kritisk etnografi – Swedish Journal of Anthropology

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kritisk etnografi – Swedish Journal of Anthropology is owned and published by the Swedish Society for Anthropology and Geography (Svenska Sällskapet för Antropologi och Geografi). The journal is peer-reviewed, online, and publishes original research articles, as well as reports from Swedish anthropological community. kritisk etnografi aims to foster responsible scholarship with global scope, local relevance and public engagement.

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URN
urn:nbn:se:u:diva-432439

ISSN
2003-1173
Contents

Introductory Note by the Editors-in-Chief
Sten Hagberg and Jörgen Hellman ........................................................................................................7

Putting Swedish Anthropology to Work

Putting Swedish Anthropology to Work
Lisa Åkesson and Maris Boyd Gillette ................................................................................................11

Developing Gender and Culture Sensitive Conversations with Sexually Abused Men by Blending Ethnography and Psychotherapy
Charlotte C. Petersson .......................................................................................................................... 21

Beyond Colour-Blind Intercultural Education: Operationalising the Concept of Culture for Future Preschool Teachers
Åsa Wahlström Smith ......................................................................................................................... 37

Facing the Challenges of Cultural Competency in Swedish Mental Healthcare
Johan Wedel ........................................................................................................................................... 55

Rapid and Focused Ethnographies to Decrease Tensions in Guinea’s Ebola Crisis
Syna Ouattara ....................................................................................................................................... 69

Harnessing the Unruly: Anthropological Contributions in Applied Reuse Projects
Staffan Appelgren and Anna Bohlin .................................................................................................. 87

A Living Intervention – Anthropology and the Search for Person-centred Teamwork in a Hospital Ward in Sweden
Lisen Dellenborg ................................................................................................................................. 105

Bricolage

What Can Anthropologists Offer in Applied Settings?
Maria Padrón Hernández .................................................................................................................. 125
To the Memory of Heidi Moksnes
Introductory Note by the Editors-in-Chief

Sten Hagberg | Professor of Cultural Anthropology, Uppsala University
Jörgen Hellman | Professor of Social Anthropology, University of Gothenburg

This issue of *kritisk etnografi* – Swedish Journal of Anthropology addresses applied anthropology, or to be more precise the potentials and practices of ethnography in applied contexts. This is a theme at the heart of the journal with its motto “to foster responsible scholarship with global scope, local relevance and public engagement”. Guest editors coordinating this issue are Professor Maris Gillette and Professor Lisa Åkesson, both from the University of Gothenburg. Gillette and Åkesson have convened a collection of papers by scholars with experiences of working ethnographically in applied settings. The contributions illustrate a number of different cases and forms where anthropology has been part of quality improvement and problem solutions.

Viewed together, the papers reflect the different practices that are included in the broad umbrella of applied anthropology. However, one common theme that runs through all of them is that anthropologists do not bring the solutions. Instead, they always work in close cooperation with the people affected and it is through this interaction that ‘solutions’, or various ‘choices’ emerge and take shape. A specific example of this is in the Bricolage section where we have included a report from Dr. Maria Padron on how anthropology may be put to use in settings fraught with conflicts, repression, and resistance.

There is also a growing interest, even demand, among students to build skills and competences that strengthen anthropology’s relevance on labour markets. Two recently established bachelor programs in Sweden – in Lund and Gothenburg – deliver applied anthropology as their thematic focus. Hopefully this issue of *kritisk etnografi* will feed into these programmes. An important recruitment to the Swedish Anthropology scene in this respect was the appointment of Steffen Jöhncke as Lecturer at the University of Gothenburg. Jöhncke is part of the editorial team of *kritisk etnografi* and has worked for a long time with Anthroanalysis at Copenhagen University. This unit specialises in the development and use of anthropological perspectives in practice.

Since the journal was launched in August 2018 with the inaugural issue that dealt with “The Public Presence of Anthropology” (Vol 1, No 1, 2018) and developed around Didier Fassin’s Vega Symposium in 2016, we have worked hard to consolidate the journal’s publication and dissemination. The second issue, which was also a double issue, was themed “Comparative Municipal Ethnographies” (Vol 2, No 1-2, 2019) focused on the anthropology of local politics across the world. The first issue of 2020 inquired into “The Anthropology of Wellbeing in Troubled Times” (Vol 3, No 1, 2020), and was developed around Paul Stoller’s 2013 Vega Symposium. The current issue focuses on ethnographic practices in applied
contexts. Two issues will be published in 2021. The first one is a Varia issue that welcomes any research paper irrespective of theme and focus. The second will explore “Anthropology and Water” with Professor Karsten Pearregaard and Professor Paula Uimonen as guest editors.

As Editors-in-Chief of kritisk etnografi – Swedish Journal of Anthropology we would like to emphasise that we welcome suggestions and proposals, papers and shorter pieces from colleagues at Swedish universities and beyond.

Spread the word! Aux plumes! Fatta pennan!

* *

On 15 June 2020, anthropologist Heidi Moksnes passed away, much too early. She held a PhD in Social Anthropology from the University of Gothenburg from 2003 with a thesis entitled Mayan suffering, Mayan rights: Faith and citizenship among Catholic Tzotziles in Highland Chiapas, Mexico. She worked for long time at Uppsala University, and in 2014 she became Senior Lecturer in Social Anthropology at Stockholm University.

Heidi was a dear friend to many of us, and a deeply engaged anthropologist who spent her academic life working for justice for Chiapas in Mexico and for indigenous rights at large. She was principled, energetic, professional and dedicated. Her fervent respect for and love of life made her a role model.

This special issue is dedicated to the memory of Heidi Moksnes.
Putting Swedish Anthropology to Work
Putting Swedish Anthropology to Work

Lisa Åkesson | Professor of Social Anthropology, University of Gothenburg
Maris Boyd Gillette | Professor of Social Anthropology, University of Gothenburg

This special issue of *kritisk etnografi* conjoins trends at three scales. First and most importantly, in Sweden and elsewhere around the world we see a widespread and accelerating sense of public crisis. Reports and commentaries in traditional and social media, mass actions on the streets and online, volatile voting patterns and deepening threats to democratic rights and institutions all testify to collective alarm around a range of issues affecting how we live and what the future will bring. The corona pandemic, climate change, and divisive debates on migration and integration are the most obvious manifestations of this distress in Sweden and Europe, but many other subjects, including the withdrawal of the welfare state and growing economic disparities, are also significant loci of public anxiety.

Second, academic anthropologists have been troubled about the public contribution of anthropology as a distinct endeavour in relation to other social science fields. Over the past fifteen years, many have argued that anthropologists should “engage” and establish a more meaningful “public presence”; in some cases, such calls have been accompanied by efforts to identify and discuss existing anthropological “outreach” (e.g., Andersson 2018; Erikson 2006; Fassin 2018; Low and Merry 2010). Academic anthropologists have sharply criticised the discipline for not doing more to deliver anthropological knowledge and perspectives beyond the academic journals and publications that are the typical outlets for scholarly work (e.g., Burman 2018; Podjed et al. 2016; Sillitoe 2006). In Sweden, concerns that the discipline should become more “relevant” and useful to our interlocutors and the broader public have been driven in part by increasing expectations from funding agencies that anthropologists collaborate with actors outside the university (O’Dell 2018: 59-60, 65).

Third, anthropologists inside and outside the university are questioning whether the anthropology curriculum adequately serves our students (e.g., Copeland and Dengah 2017; Lassiter and Campbell 2010; Roberts 2006; Stefanelli 2017). Several anthropologists have pointed out that the undergraduate anthropology curriculum has not kept pace with the discipline’s evolution or the opportunities available to our students after they conclude their degrees (ibid.; see also Jöhncke Forthcoming; MacClancy 2017: 2). Indeed, some suggest that the anthropology curriculum may hamper our students’ ability to operationalise their education outside the academy (Graffman and Börjesson 2011; Jöhncke Forthcoming; Rylko-Bauer et al. 2006). Rather than encouraging our former students to hide their primary subject area (see Graffman 2013), academic anthropologists should be helping them put anthropology to work. Revising the anthropology curriculum deserves a more prominent place in our discussions about the discipline: how and what we teach affects our ability to address the widespread public sense of crisis, academic worries about anthropology’s relevance and contribution to the societies in which we live, and our students’ careers after university.
This set of case studies by Sweden-based anthropologists who are putting anthropology to work, plus a reflective essay from an anthropologist at work, is our response to these three trends. The contributors to this special issue apply ethnographic and anthropological perspectives, methods, and theory as they work together with (other) stakeholders on concrete projects to, as other anthropologists have put it, “make a better world to live in” (Pink and Fors 2018: 87). In the articles and essay that follow, they reflect on what they do and why and how they do it, with special attention to the role that their disciplinary background plays in these engagements. When Sweden-based anthropologists work in and with public organisations, national and international NGOs, museums, civil society groups and private firms to address issues of broad collective concern, Swedish anthropology not only offers a “public presence” but contributes to positive social change. When anthropologists write about these experiences, as the participating authors in this special issue do, they provide material that university anthropologists can use to revise and hone the anthropology curriculum.

