or depressed
☐ I am somewhat anxious or depressed
☐ I am very anxious or depressed

7. How much do you weigh? (in whole kg) ☐☐☐

8. How tall are you? (in whole cm) ☐☐☐

9. We will now ask you to state your physical activity on a scale from very low to very high. The scale below runs from 1 to 10. Physical activity includes both housework and activity at work, as well as exercise and other physical activities such as walking, etc. Mark the number that best matches your level of activity:

	1	2	3	4	5	6	7	8	9	10	
Very low	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Very high

Family and linguistic background

People of different ethnic backgrounds live in Northern Norway. That is, they have different languages and cultures. Examples of ethnic backgrounds, or ethnic groups, are Norwegian, Sami and Kven.

10. What language(s) do/did you, your parents and your grand-parents speak at home? (Put one or more crosses)

	Norwegian	Sami	Kven	Other, describe:
Mother's father	☐	☐	☐	☐ ....
Mother's mother	☐	☐	☐	☐ ....
Father's father	☐	☐	☐	☐ ....
Father's mother	☐	☐	☐	☐ ....
Father	☐	☐	☐	☐ ....
Mother	☐	☐	☐	☐ ....
Myself	☐	☐	☐	☐ ....

11. What ethnic backgrounds do you, your father and your mother have? (Put one or more crosses)

	Norwegian	Sami	Kven	Other, describe:
My ethnic background is	☐	☐	☐	☐ ....
My father's ethnic background is	☐	☐	☐	☐ ....
My mother's ethnic background is	☐	☐	☐	☐ ....

12. What do you consider yourself to be? (Put one or more crosses)

Norwegian	Sami	Kven	Other, describe:
☐	☐	☐	☐ ....

13. How would you assess your skills in understanding, speaking, reading and writing the Sami language?

	Very well	Fairly well	With difficulty	A few words	None at all
Understand	☐	☐	☐	☐	☐
Speak	☐	☐	☐	☐	☐
Read	☐	☐	☐	☐	☐
Write	☐	☐	☐	☐	☐

Employment, benefits and economy

14. What is your family's/household's gross income per year?

☐ Less than NOK 150,000 ☐ NOK 150,000–300,000
☐ NOK 301,000–450,000 ☐ NOK 451,000–600,000
☐ NOK 601,000–750,000 ☐ NOK 751,000–900,000
☐ More than NOK 900,000

15. How many people live in your household?
Number of people .... ☐☐

16. How many years of education have you completed?
(Include all years you have attended school or studied) .... ☐☐

17. Did you attend boarding school (either state or private) when you were in elementary/middle school? .... ☐ Yes ☐ No

18. What have been your main sources of income in the last year? (Put one or more crosses)

☐ Employed work:
☐ Full-time ☐ Part-time ☐ Seasonal
☐ Self-employed work:
☐ Full-time ☐ Part-time ☐ Seasonal
☐ Age pension/contractual pension
☐ Cash benefit/transition benefit/parental benefit
☐ Unemployment benefit
☐ Sick pay
☐ Work assessment allowance
☐ Disability pension
☐ Social benefits
☐ Support from spouse/parents/siblings/children
☐ Loans/student loans and allowance
☐ Other (saved means/inheritance, etc.)

19. Do you worry you may lose your current job or income in the next 2 years? .... ☐ Yes ☐ No

20. Would you consider moving from your current municipality if you were offered work elsewhere?

☐ Yes ☐ Only seasonally ☐ No ☐ Don't know

21. If you are employed, how happy are you in your current job/industry?

☐ Very happy ☐ Satisfied ☐ Not satisfied ☐ Very unhappy

22. Based on your health and work experience, how likely are you to continue in employed work/industry until the following ages?

	Very likely	Likely	Not very likely	Very unlikely
62 years	☐	☐	☐	☐
67 years	☐	☐	☐	☐
70 years	☐	☐	☐	☐
Older than 70 years	☐	☐	☐	☐

23. If you are self-employed, what type of industry do you work in? (Put one or more crosses)

- ☐ Reindeer husbandry
- ☐ Farming
- ☐ Business
- ☐ Fishing
- ☐ Forest farming
- ☐ Other

Psychological health

24. Below is a list of various problems. Have you experienced any of these <u>in the last 4 weeks</u>? (Put one cross for each problem)

	Not affected	Slightly affected	Affected quite a lot	Severly affected
Suddenly scared for no reason	☐	☐	☐	☐
Feeling fearful or anxious	☐	☐	☐	☐
Faintness or dizziness	☐	☐	☐	☐
Feeling tense or keyed up	☐	☐	☐	☐
Blaming yourself for things	☐	☐	☐	☐
Insomnia/sleeplessness	☐	☐	☐	☐
Feeling blue/melancholic	☐	☐	☐	☐
Feeling of worthlessness/of little value	☐	☐	☐	☐
Feeling everything is an effort	☐	☐	☐	☐
Feeling hopeless about future	☐	☐	☐	☐

25. The questions below relates to how you have been feeling over <u>the last week</u>. For each statement, please indicate which is closest to how you have been feeling. How often in <u>the last week</u> have you felt the following?
(Put one cross on each line in the box with the most applicable answer.)

	All the time	Almost all the time	Often	Some-times	A few times	Not at all
I have felt cheerful and in good spirits	☐	☐	☐	☐	☐	☐
I have felt calm and relaxed	☐	☐	☐	☐	☐	☐
I have felt active and vigorous	☐	☐	☐	☐	☐	☐
I have felt fresh and rested	☐	☐	☐	☐	☐	☐
My daily life has been filled with things that interest me	☐	☐	☐	☐	☐	☐

26. <u>In the last 12 months</u>, have you experienced uncomfortable memories that have disturbed you, without being able to do anything about them?

☐ No ☐ Yes, but rarely ☐ Sometimes ☐ Often

27. <u>In the last 12 months</u>, have you consciously avoided situations to avoid uncomfortable memories or feelings, in a way that stopped you from doing what you wanted to do?

☐ No ☐ Yes, but rarely ☐ Sometimes ☐ Often

28. <u>In the last 12 months</u>, have you been unable to react emotionally to situations where most people react?