‘Anthropology in Use’ or ‘Applied’ Anthropology

Putting anthropology to work, or as Willigen describes it, “anthropology in use” (1980), refers to processes and projects through which anthropologists, operating with other social actors, take part in concrete efforts to improve social situations and human lives beyond the university. At the heart of this work is collaboration, with the goals of “solving problems,” “getting answers” and improving the circumstances in which groups of people live (Pink 2006: 9; Pelto 2013: 42, 315; see also Willigen 1980: 3; cf. O’Dell 2018). Whereas academic anthropology can be primarily an intellectual endeavour, anthropology “in use” entails interventions and outputs that “have impact” beyond academia (see Pink and Fors 2018: 72).

Applied anthropology and its relation to academic anthropology has been discussed extensively (e.g., Pink 2006; Lysholm, Hansen and Jöhncke 2013; Rylko-Bauer et al. 2006; Singer 2008). Much of this literature has argued for the importance of applied anthropology. Frequently however, scholars draw boundaries and highlight differences between “anthropologists” – which means academic anthropologists – and “applied anthropologists” or “practitioners”. For example, Nolan (2017: 28) writes that anthropologists “are found in three distinct categories: academic, applied and practitioners”. The first produce “sound, well-grounded knowledge” and the second are “focused on the application of anthropological research” (ibid.), while the third “work on problems for which they are expected to deliver solutions and results” (ibid., 37). Surely Nolan does not intend us to think that “solid, well-grounded knowledge” and “the application of anthropological research” are not involved when anthropologists “deliver solutions and results”? Another classification scheme contrasts “anthropological research in service of broad disciplinary goals such as deepening human understanding” with “supplying data to policy- and law makers”, or “direct use of anthropology in the service of the Other, that may involve participating in direct action” (Rylko-Bauer et al. 2006: 184). Here too we wonder at the (probably unintended) implications of this apparent division of labour: can anthropology in use not also contribute to deepening human understanding, and might not anthropologists who collaborate with policy- and law makers seek to serve “the Other”? Our point is that these categories create differences rather than provoking recognition of what all anthropologists share. After all, producing knowledge is an intervention, even if less directly efficacious than collaborating with policy- and law makers or fighting for and with communities seeking reparations or
rights. Categorising anthropologists as A, B or C reinforces the notion that anthropologists, depending on where and how they work, and with what end goals intended, are different in ways that matter more than what unites them. Such claims about difference, as every anthropologist knows, can easily be deployed to support hierarchical claims about which anthropology is more “rigorous” or “important.”

In our view, classifying anthropologists in categories such as “academic”, “applied”, “action researchers” or “practitioners” points us in the wrong direction. We do not deny that one’s conditions of employment affect one’s work. An important reason why the vast majority of anthropology publications in scholarly journals and academic presses are written by academic anthropologists is because academic anthropologists are the ones whose jobs require and enable publishing in these venues. Nevertheless, we think it is more useful for Swedish anthropology (and for other national anthropologies, if possible) to focus on what anthropologists share, regardless of whether they are putting anthropology to work in practical settings or producing scholarship. The perspectives, methods, practices, and knowledges that characterise anthropology are recognisable and distinctive, in an academic publication, a museum exhibit, a report for a government agency, a workshop, or some other intervention. A more productive approach to the subject of “anthropology in use” focuses on our shared disciplinary skills, tools, and sensibilities, which we argue, can be found in a range of academic and non-academic efforts aimed at improving the world around us.

Swedish Anthropology at Work

Sweden developed a home-grown social and cultural anthropology several decades after the discipline was taught and practiced in other nations, most notably the US and UK (Hannerz 2018: 55-57). Sweden’s anthropology, at least in terms of formal labels, began in the 1970s and therefore was oriented toward the emergence and development of newly independent nations after colonialism’s end (ibid.: 57, 59). This had at least two practical consequences for Swedish anthropology at work. First, the soul-searching and rancour that characterised anthropologies in nations where anthropologists followed colonial regimes, and sometimes worked for them, was not a part of Sweden’s disciplinary development (for discussions of this issue in other national contexts, see Pink 2006: chapters 1 and 2; Rylko-Bauer et al. 2006; Sillitoe 2006). Second, the discipline developed as both academic and in use, especially with regard to development in what was then called “the Third World”. The Development Studies Unit at Stockholm University, which operated from the mid-1970s through to the late 1990s, is a key manifestation of this relationship. Anthropologists working through this organisation engaged on short and long term contracts as “experts” in development projects in Africa, Asia and Latin America (Sørensen and Gibbon 1999).

Though they began later, several other university-based institutions have also hosted anthropologists at work. Many of these organisations, such as the University of Gothenburg’s Center for Research on the Public Sector (CEFOS); the Stockholm Center for Organizational Organisational Research (SCORE), which is a collaboration between Stockholm University and the Stockholm School of Economics (Stockholms Handelshögskola); and Dalarna College’s Solar Energy Research Centre, focus or focused on the Swedish context. Anthropologists who worked at these sites have investigated risk in the transportation sector (Boholm et al. 2011); employment and learning in Swedish
workplaces (Garsten et al. 2006); and energy use and climate change mitigation (Henning 2005), as well as many other issues.

Since the 1990s, anthropologists with PhDs from Stockholm, Gothenburg, Lund, Uppsala, and Linköping have put anthropology to work in health and medical care, public sector institutions, business and the private sector, and organisations addressing environmental concerns and sustainability. Since their research is directed toward solving problems and developing interventions that promote positive change, rather than producing peer-reviewed articles or books, this work is harder to document than academic scholarship. Nevertheless, traces of this Swedish “anthropology in use” can be found in reports, opinion columns, conference papers, and research descriptions, as well as, at times, in academic publications. In the health and medical field, we see anthropologists at work on person-centred health care (Brink and Skott 2013; Dellenborg and Lepp 2018; Dellenborg et al. 2019), social and cultural factors that influence physiology and pathology (Johnsdotter and Eriksson 2013), and post-war trauma and therapy (Eastmond 2017). In the public sector, anthropologists have worked on Swedish schools’ and preschools’ management of students’ socioemotional problems (Hultin and Bartholdsson 2015), mother-tongue teaching and cultural identity for national minorities (Sjöström 2016), and the Swedish Tax Agency’s internal research processes (Björklund Larsen 2014). Youth consumer behaviour and sustainable business practices are among the topics that anthropologists have collaborated on related to business (Edmonson et al. 2020; Sveriges Radio 2019). Among the many projects and collaborations concerning the environment are work on climate change in Arctic regions (Ogilvie et al. 2016) and renewable energy in rural development (Henning et al. 2011).

The preceding sketch gives visibility to Swedish anthropology at work, but is far from complete. In Sweden, as elsewhere, anthropology need not be and often is not university-based. Many of those who put anthropology to work do not have PhDs. In recent years, several universities with degree programs in anthropology have posted profiles of alumni who discuss how they use anthropology in their careers. This kind of resource could profitably be used to enrich our understanding of Swedish anthropology in use.

Case Studies of Anthropologists at Work

Case studies of anthropology in use are commonly published by North American anthropologists and Europeans from settings outside of Sweden, with examples related to community activism, healthcare, climate change adaptation, consumer research, native rights, and other subjects (e.g., Caldwell 2016; Cremers et al. 2016; Furman et al. 2018; Gillette 2011; Hansen and Rosset 2017; Hara and Shade 2018; Krmpotich and Peers 2013; Roberts 2006 etc.). This kind of publication, in which anthropologists describe and reflect on projects conducted in conjunction with a range of stakeholders, is less frequent in Sweden, although significant contributions have been published concerning research in the health sector, development, and business (see, e.g., Graffman 2013; Graffman and Börjesson 2011; Hagberg and Widmark 2009; Scott et al. 2013). This special issue continues the important task of publishing case studies of anthropology at work by Sweden-based anthropologists, adding new examples related to healthcare, preschools, municipal offices, and museums, as well as the personal reflections of an anthropologist who works for an NGO. These texts illuminate the distinctive contributions that anthropologists make (grounded in our disciplinary perspectives, skills, and knowledge) to interventions intended
to produce positive social change, and show how anthropologists revise and even abandon the classic disciplinary research model, also known as “the lone ethnographer” (Galman 2007), by working collaboratively and applying methods other than long-term participant observation. Such case studies provide useful materials for efforts to revise and update the anthropology curriculum.

The Anthropology in Swedish Anthropology at Work

We are not the first to argue that anthropology at work is anthropology (e.g., Stull and Schensul 1987), but we believe that the message bears repeating. The articles in this special issue illustrate perspectives, strategies, and modes of thought that characterise anthropology in all its contexts, primarily intellectual or practical as they may be. We highlight here the following anthropological manoeuvres, seen in all of the contributions: 1) curious and/or critical questioning that challenges common sense or common knowledge; 2) persistent and insistent attention to social relations, context, and the workings of power; and 3) applying theory to analyse and/or reframe the object of study and intervention. All three of these moves are central to the discipline, and as the articles in this issue reveal, contribute powerfully to social interventions and change-making processes.