☐ No ☐ Yes, but rarely ☐ Sometimes ☐ Often

29. Indicate how well the following statements describe you and your family:

	Does not fit				Fits well
I fully trust my own assessments and decisions	☐	☐	☐	☐	☐
I am happiest in the company of others	☐	☐	☐	☐	☐
I am very happy with my family	☐	☐	☐	☐	☐
My self-confidence gets me through difficult periods	☐	☐	☐	☐	☐
I make new friends easily	☐	☐	☐	☐	☐
There is a high level of unity within my family	☐	☐	☐	☐	☐
I use times of adversity as an opportunity to grow	☐	☐	☐	☐	☐
I easily connect with new people	☐	☐	☐	☐	☐
My family is positive about the future even in difficult periods	☐	☐	☐	☐	☐
I accept events in my life that are impossible to change	☐	☐	☐	☐	☐
It is easy for me to find something interesting to talk about	☐	☐	☐	☐	☐
In my family, we are loyal to each other	☐	☐	☐	☐	☐

Tobacco and drug use

30. Do you smoke, or have you smoked previously?

☐ Yes, daily ☐ Yes, previously ☐ Yes, sometimes ☐ No, never

How many cigarettes do you usually smoke per day? ☐☐

Age in years

How old were you when you started to smoke daily? ☐☐

31. Do you use, or have you previously used, snus?

☐ Yes, daily ☐ Yes, previously ☐ Yes, sometimes ☐ No, never

If you use snus daily, how many portions do you use per day? ☐☐

If you use snus occasionally, how many portions do you usually use per week? ☐☐

Age in years

If yes, how old were you when you started to use snus daily? ☐☐

32. How often in the last year have you consumed alcohol?
(Light and alcohol-free beer should not be included)

- ☐ Never consumed alcohol
- ☐ Not had alcohol in the last year
- ☐ A few times in the last year
- ☐ Approximately once per month
- ☐ 2–3 times per month
- ☐ Approximately once per week
- ☐ 2–3 times per week
- ☐ 4–7 times per week

33. Have you consumed alcohol in the last 4 weeks? ☐ Yes ☐ No

If yes, have you had so much that you have felt strongly intoxicated (drunk)?

☐ No ☐ Yes, 1–2 times ☐ Yes, 3 times or more

34. Would you describe your alcohol consumption or drinking pattern as periodic (drinking often and a lot in periods, to then have longer periods with no alcohol consumption)**?**
(Put one or more crosses)

☐ Yes, in the last 12 months ☐ Yes, previously ☐ No

35. Have you ever used narcotic drugs?
(Put one or more crosses)

	Yes, in last year	Yes, previously	No
Weed/marijuana (cannabis)	☐	☐	☐
Other drugs such as LSD, amphetamines, ecstasy, cocaine, heroin, GHB, etc.	☐	☐	☐

Religion and beliefs

36. Are you, your parents or your grandparents affiliated with any of the following religious organizations? (Put one or more crosses)

	Me	Mother	Father	Grand-parents
The state church	☐	☐	☐	☐
Laestadian congregation	☐	☐	☐	☐
Other religious organization/community	☐	☐	☐	☐
Please state which one: ______				
Non-religious life-stance organization/community	☐	☐	☐	☐
Please state which one: ______				
Not member of any religious/life-stance organization	☐	☐	☐	☐

37. What is your view on religion?

- ☐ I am a Christian (practicing Christian)
- ☐ I think there is a God, but religion doesn't mean that much to me in my daily life
- ☐ Unsure
- ☐ I don't think there is a God

38. In the last 6 months, how often have you been to:
(Put one cross per line)

	More than 3 times per month	1–3 times per month	1–6 times in last 6 months	Never
Church	☐	☐	☐	☐
A conjugation building	☐	☐	☐	☐
A Humanist Association event	☐	☐	☐	☐
Another religious building	☐	☐	☐	☐

Experienced discrimination

Discrimination occurs when a person or group of people are treated less favorably than others because of, for example, their ethnicity, religion, faith, disability, age or sexual orientation.

39. Have you experienced discrimination?

☐ Yes, in the last 2 years ☐ Yes, previously ☐ No ☐ Don't know

If you answered "Yes" to the last question, answer questions 40–47. If you answered "No", go to question 48.

40. If you have experienced discrimination, how often does/did it happen?

☐ Very often ☐ Sometimes ☐ Rarely

41. Why do you think you are/were discriminated against?
(Put one or more crosses)

- ☐ Physical disability
- ☐ Learning disability
- ☐ Religion or faith
- ☐ Ethnicity
- ☐ Age
- ☐ Other reasons, specify: ______
- ☐ Sexual orientation
- ☐ Gender
- ☐ Nationality
- ☐ Geographical provenance
- ☐ Illness
- ☐ Don't know

42. Where did the discrimination occur? (Put one or more crosses)

- ☐ On the internet
- ☐ At school/education
- ☐ In the workplace
- ☐ In connection with a job application
- ☐ In voluntary/organizational work
- ☐ When dealing with the government
- ☐ Among family/relatives
- ☐ While renting/buying a property
- ☐ While applying for a bank loan
- ☐ In connection with medical treatment
- ☐ In a shop or restaurant
- ☐ In your local community
- ☐ Other, please specify: ______

43. Who discriminates/discriminated against you?
(Put one or more crosses)

- ☐ A government employee
- ☐ Someone not known to me
- ☐ Work colleagues
- ☐ One or more people from my ethnic group.
- ☐ One or more people from another ethnic group.
- ☐ Co-students
- ☐ Teachers/staff
- ☐ Other

44. Did you actively do anything to end the discrimination? ☐ Yes ☐ No

45. Have you ever been in contact with the Equality and Anti-Discrimination Ombudsman for advice or help with discrimination?

☐ Yes ☐ No ☐ I don't remember

46. How much does/did the discrimination affect you?

☐ Not at all ☐ A bit ☐ Somewhat ☐ A lot

47. Have you ever been discriminated against for being Sami?

☐ Yes ☐ No ☐ Don't know ☐ I'm not Sami

Violence and abuse

48. Has anyone ever systematically and over a longer period tried to subdue, degrade, or humiliate you? (Put one or more crosses)

☐ No, never ☐ Yes, as a child (under 18)
☐ Yes, as an adult (18 or older) ☐ Yes, in the last 12 months

If yes, who?

☐ A stranger ☐ A spouse/partner
☐ Family/a relative ☐ An acquaintance

49. Have you experienced physical attacks/abuse? (Put one or more crosses)

☐ No, never ☐ Yes, as a child (under 18)
☐ Yes, as an adult (18 or older) ☐ Yes, in the last 12 months

If yes, by whom?

☐ A stranger ☐ A spouse/partner
☐ Family/a relative ☐ An acquaintance

50. Have you been sexually abused? (Put one or more crosses)

☐ No, never ☐ Yes, as a child (under 18)
☐ Yes, as an adult (18 or older) ☐ Yes, in the last 12 months

If yes, by whom?