Curious and/or critical questioning is essential for all of the anthropologists in this special issue. Petersson, in her collaborative work to improve therapeutic outcomes for male victims of sexual violence, uses “curious questions” about patient experiences to help a client identify how gender expectations influenced his life and his embodied and psychic experience of sexual assault. Wahlström Smith, as she seeks to help future preschool teachers challenge the uses of “culture” in teachers’ interactions with children and parents, encourages them to ask who talks about culture, for what reasons, and in relation to whom. Wådel, who writes about an anthropologically-informed reformulation of the notion of cultural competence in mental health care, also stresses the importance of an inquisitive attitude and openness to learning. Ouattara, who presents his work during the World Health Organization’s intervention to manage the Ebola crisis in Guinea, provides several examples where he and his team began with curious questions, with members of Ebola virus response teams prior to going to “the field,” and with local residents of villages whom the WHO understood as targets of intervention. Appelgren and Bohlin detail how “simply asking a why-question, rather than starting from the notion that one knows what is going on” helped their collaborators concerned about reusing office furniture in municipal offices to develop new insights about their own decision-making practices. Dellenborg, helping to improve healthcare delivery on a hospital ward, outlines multiple examples of how she supported the medical workers “in problematising what they take for granted in their environment”, by “poking a finger” at things so ordinary that no one (on the inside) could see them. Finally, Padrón, who contributes a personal essay in which she discusses projects in Sweden and Western Sahara that she has undertaken as an anthropologist at work, identifies the discipline’s penchant for asking about everyday life and attending to apparently mundane knowledge as key to the practice of international solidarity work and transformative social change.

Drawing attention to the influence of social relations, context, and the workings of power is a second strategy visible in the contributions. Petersson describes how narrative therapy is a clinical practice informed by anthropological insights about the importance of sociocultural norms, practices, and relationships concerning gender in this case. In the case
study she describes, the patient was invited to tell Petersson and her therapist collaborator narratives about his life experiences and events that “were not a part of his problematic story line”; it is through contextualising and recontextualising his experiences and “problem” that the patient comes to a new understanding and mastery of his troubling symptoms. Wahlström Smith highlights the importance of social relationships and context in her study: first, as a way to see the workings of power, as for example when Swedish preschool culture is normalised as “good”; second, as a way that preschool teachers can move beyond essentialisms by building “trusting relationships that bridge difference” and recast what is understood as difference. Wedel and Ouattara, as well as Padron in her reflections on her work experiences, emphasise the radical anthropological notion that ordinary people are experts on their own lives, fully capable of pointing out the social, material, economic, and political structures that affect them. In these texts, rich understandings of local needs, experiences, and circumstances are the springboard for productive interventions. Dellenborg and Appelgren and Bohlin also stress that the anthropologist’s position and relationships in these contexts matter. As their articles demonstrate, strong, trusting relationships between anthropologist and collaborators are crucial to the anthropologist’s capacity to contribute meaningfully to change and improvement.

The third “classic” anthropological move that characterises our case studies is applying theory to analyse and/or reframe the object of study and intervention. Petersson employs anthropological models of gender and culture as constructed, dynamic, and malleable in her therapeutic collaborations. Wahlström Smith and Wedel both use the anthropological culture concept, which stresses culture’s processual, open-ended quality, as well as drawing on (albeit to different degrees) a larger body of theory that is often described under rubrics such as critical race theory or decolonisation theory. Dellenborg employs game theory, notably Ortner’s notion of serious games, as well as theoretical models of teamwork. For Appelgren and Bohlin, posthumanism offers key analytic insights that help them and their partners “change attitudes, policies and regulation”.

Revising the Classic Research Model: Collaboration and Methods

Anthropological research has often been described as a lone anthropologist’s total immersion in the life-ways and -worlds of a target group and/or field site that is sustained over a year or longer (e.g., Bundgaard and Rubow 2016; Jöhncke Forthcoming). This classic model is no longer dominant in the discipline. Within the academy, multiple terms used to describe field research, such as multi-sited field research, anthropology by appointment, polymorphous engagements, and so on, show that we work in a myriad of manners (see, e.g., Gusterson 1997; Hannerz 2018: 59-60; Roberts 2006 etc.). Similar expansion of research models and methods are found in anthropology at work, where collaboration is often central, and methods other than long-term participant observation useful.

Collaboration takes many forms, as the contributions to this special issue demonstrate. Dellenborg, for example, describes workshops for reflection and dialogue among the hospital staff that she and her research group developed, in which she occupied the dual roles of anthropologist and moderator, helping the medical workers become aware of the structural and cultural aspects that influenced their everyday work and understand how work looked from the other healthcare workers’ perspectives. Petersson also played a multifunctional role as an “outsider witness” and an anthropologist when she collaborated with a psychotherapist
learning to implement the anthropological modes of thinking that characterise narrative therapy. She supported the therapist through feedback and also played a role in the therapy process itself which was significant for patients. Wahlström Smith describes a shared journey with her students in a university preschool teacher education program, concluding her article by emphasising key perspectives that her students’ research suggests, which she argues can inform a truly anti-racist pedagogy and practice. Appelgren and Bohlin give examples of collective “speculative acts”, shared thought experiments with their non-academic partners that stimulated reflection and new insights. Working in teams and collaborating with a variety of stakeholders are also central to putting anthropology to work in the cases that Wedel and Ouattara discuss, as well as in Padron’s experiences.

A number of methods characterise the endeavours described in this special issue. Long-term participant observation most certainly has a place in anthropology at work, as the articles by Wedel and Dellenborg testify. Yet shorter, more intensive field techniques, supported by deep dives in the scholarly literature, are also productive, as Ouattara describes. Discourse analysis and critical attention to the realities performed by the words that we employ are methods that Appelgren and Bohlin and Wahlström Smith put to good use. Comparative ethnographic analyses led to instructive insights in the cases that Wedel and Dellenborg present. Speculation, role-playing, and defamiliarisation are methods discussed by Appelgren and Bohlin and Dellenborg. These are just a few of the many methods employed by anthropologists at work; others include digital mapping, photo-video- and object elicitation, co-creating archives, and many others.

The anthropologists in this special issue demonstrate that it is time (if not past time) to revise how we represent anthropological research not only to ourselves but to our students. We need to teach the Malinowskian model of long-term participant observation, but we cannot stop there if we hope to prepare our students for how they are likely to work in the future. Research practices that entail modes of collaboration and draw on other methodologies are equally important for the anthropology classroom (see Bundgaard and Rubow 2016; Lassiter and Campbell 2010; Pelto 2013). They deserve a stronger presence in the undergraduate anthropological curriculum.

Operationalising Anthropology

Many anthropologists have argued that anthropology is useful (e.g., Copeland and Dengah 2017; Stefanelli 2017). Unfortunately, academic anthropology has a tendency to deliver a message of potential contribution, rather than describing what anthropologists actually have contributed (see Roberts 2006: 72; Jöhncke Forthcoming). This is, in part, an artefact of the fact that academic anthropologists, often motivated by theoretical and intellectual concerns, tend to represent the discipline (at least to itself, at for example annual anthropology conferences or in anthropology publications), rather than anthropologists who are employed in other settings. Few anthropologists working outside the academy spend time writing about why anthropology matters or what anthropology can contribute. They are instead at work demonstrating that anthropology matters, addressing public concerns and contributing to social betterment.

This special issue of kritisk etnografi, which brings together accounts from Sweden and other places, demonstrates that anthropology’s contributions have not been deferred. Anthropologists are lending their tools, experience, and perspectives to practical initiatives
that address problems, reduce suffering, and improve the quality of human life for people in a wide range of settings. They are operationalising their knowledge, sensibilities, and methodologies in service of concrete, tangible goals outside the academy. By shifting focus to these examples, we show how the discipline is realising its promise, by engaging, intervening, and making a difference. This special issue also contributes to the project of revising the anthropology curriculum by providing case studies that communicate, in practical terms, how anthropology is useful. We hope it is an effort upon which many more of Sweden’s anthropologists will build.

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Developing Gender and Culture Sensitive Conversations with Sexually Abused Men by Blending Ethnography and Psychotherapy

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ABSTRACT

Child sexual abuse can have long-term impact on the survivors’ emotional, physical, and psychological wellbeing. Male survivors of sexual abuse are less likely to disclose and report their experience compared to females because of aspects related to male gender socialisation. Feelings of shame, guilt or confusion about sexual or masculine identity silence sexually abused men. They report difficulties in both seeking and receiving formal support services tailored to their specific needs. This article presents collaborative work performed by an anthropologist and a psychotherapist during therapy of adult men with a history of sexual abuse. By using certain tools of ethnography in narrative therapy, we developed culture- and gender-sensitive conversations with sexually abused male clients from diverse backgrounds. A case study is provided to demonstrate how we worked with the various stages and practices of ethnography and narrative therapy, focusing on how sexually abused men were invited to unpack the discourses of masculinity that influenced their ways of understanding themselves and their traumatic past. The article offers an example of how anthropological knowledge and methods can be applied in contexts of clinical social work and demonstrates the way that postmodernist and constructive therapies combined with the tools of ethnography can generate constructive conversations about gender for sexually abused men.