☐ A stranger ☐ A spouse/partner
☐ Family/a relative ☐ An acquaintance

51. If you have experienced any kind of abuse, have you confided in anyone? (Put one or more crosses)

☐ No ☐ Someone in my family ☐ Friends ☐ Professionals

Dental health

52. How is your dental health?

☐ Poor ☐ Not very good ☐ Good ☐ Very good

53. Do you have dentures? ☐ Yes ☐ No

54. Do you use any of the following, and if so, how often?

	Regularly/ daily	Not regularely/ a few times per week	Not regularly/ a few times per month	Less/ never
Toothbrush	☐	☐	☐	☐
Fluoride toothpaste	☐	☐	☐	☐
Dental floss	☐	☐	☐	☐
Toothpicks	☐	☐	☐	☐
Fluoride tablets	☐	☐	☐	☐
Mouth wash	☐	☐	☐	☐
Denture brush	☐	☐	☐	☐

55. When did you last see a dentist or dental nurse?

☐ Less than a year ago ☐ 1–2 years ago
☐ 3–5 years ago ☐ More than 5 years ago

56. If more than 2 years ago, what is the reason?
(Put one or more crosses)

- ☐ The dentist didn't send me notice of any appointment
- ☐ There is a long wait at the dentist
- ☐ I haven't had time
- ☐ Financial reasons
- ☐ I have not needed dental treatment
- ☐ I am scared of going to the dentist
- ☐ Other reasons:

____

57. How do you access dental services? (Put one or more crosses)

☐ Regularly get an appointment with dentist or dental nurse

☐ Regularly request an appointment

☐ Request an appointment when I'm in pain or have lost a filling

☐ I don't go to the dentist that often

58. In the last 2 years, have you been given one or more of these diagnoses by a dentist?

	Yes	No	Don't know
Serious gum disease	☐	☐	☐
Mild gum disease	☐	☐	☐
Mouth dryness	☐	☐	☐
Cavities in one tooth or more	☐	☐	☐
Other diagnoses	☐	☐	☐

59. Are you satisfied with your teeth or prosthetics? Indicate the answer below where 1 is very dissatisfied and 5 is very satisfied.

	1	2	3	4	5	
Very dissatisfied	☐	☐	☐	☐	☐	Very satisfied

60. How often did you brush your teeth as a 10-year-old?

☐ Once per day or more

☐ Sometimes

☐ Rarely or never

61. How often did your parents or guardians check that you had brushed your teeth when you were 10 years old?

☐ Often (almost daily) ☐ Sometimes ☐ Never

62. If a child younger than 6 years old is living with you, how often do you help them to brush their teeth or check that they have brushed their teeth?

☐ Often (almost daily) ☐ Sometimes ☐ Never

63. If a child between 6 and 12 years old is living with you, how often do you help them to brush their teeth or check that they have brushed their teeth?

☐ Often (almost daily) ☐ Sometimes ☐ Never

64. If you have a child between 0 and 12 years old living with you, do you have set rules for the children for eating chocolate and other sweets?

☐ Yes ☐ No

65. How satisfied are you with the dental health care offered in your municipality?

Very dissatisfied ☐ ☐ ☐ ☐ ☐ ☐ Very satisfied ☐ Don't know

Suicide and suicidal behavior

66. Have you lost anyone close to you through suicide? ☐ Yes ☐ No

67. Have you ever thought about committing suicide

☐ Yes, in the last year ☐ Yes, previously ☐ No, never

68. Have you ever tried to commit suicide?

☐ Yes, in the last year ☐ Yes, previously ☐ No, never

69. Have you ever hurt yourself on purpose?

☐ Yes, in the last year ☐ Yes, previously ☐ No, never

If you have tried to commit suicide, please answer the following questions. If you answered "No" to question 68, please go to question 76.

70. How did you try to commit suicide?
(Put one or more crosses)

☐ Hanging ☐ A gun

☐ Sharp object ☐ Overdose of pills/medicines

☐ Another way

71. Why did you try to commit suicide?

A clear desire to die	☐ Yes	☐ No
The situation felt intolerable	☐ Yes	☐ No
I wanted help from somebody	☐ Yes	☐ No

72. Were you intoxicated/high when you tried to commit suicide? ☐ Yes ☐ No

73. How old were you the first time you tried to commit suicide? ☐☐

74. How many times have you tried to commit suicide? ☐☐

75. Did you tell anyone about the suicide attempt(s)?
(Put one or more crosses)

☐ No ☐ Someone in my family ☐ Friends ☐ Professionals

Gambling

76. Have you ever felt a need to gamble for more and more money? (Put one or more crosses)

☐ Yes, in the last year ☐ Yes, previously ☐ No

77. Have you ever lied to people who are important to you about how much you gamble? (Put one or more crosses)

☐ Yes, in the last year ☐ Yes, previously ☐ No

78. Have you ever had periods where you, having lost money on gambling one day, returned to win it back another day? (Put one or more crosses)

☐ Yes, in the last year ☐ Yes, previously

☐ No ☐ Don't know/don't remember

79. Have you played role-playing games online in the last year?

☐ Yes, daily ☐ Yes, weekly

☐ Yes, monthly or less frequently ☐ No

Experience and use of health services

80. Who is the doctor you normally use

☐ Your GP ☐ Another doctor

81. How long have you had your current GP?

☐ Less than 6 months ☐ 6 to 11 months

☐ 12 to 24 months ☐ More than 2 years

82. In the last 12 months, have you contacted your doctor for help or advice for yourself? ☐ Yes ☐ No

If yes, did you get the help you asked for?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

83. How satisfied are you with the following aspects of the doctor's service (regular GP scheme)?

	Very satisfied	Satisfied	Dis-satis-fied	Very dis-satisfied	Don't know
The doctor's accessibility on the phone	☐	☐	☐	☐	☐
The waiting time for an appointment	☐	☐	☐	☐	☐
Time with the doctor	☐	☐	☐	☐	☐
The doctor's understanding of your problems	☐	☐	☐	☐	☐
Their information about your health issues, examination and treatment plan	☐	☐	☐	☐	☐
In total, how satisfied are you with the municipal health service?	☐	☐	☐	☐	☐

Specialized health service refers to hospitals, district psychiatric centers (DPS), specialized doctors services and individual specialists.

84. In the last 12 months, have you been for examination or treatment for *physical problems* to the following?

☐ The hospital ☐ Specialist medical center

☐ Private specialist ☐ None of these

85. In the last 12 months, have you been for examination or treatment for *psychological problems* to the following?

☐ Psychiatric hospital ☐ District psychiatric center

☐ Private specialist ☐ None of these

86. If you have been for treatment with a specialist for physical or psychological problems in the last 12 months, answer the following questions. Answer on a scale from 0 to 10, where 0 = to a small extent, 10 = to a large extent.

Did you get a chance to say what you felt was important about your condition?

	0	1	2	3	4	5	6	7	8	9	10	Not relevant
Physical issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Did the doctors speak to you in a way you understood?

	0	1	2	3	4	5	6	7	8	9	10	Not relevant
Physical issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Did you feel you got to help make decisions about your treatment?

	0	1	2	3	4	5	6	7	8	9	10	Not relevant
Physical issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Did the treatment help you improve?

	0	1	2	3	4	5	6	7	8	9	10	Not relevant
Physical issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you trust the hospital or specialist who saw you?

	0	1	2	3	4	5	6	7	8	9	10	Not relevant
Physical issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

All in all, how satisfied are you with the care and treatment you eventually received?

	0	1	2	3	4	5	6	7	8	9	10	Not relevant
Physical issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Experiences with referrals

87. In the last 12 months, have you wanted to be referred to a specialist, but been refused?

For physical problems

- ☐ No, never
- ☐ Yes, once
- ☐ Yes, many times
- ☐ Not relevant

For psychological problems

- ☐ No, never
- ☐ Yes, once
- ☐ Yes, many times
- ☐ Not relevant

88. In the last 12 months, have you wanted to be referred to a physiotherapist, chiropractor, or similar, but been refused?

- ☐ No, never
- ☐ Yes, once
- ☐ Yes, many times
- ☐ Not relevant

89. If you were referred, how long did you wait for an appointment?

Number of weeks ☐☐

90. Have you requested free hospital choice on referral to specialized treatment?

- ☐ Yes
- ☐ No
- ☐ Not relevant

Language during doctors visits

91. Last time you visited your doctor, what language did you speak?

	Norwegian	Sami	Other, describe:	
I spoke	☐	☐	☐	....
The doctor spoke	☐	☐	☐	....

92. Last time you were at the hospital/with a specialist, what language did you speak?

	Norwegian	Sami	Other, describe:	
I spoke	☐	☐	☐	....
The doctor spoke	☐	☐	☐	....

93. In what language(s) do you primarily want to talk to health personnel? (Put one or more crosses)

Norwegian	Sami	Other, describe:	
☐	☐	☐	....

Use of interpreter

94. If you have answered "Sami" but were not offered a Sami-speaking doctor at your last doctors visit, did they offer you an interpreter?

With your general practitioner:

- ☐ Yes
- ☐ No
- ☐ I do not want an interpreter
- ☐ Not relevant

In the hospital/with a specialist:

- ☐ Yes
- ☐ No
- ☐ I do not want an interpreter
- ☐ Not relevant

95. If a Sami-speaking interpreter was offered at the last doctors visit, who was the interpreter?

With your general practitioner:

- ☐ A government interpreter
- ☐ Family
- ☐ An employee at the office
- ☐ Other

In the hospital/with a specialist:

- ☐ A government interpreter
- ☐ Family
- ☐ Another hospital employee
- ☐ Other

96. If you have ever been to a doctors appointment or treatment where a Sami-speaking interpreter was used, how satisfied were you with the communication/conversation between you and the doctor/health professional?

With your general practitioner:

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied
- ☐ Don't know

In the hospital/with a specialist:

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied
- ☐ Don't know

97. Have you ever experienced not receiving Norwegian/Sami interpretation assistance even though you asked for it?

- ☐ Yes, I have asked for an interpreter but not received one
- ☐ No, I have always had an interpreter if I asked for one
- ☐ I have never asked for an interpreter

Thank you for participating in the survey!

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | 0-110901 – NORSK

Invitation letter—Norwegian and Northern Sámi

Forespørsel om deltakelse i forskningsprosjektet SAMINOR 2

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i et forskningsprosjekt for å få mer kunnskap om helse, sykdom og levekår i områder med samisk og norsk bosetting. Du som deltar i denne undersøkelsen vil bli bedt om å svare på et spørreskjema om helse og levekår.

Du er invitert til å være med i denne studien fordi du er i alderen 18-69 år og bosatt i en av kommunene som er valgt ut til å inngå i undersøkelsen. Studien utføres av Senter for samisk helseforskning ved Universitetet i Tromsø.

Det overordnede målet med SAMINOR 2 helseundersøkelsen er å få mer kunnskap om forekomst av både risikofaktorer og ulike sykdommer samt deres mulige årsaksforhold.

Hva innebærer studien?

I undersøkelsen vil du bli invitert til å svare på vedlagte spørreskjema og sende det tilbake til oss eller benytte vår nettbaserte spørreskjemaløsning. Dersom du velger nettbasert løsning framfor spørreskjemaet går du til http://saminor.uit.no og benytter følgende brukernavn og passord:

Hva skjer med den innsamlede informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste. Det betyr at opplysningene er avidentifisert. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Etter godkjenning fra Datatilsynet kan opplysningene dine settes sammen med opplysninger fra andre registre for forskningsformål. I alle disse tilfellene blir navnet og personnummeret fjernet. Dette kan være registre om trygd, sykdom, inntekt, utdanning, yrke og opplysninger fra tidligere SAMINOR- eller andre helseundersøkelser (både spørreskjema og blodprøver). Aktuelle registre er Kreftregisteret, Dødsårsaksregisteret, Reindriftsforvaltningens database, Folkeregisteret og folketellinger. Forsikringsselskaper eller andre kommersielle institusjoner vil ikke få tilgang til dataene. All videre behandling av helseopplysninger skjer etter godkjenning av Regional komité for medisinsk og helsefaglig forskningsetikk.

Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Du kan seinere bli kontaktet med forespørsel om du vil svare på tilleggspørreskjema eller vil delta i en klinisk helseundersøkelse. Prosjektslutt er satt til 31.12.2067. Etter dette vil dataene slettes eller anonymiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Ved å svare på skjemaet og returnere det per post eller svare på nettbasert skjema samtykker du i deltakelse i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Du har rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte **Anne Karen Hætta tlf. 404 90 467** eller **Ketil Lenert Hansen tlf. 907 91 116**, ved Senter for samisk helseforskning, Universitetet i Tromsø. Du kan bli kontaktet igjen per post med invitasjon om å delta i SAMINORs kliniske helseundersøkelse og nye spørreskjemaundersøkelser.

Økonomi

Studien er finansiert gjennom forskningsmidler fra de tre nordligste fylkeskommunene, Helse Nord, Samisk nasjonalt kompetansesenter, psykisk helsevern (SANKS), Sametinget, Universitetet i Tromsø og Helse og omsorgsdepartementet. Ingen av disse instansene har interessekonflikter i undersøkelsen.