Key words: child sexual abuse, masculinities, psychotherapy, narrative therapy, ethnography, applied anthropology

Introduction

Anthropology and psychotherapy have a long historical and, sometimes, controversial relationship. Readers may be familiar with Malinowski’s (1927) examination of the psychoanalytical model based on data from the Trobriand Islands, which caused him to argue that the Oedipal complex was not universal. The critical stance of anthropology is still challenging to the field of psychotherapy, which adheres to medical science. Anthropologists have critiqued psychotherapy’s exclusive focus on the inner world of bounded individuals because it excludes social and cultural aspects of illness (Kleinman 1988; Martin 2019).

When reviewing the clinical and research literature on the psychological consequences of sexual assault, we can see how the body is depicted as a biological fact, reacting to a certain stimulus in the environment. In general, therapy with individuals who have experienced physical or sexual violence focuses on identifying and treating the effects of such experiences rather than addressing how individuals respond to violence (Wade 1997). Cultural constructions of gender affect the way men understand, process, articulate and
Anthropologists have stressed the importance of crossing disciplinary boundaries in order to carry out applied anthropology and expand the field and its knowledge base (Hastrup 2017; Podjed et al. 2016). As an anthropologist, I have spent the last 15 years of my professional life working with sexual health and violence by combining the fields of medical anthropology and social work. I have moved between conducting anthropological research within academia and realising social work in the community by supporting abused women, children and men in shelters and consulting rooms. However, it was not until 2019 that my knowledge and skills as an anthropologist were purposefully applied in a clinical setting when I had the opportunity to conduct collaborative work with a group of psychotherapists. I first met the psychotherapists at a conference where I presented the findings of my research concerning sexual violence against males (Petersson and Plantin 2019). My presentation outlined how notions of masculinity may facilitate or impede the process of recovery for male survivors of sexual abuse and invited psychotherapists to discuss the ways in which they can address masculinity as part of their services to help boys and men recognise that such ideas can interface with their experience of sexual abuse. Narrative therapy (White and Epston 1990), which critically examines wider social discourses and encourages clients to reauthor their life stories, was mentioned at the conference as an alternative therapeutic approach for male survivors of sexual abuse (O’Leary 1998). The psychotherapists contacted me a few months after the conference and asked if I could provide them with consultative support in their process of developing gender and culture sensitive practices in their work with sexually abused boys and men from diverse backgrounds.

This article draws on my experience as an anthropologist and the collaborative work I performed with a psychotherapist during therapy of adult men with a history of sexual abuse in childhood or adolescence. The purpose of our collaboration was to cultivate practices that support sexually abused men in reframing their life stories by embracing and reinforcing the use of certain aspects of ethnography within narrative therapy. The article provides a window on the process by which the two disciplines join, blending the methodological tools of ethnography and psychotherapy in order to develop a more culture- and gender-sensitive therapeutic approach to sexually abused males. It offers an example of how anthropological knowledge, perspectives and methods can be applied in contexts of clinical social work.

Male Child Sexual Abuse and Masculinity

Research on child sexual abuse (CSA) has grown significantly during the last decades, including in particular the victimisation of females. Male CSA has received less attention and is less common, but awareness is growing. CSA is known to have adverse, long-lasting health outcomes for both genders (Cutajar et al. 2010; Easton et al. 2011). Research that
studies the long-term impact of CSA on males shows increased risk for adverse mental health outcomes, including anxiety, depression, post-traumatic stress disorder (PTSD), hostility, loneliness, isolation, and alcohol and substance abuse (Alaggia and Millington 2008; Boroughs et al. 2015; Easton and Kong 2017). Sexually abused males also report struggling with sexual dysfunction, sexual risk behaviours (Mattera et al. 2018) and troubled thoughts about fatherhood (Price-Robertson 2012). In Sweden, studies seeking to establish prevalence rates and health outcomes show that male CSA is widespread and significantly affects the men’s wellbeing (NCK 2014; Swahnberg et al. 2012).

Much research on male CSA has emphasised the impact of dominant masculine constructions (e.g., Alaggia and Millington 2008; Easton and Kong 2017; O’Leary 1998). Male sexual abuse stands in contrast to conventional masculine attributes such as being dominant, physically strong, able to defend oneself, emotionally in control, sexually assertive and heterosexual. Such norms can make sexually abused boys/men feel that they did something to trigger the assault or did not do enough to ward it off. They often report confusion regarding their sexual identity and worry about being labelled as homosexual (if the perpetrator was a man) or weak (if the perpetrator was a woman) (Corbett 2016). In some cases, the experience of CSA undermines the men’s own sense of power and control, which may result in accentuated masculine attributions, including the display of aggression, violence, hyperactivity, hypersexuality and overcontrolling behaviour (Lisak 1994). Strong feelings of shame and self-blame hinder men from disclosing their history of CSA. Males are much less likely to report their experience of sexual abuse and seek psychotherapeutic help than female victims (O’Leary and Barber 2008). Those men who turn to professional support services face a number of obstacles. Many rape crisis centres refuse services to sexually abused men and some offer counselling that is insensitive to the assaulted men’s specific needs (Corbett 2016).

Masculinities are not fixed but involve practices that can be remade (Connell 1995). In Sweden, a context that has been strongly anchored in unique gender equality policies aimed at producing equal conditions for men and women both at work and in family life, men relate to transforming masculinities (Plantin 2015). The term “emergent masculinities” has been applied within the field of medical anthropology to capture new forms of embodied masculinities that emerge in relation to processes of social change (Inhorn and Wentzell 2011: 802). Men act out masculinities differently and respond differently to major events in their personal lives, including bodily changes such as aging, illness, traumatic experiences and medical treatment. Research shows how men with experience of CSA can move away from an identity formed by the trauma (Andersen 2008; O’Leary 1998). To understand, accept and recover from the abuse, men may renegotiate their masculine identity by adopting multiple and alternative forms of masculinities (Kia-Keating et al. 2005; Petersson and Plantin 2019). Research suggests that this group of men can be supported by therapy that helps them to deconstruct the gender system that affects their ways of understanding sexual abuse. In fact, research on the overrepresentation of male survivors of CSA in mental health populations found that those men who were able to reinterpret and reframe their experience of abuse were also associated with more positive health outcomes (O’Leary and Gould 2010).
Integrating Gender and Culture in Psychotherapy

As noted in the introduction, anthropologists have a long interest in the intersection of culture and psychology. Well-known anthropological literature draws on a combination of ethnography and psychotherapy (Crapanzano 1980) and psychoanalytical perspectives have been applied to analyse ethnographic data (Schwartz et al. 1992). Psychotherapists have in general been more reserved when it comes to adopting anthropological knowledge. Notions of power, gender and cultural difference did not enter psychotherapy until the end of the 1980s. At that time, anthropologists like Kleinman (1988: 131) argued that a therapeutic explanatory system must provide a “symbolic bridge” between people’s experiences and the socio-cultural context. Since then, mental distress has gradually been associated with gender and cultural expectations, including the social position and power of the individual. Feminist therapy has critiqued stereotypical gender ideas and sexist assumptions within traditional forms of therapy and demonstrated how gender biases are reproduced in therapeutic relationships (Seem and Clark 2006). To engage men more effectively in psychological treatment, addressing their experiences of masculinity and how this may be related to their presented problems has become increasingly important within psychotherapy (Addis and Mahalik 2003; Berger et al. 2013). Nowadays, cultural competency, which includes masculinity, is an important skill in psychotherapy and clinical competencies have been developed for psychotherapists working with men (Liu 2005). The American Psychological Association (APA) established practice guidelines to enhance gender- and culture-sensitive psychological practice with boys and men from diverse backgrounds (APA 2018). According to the guidelines, these practices are applicable to any psychotherapeutic approach across various professions, such as nursing, social work, counselling, school counselling and psychiatry.

Within medical anthropology, the cultural competency model has been questioned because it assumes that culture resides inside of practitioners and clients (Kleinman and Benson 2006). Culture, in the mind of psychotherapists, refers to the identity of individuals or to a certain ethnicity (Martin 2019). Thus, culture and gender may easily be represented in stereotypic terms and clients are assumed to have culturally-rooted responses and reactions that may clash with those of others. Often psychotherapy frames cultural competency as the counsellors’ capacity to negotiate the cultural differences that exist between counsellor and client (Martin 2019). Models that place emphasis on concepts such as “structural vulnerability” (Quesada et al. 2011) and “structural competency” (Hansen et al. 2018) have been employed in clinical settings to overcome problems of the cultural approach, reduce inequalities and enhance health outcomes. Kleinman and Benson (2006), however, suggest that clinicians should be trained in ethnography rather than cultural competency. Ethnography is useful for investigating the relationship between individuals and sociocultural contexts because it places emphasis on what people do, their engagement with others and their lived experience of illness. From an ethnographic perspective, culture is a process that cannot be separated from political, economic, religious, psychological and physiological circumstances. Cultural processes may differ not only between members of different social groups but also between individuals within the same social group. Variables such as age, gender, class, ethnicity, religion, disability and sexuality affect experience. Ethnographic techniques can help psychotherapists to understand illness and distress the way that their clients understand, feel and respond to it (Kleinman and Benson 2006).
Ethnography and Narrative Therapy

While the work of an ethnographer and a psychotherapist are different in many aspects, certain similarities exist. Anthropology and psychotherapy (in particular psychoanalysis) are both involved in studying lives over time while trying to remain as close as possible to people’s experiences. By relying on participant observation, listening and interpretation, both try to understand the significance of meaning. The similarities between ethnography and psychotherapy open opportunities for anthropologists and psychotherapists to learn from each other. In the collaborative work upon which this article is based, I supported the psychotherapists in adopting certain ethnographic techniques that narrative therapy draws upon. Before identifying these techniques, a brief summary of narrative therapy is needed.

Narrative therapy, with its origin in family therapy, was developed by social workers Michael White and David Epston (White and Epston 1990). This approach is influenced by anthropologists like Bateson (1972), Geertz (1973), Turner (1969), Bruner (1986) and Myerhoff (1986). Rooted in postmodern philosophy and social constructionism, narrative therapy takes specifically into account Foucault’s (1973) ideas concerning discourse and power and is based on the idea that dominant discourses in a given context shape individual constructions of identity and truth claims. Traditional therapies, situated within positivism or liberal humanism, depict problems such as depression, anxiety or abuse, as individual pathologies associated with specific biological or characterological circumstances. In contrast, White and Epson (1990) argue that people live storied lives and that stories constitute us. The counsellor should therefore pay attention to the stories that people create to make sense of their world (White 2007). Narratives both describe and shape people’s lives and reflect the meanings that they make of their lived experience. The way that clients tell their narratives is connected to their identity. Narrative therapists are particularly interested in the way that discourses surrounding gender, culture, ethnicity, class and sexuality shape and influence people’s understanding of themselves and their lives. When a dominant narrative does not sufficiently represent lived experience, the individual may suffer from problematic behaviour or distress (Brown and Augusta-Scott 2007; White 2007). Narrative therapists consider problems as separate from the individual, and the role of the therapist is to assess the problem rather than the person’s biology or disorder—a process that is called externalisation. The therapist must distinguish between the effects of what the clients find to be problematic and their preferred ways of being and acting in their world (White and Epston 1990).

To develop gender- and culture-sensitive conversations with sexually abused men in our collaboration, we focused on three aspects of ethnography. The first concerns ethnographic enquiry. The way that narrative therapists ask questions of their clients is similar to ethnography. White and Epston (1990) were influenced by Geertz, who emphasised the importance of approaching culture from the native’s point of view. Like ethnographers, narrative therapists take the stance of a curious interviewer. We adopted person-centered interviews, which combine both informant and respondent techniques of interviewing (Levy and Hollan 2000). By moving back and forth between questions that focus on the client’s understanding of the external context, and questions that require intimate and personal responses, the interactions, conflicts, coherence and transformations between the private and the sociocultural context can be unpacked. In narrative therapy, a sexually abused male client may present internalised descriptions of himself as personal problems, but in therapeutic conversations these personal problems can be related to dominant constructions...
of masculinity (O’Leary 1998). Meanings that are made of male sexual abuse are influenced by cultural understandings of gender and power. By externalising hegemonic discourses on masculinity and discussing the way they may shape, influence, constrain and disempower men’s lives, the client reaches an understanding of how these discourses work and becomes able to question them.

The job of a narrative therapist is to help the client reach new and more useful understandings of his place in social contexts and relationships. This leads us to the second area of emphasis that our collaborative work developed upon, namely the role of collectives for social change or change in relationships. According to narrative therapy, identities are formed in relationships with others. Such relationship thinking is well established in anthropology and Bateson’s work on cybernetics is developed from this tradition. During narrative therapy, the client is invited to reflect on or step into alternative ways of thinking or being and develop preferred stories of the self (White 2007). An outsider witness may be invited to the therapy sessions, whose participation, feedback and personal responses to the conversations in the therapy room will expand and enrich the client’s story by giving it multiple meanings (White 2007). This outsider witness can be another therapist or professional, people with inside knowledge, family members or friends of the client. This technique is inspired by the work of Myerhoff (1986), who saw similar ceremonies arranged in an isolated Jewish community in Venice, California, in order to deal with experiences of invisibility and marginality. In narrative therapy, this technique helps clients to present themselves in preferred ways and to regain strength, agency, power and voice.

The third aspect of ethnography in our collaborative work concerned positionality in the therapeutic alliance. In traditional models of psychotherapy, such as psychoanalysis, the therapist tends to take the role of an expert. Psychoanalytical tools involve close observation of the relationship that develops between the psychoanalyst and the client, resulting in a power imbalance between them. In classical ethnography, little attention was paid to the researcher’s position vis-à-vis the people s/he studied, but in the 1990s the field of autoethnography began to develop (Reed-Danahay 1997; Tedlock 1991). Autoethnography problematises ethnographic knowledge by discussing dichotomies such as insider/outsider, familiar/unfamiliar and objective observer/subjective participant; it represents a reflexive and collaborative approach in which both ethnographer and interlocutor are seen as embodied subjects whose relationship needs to be explored.

Our collaborative work was informed by these insights. Whereas some therapists have tried to resolve issues of power imbalance by adopting a neutral and not-knowing position and letting the client be the expert in the therapeutic encounter (see Brown and Augusta-Scott 2007), adopting a neutral stance with clients who are dealing with experiences of sexual abuse may have serious consequences. We chose instead to acknowledge and be clear about our position and work from the premise that therapist and client are both embodied subjects with knowledge, agency, and power (ibid.). The clients were aware of the expertise of both the therapist and the anthropologist regarding sexual abuse. As professionals, we were going to help clients to deconstruct and re-author oppressive stories, including the relations of power that constitute them (White and Epston 1990).

In Sweden, the adoption of narrative therapy in practice is limited and mainly situated with family therapy. Yet extensive research supports the use of narrative therapy, which has been employed with good results on clients who suffer from depression (Vromans
and Schweitzer 2011), eating disorders (Weber et al. 2006), schizophrenia (White 1987) and who have experienced physical or sexual violence (Brown and Augusta-Scott 2007; Lee 2017; O’Leary 1998). A growing interest in narrative therapy is found among psychotherapists who work in marginalised and indigenous communities where people have been traumatised by war, genocide and violence (e.g., Denborough et al. 2008; Kangaslampi et al. 2015; Mitchell 2006). However, using the narrative approach in acute situations and when the client’s safety is threatened has been questioned. According to Miller (2012), the narrative approach to therapy should be introduced first when the immediate crisis has passed. White and Epston (1990) argue that experiences such as violence and abuse should never be externalised in narrative therapy. It is the attitudes and beliefs that underpin the violence that should be externalised, including the strategies that maintain the abuse, such as the secrecy and isolation.

The Anthropological Assignment and Clinical Setting

The collaborative work presented here occurred during four months of clinical participation in 2019. The professionals at the clinic were all female psychologists or social workers with additional training in cognitive, psychodynamic and family therapies. The clinic, which is a small private psychotherapy practice, specialises in treating emotional and psychological trauma, including experiences of violence and sexual assault. It provides individual, couples and group therapy and arranges self-help recovery groups. The clients are of different ages and have various social and cultural backgrounds. Sexually abused male clients typically arrive for treatment of difficulties such as anxiety, hyperactivity, hypersexuality, hostility, identity crisis, sexual dysfunctions, PTSD and self-harming behaviour. The male clients’ first visit to the clinic generally takes place several years after the sexual abuse was experienced. The majority of male clients are of Swedish origin, but clients with culturally diverse backgrounds have increased slightly over the years, which was one reason why the clinicians sought an anthropologist to support them.

By cultivating narrative practices and placing emphasis on ethnography, the psychotherapists at the clinic wanted to develop a gender- and culture-sensitive approach to counselling. Inspired by family therapy training techniques, which include working in a team that observes the therapy sessions by being present in the therapy room or via a telephone or video link, my role was to assist, observe and supervise the psychotherapist during our work. By discussing with me each counselling session after it had finished, the psychotherapist would receive methodological support and feedback. Because of the traumatic and sensitive character of the clients’ experiences, we decided that I should be present in the therapy room rather than via a screen. The psychotherapist had the main responsibility for the conversations held during therapy. I was expected to assist the therapist in ethnographic enquiry, clients’ engagement with others, and shared reflections on positionality. In fact, developing self-awareness of the knowledge, biases, norms and values that we would bring with us into the therapy room as two female middle-aged professionals started before the therapy sessions. We shared the stance that adverse mental health outcomes of sexually abused men may be linked to specific masculine perceptions and attitudes. Further, we did not prescribe a specific male role for the clients to adopt. Men “do gender” by combining various forms of masculinity, both conventional norms and new cultural influences that, for example, place emphasis on emotional expressiveness, caring, love, reciprocity and gender equality.
The psychotherapist identified clients for whom the adoption of a narrative approach would be suitable. The clients were informed about the purpose of our collaborative work and then asked if they wanted to participate. Client anonymity and confidentiality were promised. The clients who approved were asked how they felt about sharing their sensitive and painful experiences with two female professionals. All stated that they preferred working with female therapists as they felt more comfortable in talking about issues of sexual abuse with women.