Informasjon om utfallet av studien

Resultater av undersøkelsen vil publiseres i internasjonale og nasjonale vitenskapelige tidsskrifter i tillegg til ulike populærvitenskapelige kanaler og media.

Hilsen fra

Magritt Brustad
Professor Dr. Scient.

Ragnhild Vassvik Kalstad
Avdelingsleder

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-110901 – NORSK

Jearaldat searvat SAMINOR 2 dutkanprošektii

Duogáš ja áigumuš

Dá lea dutnje jearaldat searvat dutkanprošektii man ulbmil lea loktet gelbbolašvuođa dearvvašvuođa, buozalmasvuođa ja eallindili birra guovlluin gos ásset sápmelaččat ja dážat. Don guhte searvvat dán guorahallamii bivdojuvvot vástidit jearahallanskovi mii lea dearvvašvuođa ja eallindili birra.

Don leat bovdejuvvon searvat dán dutkamii go don leat gaskal 18-69 jagi, ja orut ovtta dain gielddain mii lea válljejuvvon gullat guorahallamii. Lea Sámi dearvvašvuođadutkama guovddáš Romssa universitehtas mii čađaha dutkama.

SAMINOR 2 dearvvašvuođadutkama oaiveulbmil lea oažžut eanet gelbbolašvuođa riskafáktoriid ja iešguđetge dávddaid gávdnosiid ektui ja vejolaš sivaid daidda.

Maid mielddisbuktá dutkan?

Guorahallamis bovdejuvvot vástidit jearranskovi mii lea dás mielddusin ja sáddet dan ruovttuluotta midjiide, dahje atnit jearahallanskovi mii lea interneahtas. Jus ovdal válljet neahttačovdosa, go dán jearahallanskovi de manat http://saminor.uit.no ja geavahat čuovvovaš geavaheaddjinama ja čoavddasáni:

Mii dáhpáhuvvá dieđuin mat leat du birra?

Dieđut mat registrerejuvvojit du birra galget dušše geavahuvvot nu go lea čilgejuvvon dutkama áigumušas. Buot dieđut gieđahallojuvvojit nama ja riegádannummira haga dahje eará mihtilmas dieđuid haga. Biddjojuvvo koda mii čatná du iežat dieđuide nammalistu bokte. Dat mearkkaša ahte dieđuin leat váldojuvvon eret oasit mat sáhttet leat identifiserejeaddjin. Leat dušše autoriserejuvvon bargit geat gullet prošektii geain lea vejolašvuohta nammalisttuid oaidnit ja geat sáhttet gávdnat du dieđuid nama bokte. Dutkanulbmilin sáhttet dieđut du birra biddjojuvvot oktii dieđuiguin mat leat eará registariin Datatilsynet dohkkehemiin. Buot dáin oktavuođain váldojuvvo namma ja persovdnanummir eret. Dát sáhttet leat registarat oaju, buozalmasvuođa, sisaboađu, oahppu, virggi ja eará dieđuid birra mat leat vižžon ovdalaš SAMINOR- dahje eará dearvvašvuođadutkamiin (sihke jearahallanskovit ja varraiskosat). Áššáigullevaš registarat leat Borasdávdaregisttar, Jápminsivvaregisttar, Boazodoaluhálddahusa diehtovuođđu, álbmotregisttar ja olmmošlohkamat. Dáhkádusfitnodagain dahje eará kommersiála ásahusain ii leat vejolašvuohta oažžut dieđuid. Viidásat gieđahallan dearvvašvuođadieđuin dáhpáhuvvá Regional komité for medisinsk og helsefaglig forskningsetikk dohkkehemiin.

Ii leat vejolaš du identifiseret dutkama bohtosiin go dat almmuhuvvojit. Duinna sáhttá váldot oktavuohta maŋit áiggis ja dalle jerrojuvvot hálidat go vástidit liigejearaldagaid dahje searvat klinihkalaš dearvvašvuođaiskosii. Prošeavtta loahpaheapmi lea biddjon 31.12.2067. Dan maŋŋá sihkkojuvvojit dieđut dahje anonymiserejuvvojit.

Eaktodáhtolaš searvan

Lea eaktodáhtolaš searvat dutkamii. Go vástidat skovi ja sáddet dan ruovttuluotta poastta mielde dahje go vástidat skovi neahtas de mieđat searvat dutkamii. Sáhtát vaikke goas geassádit dutkamis, it dárbbaš almmuhit makkárge siva jus geassádat. Dus lea vuoigatvuohta beassat oaidnit makkár dieđut leat registrerejuvvon du birra. Ja dus lea vuoigatvuohta divvut jus leat boasttuvuođat registrerejuvvon du birra. Jus geassádat dutkamis, sáhtát gáibidit ahte dieđut du birra sihkkojuvvojit, eaktun ahte dieđut eai jo leat geavahuvvon analiissain dahje geavahuvvon dieđalaš publikašuvnnain.

Jus don maŋit áiggis hálidat geassádit dahje jus leat jearaldagat dutkama ektui, sáhtát váldit oktavuođa **Anne Karen Hættain tlf. 404 90 467** dahje **Ketil Lenert Hansen tlf. 907 91 116**, Sámi dearvvašvuođadutkama guovddáš, Romssa universitehta. Sáhtát poastta bokte oažžut bovdejumi searvat SAMINORa klinihkalaš dearvvašvuođadutkamii/iskosii ja ođđa jearahallanskovidutkamiidda.

Ruhtadilli

Golbma davimus fylkkagieldda, Dearvvašvuohta Davvin, Romssa universitehta, Sámi našunala gealboguovddáš - psyhkalaš dearvvašvuođadikšu (SÁNAG), Ođasmahttin-, hálddahus- ja girkodepartemeanta (FAD), Sámediggi ja fuolahusdepartemeanta leat ruhtadan dutkama dutkanruđaiguin. Dáid instánssain eai eat beroštusriiddut dutkama oktavuođas.

Dieđut dutkama bohtosiid birra

Dutkama bohtosat almmuhuvvojit internašunála ja našunála dieđalaš áiggečállagiin ja iešguhtetge popularadieđalaš kanálain ja mediain.

Dearvvuođat

Magritt Brustad
Professor Dr. Scient

Ragnhild Vassvik Kalstad
Ossodatjođiheaddji

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-11090 – NORDSAMISK

Invitation letter—Norwegian and Lule Sámi

Forespørsel om deltakelse i forskningsprosjektet SAMINOR 2

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i et forskningsprosjekt for å få mer kunnskap om helse, sykdom og levekår i områder med samisk og norsk bosetting. Du som deltar i denne undersøkelsen vil bli bedt om å svare på et spørreskjema om helse og levekår.

Du er invitert til å være med i denne studien fordi du er i alderen 18-69 år og bosatt i en av kommunene som er valgt ut til å inngå i undersøkelsen. Studien utføres av Senter for samisk helseforskning ved Universitetet i Tromsø.

Det overordnede målet med SAMINOR 2 helseundersøkelsen er å få mer kunnskap om forekomst av både risikofaktorer og ulike sykdommer samt deres mulige årsaksforhold.

Hva innebærer studien?

I undersøkelsen vil du bli invitert til å svare på vedlagte spørreskjema og sende det tilbake til oss eller benytte vår nettbaserte spørreskjemaløsning. Dersom du velger nettbasert løsning framfor spørreskjemaet går du til http://saminor.uit.no og benytter følgende brukernavn og passord:

Hva skjer med den innsamlede informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste. Det betyr at opplysningene er avidentifisert. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Etter godkjenning fra Datatilsynet kan opplysningene dine settes sammen med opplysninger fra andre registre for forskningsformål. I alle disse tilfellene blir navnet og personnummeret fjernet. Dette kan være registre om trygd, sykdom, inntekt, utdanning, yrke og opplysninger fra tidligere SAMINOR- eller andre helseundersøkelser (både spørreskjema og blodprøver). Aktuelle registre er Kreftregisteret, Dødsårsaksregisteret, Reindriftsforvaltningens database, Folkeregisteret og folketellinger. Forsikringsselskaper eller andre kommersielle institusjoner vil ikke få tilgang til dataene. All videre behandling av helseopplysninger skjer etter godkjenning av Regional komité for medisinsk og helsefaglig forskningsetikk.

Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Du kan seinere bli kontaktet med forespørsel om du vil svare på tilleggspørreskjema eller vil delta i en klinisk helseundersøkelse. Prosjektslutt er satt til 31.12.2067. Etter dette vil dataene slettes eller anonymiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Ved å svare på skjemaet og returnere det per post eller svare på nettbasert skjema samtykker du i deltakelse i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Du har rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte **Anne Karen Hætta tlf. 404 90 467** eller **Ketil Lenert Hansen tlf. 907 91 116**, ved Senter for samisk helseforskning, Universitetet i Tromsø. Du kan bli kontaktet igjen per post med invitasjon om å delta i SAMINORs kliniske helseundersøkelse og nye spørreskjemaundersøkelser.

Økonomi

Studien er finansiert gjennom forskningsmidler fra de tre nordligste fylkeskommunene, Helse Nord, Samisk nasjonalt kompetansesenter, psykisk helsevern (SANKS), Sametinget, Universitetet i Tromsø og Helse og omsorgsdepartementet. Ingen av disse instansene har interessekonflikter i undersøkelsen.

Informasjon om utfallet av studien

Resultater av undersøkelsen vil publiseres i internasjonale og nasjonale vitenskapelige tidsskrifter i tillegg til ulike populærvitenskapelige kanaler og media.

Hilsen fra

Magritt Brustad
Professor Dr. Scient.

Ragnhild Vassvik Kalstad
Avdelingsleder

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-110901 – NORSK

Gatjálvis oassálasstet SAMINOR 2 dutkamprosjæktaj

Duogásj ja ájggomus

Dát le dunji gatjálvis oassálastátjit soames dutkamprosjæktaj man ulmmen le låpptit máhtudagáv varresvuoda, skihpudagáj ja iellemdile birra guovlojn gånnå sáme ja dáttja årru. Dån guhti oassálastá dán guoradallamij gåhtjuduvá vásstedit varresvuoda ja iellemdile birra.

Dån le gåhtjoduvvam oassálasstet dán dutkamij gå dån le 18-69 jage gaskan, ja åro avtan dáj suohkanijn mij le vállijiduvvam gullut guoradallamij. Sáme varresvuoda dutkamguovdásj Råmså universitehtan dutkamav tjádat.

SAMINOR 2 varresvuodadutkama oajvveulmme le oadtjot ienep diedojt sihke vádáfaktåvråj ja duon dan skihpudagá gávnnusij gáktuj ja vejulasj sivájt dajda.

Majt dutkam merkaj?

Guoradallamin gåhtjoduvá vásstedit gatjálvissjiemáv mij tjuovvu ja midjij dav ruoptus rádjat, jali adnet mijá gatjálvissjiemáv mij le internehtan. Jus vállji næhttatjoavddusav de maná http://saminor.uit.no ja ávkki addnenamáv ja bessambágov mij tjuovvu:

Mij dáhpáduvvá tjoahkkidum diedoj duv birra?

Diedo ma registreriduvvi duv birra galggi dåssju aneduvvat nav gåktu le tjielggiduvvam dutkama ájggomusán. Gájkka diedo giehtadaláduvvi namá ja riegádimnummara dagá jali ietjá dåbddelis diedoj dagá. Biejaduvvam le kåvddå mij tjádná duv ietjat diedojt nammalista baktu. Dat merkaj diedo le vállijiduvvam ierit åsijs maj milta aktak ij máhte gávnnat guhti le vásstedam. Dåssju dåhkkidum prosjæktabargge oadtju nammalistav gæhttjat ja gávnnat diedojt duv birra. Dutkam måhkken máhtti diedo duv birra biejaduvvat aktan diedoj ma li ietjá registarijn Datatilsynet (Dáhtábærrájgæhttje) dåhkkidimijn. Gájkka dájs diedojs váldeduvvi namma ja persåvnnånummar ierit. Dá máhtti liehket regisstara oajo, skihpudagá, sisboado, åhpadusá, virge ja ietjá diedoj birra ma gávnnuji åvdep SAMINOR- jali ietjá varresvuodadutkamijn (sihke gatjálvissjiemá ja varraåtsålvisá). Almma regisstara li Bårredávddaregisstar, Jábmemoarreregisstar, Boatsojæládusá dáhtábássa ja Álmmuklåhkoregisstar ja ulmusjlåhkåma. Buohttidusvidnudagájda jali ietjá kommersijála institusjåvnåjda ij le vejulasjvuohta oadtjot diedojt. Divna ietjá giehtadallam varresvuodadiedojs dáhpáduvvá Regional komité for medisinsk og helsefaglig forskningsetikk (Guovlo medisijna ja varresvuodafágalasj komitea dutkametihka) dåhkkidimijn.