In the following pages, I present a case study to demonstrate how we worked with the various stages and practices of narrative therapy and ethnography, focusing on how the psychotherapist and I invited sexually abused men to unpack the discourses of masculinity that influenced their ways of understanding themselves and their traumatic past. The case illustrates our work with a specific client, who is called Omed here. Omed is an 18-year-old man from Afghanistan, who migrated to Sweden in 2014 as an undocumented and unaccompanied minor. As an orphan, Omed had spent many years of his childhood at a military base in Afghanistan where he had been exposed to significant forms of trauma, including both physical and sexual violence. Omed had attended therapy previously at other clinics. Language barriers made therapy difficult initially but Omed's wellbeing had improved during his first years in Sweden. When Omed started high school, he began to experience increasing difficulties with social anxiety, isolation and substance abuse. At the time of the narrative therapy, Omed, fluent in Swedish, explained that he was looking for an alternative therapeutic approach. He attended seven narrative therapy sessions, which varied in length between 60-75 minutes.

The following description highlights some of the events of Omed's life while others have been removed or changed to preserve his anonymity. As a result, some material is lost. Details about Omed's experience of sexual violence have been excluded as the publication of intimate and sensitive information may have consequences that are difficult to foresee. Omed read the case illustration before publication to ensure that he could not be identified and gave permission to publish the case study.

Case Study
During the first session, the therapist and I encouraged Omed to tell us about his cultural background and life circumstances. Omed disclosed that he had been kidnapped as a young boy and was raped and sold to a warlord. For several years he had to dress up in women's clothing and dance in front of groups of men who abused him sexually afterwards, a phenomenon that is called *bacha bazi* in Afghanistan. After being hospitalised for severe physical injuries, he managed to flee from Afghanistan in 2013. Together with a few other boys, he made his way to Sweden by selling sex. In Sweden, he suffered from PTSD, insomnia, anxiety and had difficulties with establishing bonds of trust and close attachments. Despite this, he was doing well in school and had made new friends, mainly other Afghan boys. Omed revealed that he had not disclosed his experience of CSA to any of his friends because of feelings of shame. He told us that he was extremely worried that his close friends or people at school would find out about his history of CSA and prostitution, and label him as gay. Omed explained that it was important for him to have Afghan friends in Sweden, mentioning aspects such as language, food, traditions and a sense of belonging to a community. Despite this, Omed recounted that he could not be himself among his Afghan
friends in a cultural sense. He described that he found most of them to be tough, insensitive, sexist and shallow – attributes that he felt that he had to adopt in order to gain respect. By contrast, Omed described himself as a highly sensitive and emotional person.

The psychotherapist started Omed’s second session by asking him what he regarded to be the core of his problem today and how he would define or label that problem. Omed said that “weakness” was his problem. He explained that if he could be tougher and not so emotional and sensitive, he would have less problems. Using an externalising conversation, the therapist asked Omed how this notion of being weak was influencing his everyday life. Omed disclosed that he was always feeling weak, anxious, fearful and unmanly. Omed was concerned that perhaps the experience of CSA had made him gay because he had continued having sex with men even after he had managed to flee from the military base. I asked Omed about how notions of being weak affected his relationship with family and friends in Sweden. Omed revealed that he had tried to be tougher, extroverted and more powerful and charismatic, like his friends, but this felt wrong. While being tough and strong made him behave in a socially approved manner, he found it difficult to identify with such attributes. Instead, his problems with anxiety increased and he began to avoid social interaction. This deprived him of interpersonal attachments and disconnected him from his cultural background. Even if he had many friends, he explained that he felt lonely, isolated and unwell.

During the following therapy session, we started to link Omed’s ideas of being weak to past contexts. I asked curious and person-centred questions, such as how it could be that Omed viewed himself as weak and from where he thought that such notions came. Omed disclosed how he, in the absence of women in Afghan war camps, had been forced to do female duties, both domestic chores and sexual activities. Our curious questions made it easy for him to explain gender roles in Afghanistan from his point of view. He said that being a young boy meant that gender roles, sometimes and by certain men, could be stretched. As a child without the protection of parents or other relatives, he was transformed into a woman. Omed said he lived in constant fear in Afghanistan. Like other boys in the same situation, he used drugs to cope with the abuse and the fear. Omed told us that his feelings of being weak had actually increased in Sweden. He explained that while male aggression and violence were normalised in Afghanistan, professionals at the migration agency, health units and social services in Sweden were shocked by his life story and tended to pity him. Professionals treated him like a damaged and fragile person. Omed said, “It makes me feel small, like a child, as if I never grew up”. Omed told us that he would like to be a father someday and have a family of his own. At the same time, he worried about being too weak and sensitive. Perhaps he would not be able to protect and support his children in a good way.

I asked Omed if he could think of any situation where he had not felt weak in Sweden. Omed mentioned his recent work as an intern at a school. With pride, he explained how he had prevented fights from breaking out when groups of boys had ended up in disputes with one another. The children respected him for his calm and diplomatic skills. Perhaps he would be a good teacher someday. As Omed continued telling us narratives about situations where he did not feel weak, hidden accounts of courage and resistance came to surface. He realised that his feelings of weakness were not a consequence of deficiency within himself. He began to separate himself from what he found to be problematic. This allowed him to take a position against the effects of CSA.
During our fourth and fifth sessions, the conversations thickened, and we began to unmask the many expectations that men are up against in various contexts. Omed revealed that he, in Sweden, often felt pressured to have updated knowledge about technology, cars, sex and sports, which were topics that he did not have any real interests in. In fact, Omed felt sickened by what he described as an exaggerated interest in sex among his friends. He said that such conversations made him feel disconnected from what he believes in and finds important, such as respect, security, interdependence and empathy. The psychotherapist and I introduced discussions on different forms of manhood and the idea that masculinities are socially and historically constructed. I gave several examples of this, including how notions of fatherhood have changed in Sweden over time. Omed could easily relate to the cultural differences of fatherhood in Sweden and Afghanistan and told us his perspectives on differences and similarities. He could reflect that he had certain ideas of gender based on experience from past contexts and that he had encountered a different gender order and gender practices in Sweden. Omed gradually realised that he had practiced certain forms of masculinity and that these norms and practices were incongruent with his lived experience of sexual abuse. Male sexual abuse contradicts many of the expectations about men's ways of being and acting. Victimisation resulted in feelings such as shame, self-blame, powerlessness and weakness. Omed understood that he had experienced extremely insecure conditions during his childhood in Afghanistan with serious threats and challenges to his life. His lived experience made him develop a certain sensitivity and empathy.

In light of these new realisations, Omed began to reinterpret the idea of himself as a weak person. He understood that he could take up other practices than those of his friends and still be a man. During our last two sessions, he started to redefine his notion of being weak as a strength. Our discussions made him realise that there were other ways of living life, and that male gender could include new cultural influences that, for example, placed emphasis on emotional expressiveness, caring, love and reciprocity. In this way, Omed was able to start reauthoring the dominant story of weakness. Together we identified individuals who supported his preferred ways of being, and social situations where he did not feel that he had to pretend to be someone else. Outsider witnesses enabled Omed to receive social recognition, which made him gain confidence and agency. He could renegotiate his masculine identity.

The Contribution of Ethnography

The experience of CSA leaves survivors forever changed, and the journey from such trauma to rebuilding one's life is complex. The case study shows how Omed's internalised and problematic stories were deconstructed and reconstructed in the process of narrative therapy. I now scrutinise more closely the role that ethnography played in this process, and reflect on how ethnography can contribute to the development of a therapeutic approach that is sensitive to gender and culture in conversations with sexually abused males.

Initially, the collaborative work was challenged by the medical gaze (Foucault 1973) of the psychotherapist, who was focused on providing the clients with a diagnosis and the correct treatment. When people's identities are labelled by diagnoses or when they are described as victims associated with certain attributes such as being weak, powerless, helpless and vulnerable, they may experience marginalisation. Omed’s previous encounters with professionals in Sweden had resulted in increased feelings of being weak and damaged. More generally, I noticed that the clients told the therapist a few fairly “thin” or undetailed stories
about their life experiences. The meanings that people create from such thin narratives are often incomplete and do not include reflections on how they would like to live their life (Combs and Freedman 2012). The contribution of ethnography in the narrative therapy process was, then, to elicit thick descriptions (Geertz 1973) from the clients, i.e., detailed, rich and meaningful life stories. We invited Omed to tell us narratives that were not only a part of his problematic story line but included other life events as well and their significance. These thicker life stories offered different meanings and possibilities than the story of being weak and abused. Omed told us about situations where he did not feel weak and revealed stories of courage and resistance. Simply engaging clients in rich storytelling does not solve what they find to be problematic, but encouraging the development of alternative stories may help clients find other perspectives and ways of responding to what they find problematic (Combs and Freedman 2012). During our conversations with Omed, he embraced life stories that were of importance to him and that could not be associated with what he found to be the problem. He told us about his work with children at the school where he was a trainee, resulting in reflections about perhaps becoming a teacher someday. Inspired by the work of Bateson (1979), White (2007) argued that the meaning we attach to an experience is often made with reference to other experiences. It is in the light of contrasting experiences that meaning is created. Thus, a story about a problem is often told in contrast to something that is preferred or desired, like Omed’s ambivalent feelings about fatherhood.

The psychotherapist found it difficult to contextualise the problems that the clients expressed and include the social, cultural and political aspects of illness. She admitted that the cultural competency model made her think that clients with a certain ethnic background need to be approached and treated accordingly. By using an ethnographic approach and considering culture from the client’s point of view, Omed became the one who told us about how he experienced gender, culture and ethnicity in various settings. We used curious and person-centred interview questions that focused on a combination of the client’s understanding of the external context and his own experiences or responses (Levy and Hollan 2000). By this, we were able to expose various gender discourses and power differentials that supported the problem addressed by Omed. The process of externalising problems, such as anger, hopelessness or weakness, separated the person from the problem. Helping clients to locate such problems in discourses reduces their self-blaming attitudes and makes it easier for them to make changes in their lives. It is easier for clients to respond to a problem that is located outside of him/herself rather than changing their biology/disorder and/or adjusting to a life with mental health difficulties. During our conversations in the therapy room, Omed was able to locate the responsibility for the abuse, including the consequences or effects he was suffering from, with the abusers in Afghanistan. Omed understood that CSA does not happen because the child is weak. It is a crime committed by adults whose actions take place within a context of children’s powerlessness and vulnerability. Omed realised that his understanding of CSA and his ways of responding to those experiences could be located in contexts of shifting masculine constructions.

The ethnographic shift in the therapy room generated the development of local, personal and contextualised knowledge. We worked from the stance that all the members of the therapeutic encounter were embodied and positioned subjects who actively engaged in deconstructing and co-authoring the clients’ stories and identities. As two female professionals who supported sexually abused male clients to deconstruct and re-author oppressive stories, we could not adopt a neutral or passive stance. Inspired by the autoethnographic approach,
we used personal reflections as a strategy to understand and analyse our positionality in the therapy room. By focusing on the clients’ engagement with others, including the processes and patterns that constitute social contexts, we could, as embodied subjects, help the clients to see that their stories contained both knowledge and power. The stories were both socially constraining and involved social agency (Brown and Agusta-Scott 2007). As outsider witnesses who listened, retold and acknowledged the preferred stories and identities of the clients, we helped to give the stories multiple meanings and new perspectives. The psychotherapist and I noted a significant shift in the power dynamics that took place both in and outside of the therapy room, as a result of which our clients gradually improved their position during therapy. They were able to make choices in their life to overcome feelings of marginalisation and isolation. In this sense, narrative therapy fosters agency and makes it possible for the clients to oppose patterns of marginality and injustice (Combs and Freedman 2012). In a conversation with Omed more than six months after the narrative therapy had finished, he told me that our curious questions and our openness and interest in his past experiences made him look at himself and his life in a different light. He felt that he was not approached as a patient with severe mental health issues. He said that he felt that he could express himself freely without experiencing discrimination or shame, which basically had been the core of his problems.

Conclusion

Research has shown that men who have experienced CSA are less likely to be well-served in therapeutic and clinical encounters. Yet professional responses can be of crucial importance for those who need to renegotiate and reformulate their identities, including male sufferers from CSA. The focus of this article has been to reflect on how ethnography can facilitate to the adoption and practice of narrative therapy. My intention is not to suggest that narrative therapy is the only suitable and effective therapeutic approach for sexually abused males. Men with a history of CSA have unique needs. Clinical practitioners must take into account the limitations of this approach, including its shortcomings as a treatment for acute and complex symptoms and PTSD.

By describing how aspects of ethnography contributed to a specific therapeutic collaboration, I hope to generate insights that others might find useful for further elaboration. Recognising gender and culture as central principles in organising individuals’ social lives, and situating individual experience of illness and distress in the larger socio-political-cultural context in which it takes place, was an approach that psychotherapists, their clients, and I found productive. Postmodernist and constructive therapies combined with the tools of ethnography can generate good conversations about gender for men who have experienced isolation and marginalisation and want to overcome feelings such as shame, guilt and self-hate.

References


Beyond Colour-Blind Intercultural Education: Operationalising the Concept of Culture for Future Preschool Teachers

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ABSTRACT Swedish preschool teachers have a duty to protect and promote cultural diversity in their teaching and care of young children. Yet, there are underlying notions of culture in the national curriculum for preschools and university preschool teacher education that accentuate rather than undermine existing racial inequality. Preschool teachers’ understandings of culture and cultural difference matter for how they treat children, parents and colleagues. This means that what university Early Childhood Education programs teach about cultural difference also matters, since students will ultimately work in preschools and apply their knowledge in practice. In this article I draw on my experience as a faculty member in a School of Education to scrutinise course literature used in preschool teacher education and my supervision of student dissertations on the topic of cultural diversity in preschools. I argue that teacher education often delivers well-intentioned, colour-blind, anti-racist approaches to cultural diversity, which inadvertently sustain rather than change the status quo around everyday and systemic forms of racism. I then discuss the supervision process through which some students came to incorporate critically oriented approaches towards race relations in their observations of preschool practice. Some students were able to rethink how preschool teachers can operationalise the concept of culture by embracing an open-ended and explorative anthropological stance. Their analysis of preschool practice, therefore, can inform a wider theory of culture, valuable for both educational sciences and anthropology in practice.

Key words: applied anthropology; intercultural education; colour-blindness; teacher education

Introduction

Anthropological perspectives on the concept of culture can contribute to improving university preschool teacher education programs and teacher practices in preschool. Preschool teachers’ understandings of culture and cultural difference matter for how they treat children, parents and colleagues. This means that what university teacher education programs teach about culture also matters, since students will ultimately work in preschools. In this article I draw on my experiences as a faculty member at a School of Education to examine underlying notions of culture in teacher education literature and how undergraduate students make sense of these notions as they go out to observe preschool teaching practice. I show that the intercultural education approach, which is endorsed in educational policy at all levels and taught in teacher education, rests upon a well-meaning, colour-blind, anti-racist stance that tends to omit or obscure historic and systemic racism as an integral part of cultural diversity and race-relations in Sweden (Mulinari and Neergard 2017; Hübinett and Lundström...
2014; Häggren 2005). I also discuss how many of the students whose dissertations I supervise observe these troubling issues, and how we work together to discover ways for preschool teachers to operationalise the concept of culture without resorting to stereotyping, essentialism and everyday racism.

I begin by positioning this article within the literature on critical race theory in education and then discuss in more detail why Swedish preschool teacher education is a particularly interesting case for studying colour-blind anti-racism. After a brief methodological description, I show how the teacher education literature and students’ analyses of preschool practice either reproduce or contest stereotyping and deficit perspectives on the culture of the ‘Other’ in preschool settings. I then argue, based on students’ own observations, for an open-ended and explorative anthropological stance that questions what it means to say that a particular social encounter in preschool is about ‘cultural difference’. The case that I explore here provides an empirical example of how educational institutions can invalidate or leave out critical discussions of race-relations in the name of anti-racism. Such ‘insidious aggressive intercultural interactions’ go unnoticed because they are politically acceptable in our time (Valencia 2010).

**Intercultural Education: Contesting or Sustaining Difference?**

For the past 40 years, intercultural education has been upheld as a possible strategy to respect and promote cultural diversity at all levels of education, from preschool to university (Mikander et al. 2018). UNESCO introduced the concept in the early 1970s with the intention that education should ‘promote understanding, tolerance and friendship among all nations, racial and religious groups’, and ‘further the activities of the United Nations for the maintenance of peace’ (UNESCO 2006: 8). The formulations of tolerance and peace, characteristic of the 1970s intercultural era, have since developed to focus on social inclusion, social equity, accessibility, and quality of education for all (Silva et al. 2020; Bove and Sharmahd 2020).

In Sweden, the national curriculum for preschools incorporates rights to culture, stating:

> Children belonging to national minorities, which include the indigenous Sami people, should … be supported in their language development in their national minority language and promoted in their development of a cultural identity. The preschool should thereby help to protect and promote the languages and cultures of the national minorities. (National Agency for Education 2018: 9).

At the same time, the policy suggests that preschool is based on a *uniform* cultural heritage, including values, traditions and history, which should be taught to children. This can be seen in statements such as, “The preschool’s task includes transferring and developing a cultural heritage – values, traditions and history, language and knowledge – from one generation to the next” (National Agency for Education 2018: 9).