Ij galga liehket máhttelis duv birra (ájnegis ulmutjin) majdik gávnnat dutkama båhtusij gå dá almoduvvi. Maŋŋela máhttá dujna váldeduvvat aktijvuohta gatjálvisáj jus hálijda vásstedit lijggegatjálvisájt jali oassálasstet klinihkalasj varresvuodadutkamij. Prosjevta loahppa le biejadum 31.12.2067. Dan maŋŋela diedo gádoduvvi jali anonymiseriduvvi.

Luojvoj oassálasstem

Oassálasstem guoradallamij le luojvoj. Gå sjiemáv vásssteda ja dav ruopptot rája, påsta maŋen jali gå sjiemáv nehtan vássteda, de miededa aj dutkamij oassálasstet. Dån máhtá goassa sidá, ja váni sivva vattek, gæssádit ietjat miededusáv guoradallamij oassálasstet Dujna le rievtesvuohta vuojnnet makkár diedo duv birra li tjoahkkidum. Dujna le aj rievtesvuohta oadtjot divodum dajt diedojt majt mij lip dujsta tjoahkkim jus la juoga boasstot. Jus gæssáda dutkamis, de máhtá gájbbedit tjoahkkidum diedojt oadtjot gádodum, jus diedo juo ælla adnuj váldedum analysajn jali diedalasj almodusájn.

Jus dån maŋnela hálijda gæssádit, jali jus dujna li gatjálvisá dutkama hárráj, máhtá aktijvuodav válldet **Anne Karen Hættajn tlf. 404 90 467** jali **Ketil Lenert Hansen tlf. 907 91 116**, Sáme varresvuoda dutkamguovdásj, Råmså universitehtta. Máhtá påsta baktu oadtjot gåhttjomav oassálasstet SAMINORa klinihkalasj varresvuodadutkamij ja ådå gatjálvissjiebmádutkamijda.

Ruhtadibme

Gålmmå nuorttamus fylkasuohkana, Varresvuohta Nuorttan, Sáme nasjåvnålasj máhtudakguovdásj – psykalasj varresvuodasuoddjim (SANKS), Råmså universitehtta, Ådåsmahttem-, háldadus-, ja girkkodepartementa (FAD), Sámedigge ja huksodepartemænnta li ruhtadam dutkamav dutkamrudáj. Dáj instánsaj ij la berustimrijddo dutkama hárráj.

Diedo dutkama båhtusij birra

Dutkama båhtusa almoduvvi internasjonálalasj ja nasjonálalasj diedalasj ájggetjállagijn ja duon dan populærdiedalasj kanálajn ja mediajn.

Varrudagáj

Magritt Brustad
Professor Dr. Scient

Ragnhild Vassvik Kalstad
Åssudakjådediddje

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O 11001 – LULESAMISK

Invitation letter—Norwegian and Southern Sámi

Forespørsel om deltakelse i forskningsprosjektet SAMINOR 2

Bakgrunn og hensikt

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Økonomi

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Hilsen fra

Magritt Brustad
Professor Dr. Scient.

Ragnhild Vassvik Kalstad
Avdelingsleder

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-11090 – NORSK

Sïjhth meatan årrodh dotkemeprosjektesne SAMINOR 2

Våarome jïh aajkoe
Daate akte gyhtjelasse dutnjien mejtie sïjhth meatan årrodh aktene dotkemeprosjektesne juktie vielie daajroem åadtjodh healsoen, skïemtjelassi jïh jielemetsiehkiej bïjre dejnie dajvine gusnie saemien jïh nøørjen årrojh. Mijjieh birrebe datnem mij lea meatan dennie goerehtimmesne, aktem gihtjemegoerem vaestiedidh healsoen jïh jielemetsiehkiej bïjre.

Datne bøøresovveme meatan årrodh daennie goerehtimmesne juktie datne leah aalterisnie 18-69 jaepieh, jïh aktene dejstie tjïeltijste årroeh mij lea veeljeme meatan årrodh goerehtimmesne. Saemien healsoedotkemejarnge Romsen universiteetesne daam goerehtimmiem dorje.

Dïhte bijjemes ulmie SAMINOR 2 healsoegoerehtimmine lea vielie daajroem åadtjodh mij gåavnese dovne vaahrafaaktovrijstie jïh ovmessie skiemtjelassijste, jïh mannasinie dagkerh fåantoeh jijhteme.

Maam goerehtimmie faarhmeste?
Goerehtimmesne datne bøøresovvh dam baalte bïejeme gihtjemegoerem vaestiedidh, jïh dam båastede mijjese seedtedh, jallh mijjen gihtjemegoerem nedtesne nuhtedh. Jis buerebh veeljh nedtesne vaestiedidh dle vaadtsah diekie http://saminor.uit.no jïh nåhtedh dam utnijenommem jïh tjeakoesbaakoem mij lea baalte bïejeme:

Mij dej tjöönghkeme bïevnesigujmie dov bïjre heannede?
Dah bïevnesh mejtie dov bïjre registrerede edtjieh ajve åtnasovvedh goh goerehtimmien aajkosne buerkiestamme. Gaajhkh bïevnesh jallh jeatjah ryøktesth damtijes bïevnesh sïjhtebe bielelen nommem jïh reakedsnommerem gïetedidh. Akte kode datnem ektede dov bïevnesidie akten nommelæstoen tjïrrh. Dihte sæjhta jiehtedh dah bïevnesh leah tjeakoes dorjeme. Ajve autoriseradamme barkijh mah leah prosjektese ektiedamme, mah luhpiem utnieh nommelæstose, jïh mah maehtieh dutnjien båastede gaavnedh. Jååhkesjimmien mænngan Daatavaaksjomistie, dle dov bïevnesh maehtieh tjåanghkan bïejesovvedh dej bïevnesigujmie jeatjah registeristie dotkemen gaavhtan. Gaajhki daej veajkoej dle nommem jïh almetjenommerem laahpehte. Daate maahta årrodh registerh tjïrkemen bïjre, skïemtjelassh, maam dïenesjamme, øøhpehtimmie, barkoe jïh bievnesh aarebi SAMINOR-jallh jeatjah healsoegoerehtimmijste (dovne gihtjemegoere jïh vïrrepryøvenassh). Sjyøhtehke registerh lea Kreftregistere, Dødsårsakregistere, Båatsoeburriej reeremen daatabaase, Almetjeregistere jïh almetjeryøknemh. Tjïrkemesielth jallh jeatjah kommersijelle institusjovnh eah sïjhth luhpiedimmiem åadtjodh daatide. Gaajhke vijriebasse gïetedimmie healsoebïevnesijstie lea jååhkesjimmien mietie Regijovnale moenehtsistie medisijnen jïh healsofaagen dotkemeetihkese / Regional komite for medisinsk og helsefaglig forskningetikk.

Ij gåaredh datnem identifiseradih goerehtimmien illedahkine gosse dejtie bæjhkohte. Mænngan maahta datnine govlehtalledh jïh gihtjedh mejtie sïjhth aktem lissiegihtjemegoerem vaestiedidh, jallh meatan årrodh aktene kliniske healsoegoerehtimmesne. Prosjekten galhkuve lea 31.12.2067. Dan mænngan sæjhta daatide laahpehtidh jallh daatide tjeakoes darjodh.

Jïjtjevyljehke meatan årrodh
Jïjtjevyljehke meatan årrodh goerehtimmesne. Gosse goerem vaestedh jïh dam påastine jallh nedtesne vaestedh, dle jååhkesjh meatan årrodh goerehtimmesne. Maahtah saaht gåessie jïh bielelen fåantoe, jååhkesjimmiem hiejhtedh jïh goerehtimmesne orrijidh. Datne reaktoem åtnah daejredh mah bïevnesh mah leah registreradamme dov bïjre. Datne aaj reaktoem åtnah fiejlieh staeriedidh jis fiejlieh sjïdteme dejnie bïevnesinie mijjieh registreradamme. Dastegh goerehtimmiem laahpah, maahtah krievedh dah bïevnesh smualkoeh, bene ij jis dah bïevnesh joe leah meatan giehtjedimmine, jallh nåhtadamme vitenskapeles bæjhkoehtimmine.

Jis datne mænngan sïjhth orrijidh jallh gyhtjelassh åtnah goerehtimmien bïjre, maahtah govlehtalledh **Anne Karen Hætta tell. 404 90 467** jallh **Ketil Lenert Hansen tell. 907 91 116**, Saemien healsoedotkemejarnge, Romsen universitetesne. Maahta datnem vihth govlehtalledh påastesne mejtie sïjhth meatan årrodh SAMINOR'en kliniske healsoegoerehtimmesne jïh orre gihtjemegoeregoerehtimmine.

Ekonomije
Goerehtimmie beetnehdåarjoem åådtjeme dotkemevierhtijste dejstie golme noerhtemes fylhkentjïeltijste, Healsoe Noerhte, Saemien nasjovnale maahtoejarnge, psykiske healsovaarjelimmie (SANKS), Saemiedigkie, Romsen universitete jïh Healsoe jïh hoksedepartemente, Saemien Nasjovnale maahtoejarnge, psykiske healsoevaarjelimmie jïh Saemiedigkie. Ij guhte dejstie suerkijste iedtjevigkieh goerehtimmesne utnieh.

Bïevnesh illedahki bïjre goerehtimmeste
Sæjhta illedahkh goerehtimmeste bæjhkoehtidh gaskenasjovnale jïh nasjovnale vitenskapeles tjaaleginie, lissine ovmessie populærevitenskapeles kanaaline jïh meedijinie.

Heelsegh

Magritt Brustad
Professor Dr. Scient

Ragnhild Vassvik Kalstad
Goevtesen åvtehke

LUNDBLAD MEDIA AS – SVANEGODKJENT TRYKKSAK – 241 762 | O-11090 – SØRSAMISK

Approval from the Norwegian Regional Committees for Medical and Health Research Ethics—Norwegian

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK nord	May Britt Rossvoll	77620757	05.12.2016	2016/1766/REK nord
			Deres dato:	Deres referanse:
			20.09.2016	

Vår referanse må oppgis ved alle henvendelser

Anna Rita Spein
Avrusning

2016/1766 NordTRO: Religion og helse i Nord-Norge

Forskningsansvarlig institusjon: Finnmarkssykehuset
Prosjektleder: Anna Rita Spein

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 24.11.2016. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

Prosjektleders prosjektomtale
Hovedvekten av forskningen viser at religion er forbundet med bedre helse, men det er store forskjeller mellom ulike religioner og etniske grupper. Noen religiøse oppfatninger og menighetsstrukturer kan disponere for angst og depresjon. Finnmark har landets høyeste andel samer, men også høyeste andel overvektige menn og røykere, og har ligget øverst på selvmordsstatistikken for menn i flere år. Det mangler regional forskning om betydningen av positive eller negative følger av religion (f.eks. læstadianismen) på helse, der man samtidig kontrollerer for etnisitet. Med utgangspunkt i spørreskjema fra SAMINOR 2-undersøkelsen om helse og levekår i områder med samisk og norsk bosetning i Nord-Norge i 2012, er NordTRO i stand til å svare på dette. Vårt hovedmål er å finne betydningen av religiøs familiebakgrunn og egen religiøs identitet for livsstilssykdommer, selvmord og bruk av helsetjenestene blant voksenpopulasjonen i områder med samisk, kvensk og norsk bosetning.

Om prosjektet
Prosjektleder beskriver at hovedmålet er å finne betydningen av religiøs familiebakgrunn og egen religiøs identitet for livsstilssykdommer, selvmord og bruk av helsetjenestene blant voksenpopulasjonen i områder med samisk, kvensk og norsk bosetning.

Det skal utelukkende behandles allerede innsamlede data. Dette er registerdata som ble samlet inn i den delen av Saminor 2 som kalles NordTRO. Prosjektet er et samarbeid mellom SANKS og UIT, hvor UiT - Norges arktiske universitet oppgis som databehandlingsansvarlig.

Saminor har behandlet søknad om utlevering av data til prosjektet og funnet at disse kan utleveres. REK legger til grunn at det er inngått tilfredsstillende avtale mellom forskningsansvarlig Finnmarkshusehuset og databehandleransvarlig UIT.

Vurdering av om samtykket for Saminor er dekkende
I det avgitte samtykket fra Saminor har deltagerne samtykket til forsking på sammenhengen mellom helse, levekår og etnisitet. Spørsmål om psykisk og fysisk helse, samt rusmidler er besvart, man må dermed anta at deltagerne var klar over at det ville bli forsket på disse opplysningene.

Besøksadresse: MH-bygget UiT Norges arktiske universitet 9037 Tromsø

Telefon: 77646140
E-post: rek-nord@asp.uit.no
Web: http://helseforskning.etikkom.no/

All post og e-post som inngår i saksbehandlingen, bes adressert til REK nord og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK nord, not to individual staff

Vedtak
Med hjemmel i helseforskningsloven §§ 2 og 10 godkjennes prosjektet.

Sluttmelding og søknad om prosjektendring
Prosjektleder skal sende sluttmelding til REK nord på eget skjema senest 30.06.2020, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK nord dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK nord. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK nord, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Kopi til:mette.kjaer@finnmarkssykehuset.no