The formulations concerning the right to culture are of crucial importance since such formal rights were denied to the ethnic minorities in Sweden until the mid-1970s. At the same time, the policy also suggests that there is one distinct Swedish culture, separate from minority cultures. In both cases (minority and Swedish), culture is constructed as fixed and bounded, rather than hybrid and fluid. This characterisation becomes clearer when seen in
contrast to, for example, the Finnish school curriculum, where all students are described as having multi-layered and multicultural identities (see Zilliacus et al. 2017).

Sweden formally incorporated the intercultural education approach in education policy in 1983 (Department for Education 1983). However, many reports have highlighted the difficulties in implementing the intentions of intercultural education in practice (Hällgren 2005; Bayati 2014; Lunneblad 2017, 2013; Åkerblom and Harju 2019; Odenbring and Johansson 2019). Researchers argue that the core of the problem is a lack of thorough analysis of the underlying theoretical concepts of intercultural education (Hällgren et al. 2006; Norberg 2000; Hammarén and Lunneblad 2017). Often, intercultural educational approaches build on simplistic, essentialist and static notions of culture and classifications of people into the categories of ‘national’ and ‘migrant’ (Åkerblom and Harju 2019; Hällgren 2005). Educators may thus reinforce differences and stereotypes instead of creating inclusive, equal and transformative pedagogies (Zilliacus et al. 2017). Gorski (2008) argues that although the goals of intercultural education are well-intentioned, the perspective rarely serves to challenge dominant racial hegemonies, prevailing social hierarchies, or inequitable distributions of power and privilege. A more productive approach would instead examine racism as an inherent part of the dominant society’s state-formation, a fundamental principle of social organisation in modern society, educational institutions, and everyday life (Mulinari and Neergard 2017; Hällgren 2005). This is where critical race theory can play a significant role. Critical race theory “challenges dominant claims of race and gender neutrality, objectivity, universalism, ahistoricism, colour-blindness, and equal opportunity” (Allen 2012: 173). I now turn to some key concepts in critical race theory as they relate Swedish racialised political and institutional contexts.

Understanding Swedish Racism

Sweden’s self-image is of a country deeply committed to Social Democratic notions of solidarity, social justice, and anti-racism, and as a champion of human rights. Yet Sweden has a violent history of exploiting black, ethnic minority and indigenous populations, as well as an extreme right-wing party represented in government, and asylum rules in line with minimum standards under EU law (Mulinari and Neergard 2017; Hübinett and Lundström 2014; Ministry of Justice 2019). Decades of austerity politics and welfare institutional fragmentation have resulted in fast-rising inequality and social ethno-racial segregation in the labour- and housing market, and in education (Ålund et al. 2017; Beach and Sernhede 2011) The widespread presence of systemic and everyday racism is evident in a recent shadow report on Sweden’s compliance with the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (Civil Right Defenders 2018). These include high rates of hate crimes and a lack of adequate protection in the criminal justice system regarding hate crimes, racial profiling, and hate speech; discrimination related to Roma EU-citizens’ rights to health care, primary education, social services and protection against hate crime and forced evictions; and breaches of Sami rights to self-determination, land, language and culture.

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1 Sweden’s involvement in the slave trade between the seventeenth and nineteenth centuries is well documented, as well as its presence in international scientific circles as a leading nation on racial biology in the early 20th century. Sweden’s modern history builds also on centuries of oppression of indigenous and national ethnic minority groups, including the Sami, Swedish Finns, Tornedalers, Roma, and Jews (Hällgren 2005).
This widespread denial of racism is evident not only in Sweden’s self-image, but also in its education systems. Swedish secondary-school text books do not always account for racism as part of Swedish history and contemporary society (Johnsson Harrie 2016). There is evidence of children’s widespread experiences of racism and discrimination in schools (Odenbring and Johansson 2019; Hällgren 2005) and that university students experience racism in teacher education programs (Bayati 2014). The Swedish Black Lives Matter protests called for teaching about Afrophobia and other forms of racism during the academic year 2020-2021 and demanded that educators revise and update teaching material to remove stereotypes and historical inaccuracies and to add anti-racism to its content (The Afro-Swedes’ forum for justice 2020). Colour-blindness and colour-blind racism likely play a role in the silencing of basic anti-racist demands and the ways in which Swedish pedagogical discourse and practice can reproduce culturally acceptable forms of institutional racism (Lundberg 2015). Colour-blind anti-racism builds on the inner logic that ‘race should not matter’ and that it is best to ignore the issue of race in order to fight racism. As a result, the colour-blind approach to racism serves to maintain white domination. In adopting ‘colour-blind’ approaches, many educators resist discussion of racial issues, claiming not to see or be affected by the racial makeup of their students (Allen 2015). In this way, teachers...

...exonerate themselves in the maintenance of racial hegemony, and fail to understand how social and institutional racism pervade the lives of students of colour both inside and outside the classroom. Additionally, by avoiding critical examinations of racism, many educators rely on their own understandings of students of colour, which in many cases reflect dominant stereotypical and deficit views of culture. (Allen 2015: 72)

Deficit theory holds that inequality is the result, not of systemic inequities in access to power, but of intellectual and ethical deficiencies in particular groups of people (Gorski 2008). Deficit theorists draw on stereotypes already well-established in the mainstream psyche in order to pathologise oppressed communities rather than problematising the perpetrators of their oppressions (Gorski 2008). For example, in Sweden, black and ethnic minorities are often represented as migrants in a permanent state of unsuccessful adjustment to mainstream society due to their alien culture (Sabuni 2019). In this way, culture can be attributed with too much explanatory value and used as a simple model to explain behaviour, actions and events (see also Wedel, this volume). This contrasts with the use of culture in contemporary anthropology, where differences between the analytical, scientific and public use of the concept of culture have long been discussed (Taylor 2003; Kuper 1999). Often the anthropologist of today is more inclined to examine why narratives of cultural difference hold currency in a particular social context, rather than regarding culture as a useful explanatory device (Skelton and Allen 2005). A recent example in Swedish anthropology shows that political rhetoric on the need to ban Muslim face veils in Swedish public life is more concerned with conceptualising Swedishness than addressing the actual prevalence and nature of the assumed ‘problem’ for Swedish culture and values (Frisk and Gillette 2019). However, anthropologists also ‘reclaim culture’ to show that it has intrinsic value in understanding ‘others’ and ‘ourselves’ without necessarily buying into exotifying and neo-colonial perspectives (Engelke 2018). Engelke warns against “reducing cultural differences to the point of inconsequence” (Engelke 2018: 240).

However, discussions about the implications of the BLM protests among educators and administrators at my university have yet to take place, at the university level and for the School of Education.
This short review shows the need to scrutinise whether teacher and preschool education programs in Sweden reproduce or contribute to changing well-intentioned yet colonising intercultural practices. I now turn to the methods and research context for the case study that I present arguing for the necessity to connect teacher education, government policy and preschool practice in such an analysis.

**Methodology and Research Context**

In the following pages I examine notions of culture in mandatory course literature from the Bachelor’s degree in Early Childhood (or preschool) Education and in 50 undergraduate student final dissertations. For their dissertations, students interviewed teachers about how they implemented the duty to respect and promote cultural diversity in preschool (National Agency for Education 2018). I provide a qualitative content analysis of this material. My purpose is to connect national policy formulations, teacher education literature and preschool practice, an alignment necessary to develop inclusive education.

The bachelor’s degree in Early Childhood Education is a three and a half year teacher education program, recognised as a professional qualification for work in nurseries and preschools with children aged one to seven. In addition to academic courses the degree includes 20 weeks of work placement in local preschools. The degree program is shaped by the values, norms and content specified in the Swedish national curriculum for preschools (National Agency for Education 2018). This is a government policy directive revised every few years that all preschools in Sweden are required to follow.

My scrutiny of the teacher education literature reveals that colour-blindness, deficit notions of culture and stereotyping inform the bachelor’s degree in Early Childhood Education as it is currently taught. I illustrate the ways in which ‘critical perspectives’ of cultural diversity are marginalised and normative assumptions about cultural difference are sustained.

Some students take a particular interest in how preschool teachers work with cultural diversity in practice and choose to explore this topic in depth for their final dissertations. I am considered a particularly suitable supervisor for these dissertations because of my disciplinary background in anthropology. Since 2016, I have supervised more than 50 students investigating this topic. These supervisions have given me the opportunity to engage closely with what students learn about cultural diversity in preschool during their degree program, as well as in the policy formulations concerning culture in the preschool national curriculum.

Below I discuss literature that is or has recently been used to teach intercultural education in the School of Education where I work. Translations provided are my own. These texts may or may not represent the authors’ current positions on the issues discussed; in some cases, more recent publications incorporate more nuanced perspectives than those presented here. I focus however on these specific texts because they are mandatory readings in the preschool teacher degree program. The Early Childhood Education degree also offers an elective module that incorporates more recently published literature, including anti-racist literature. This course is not compulsory and is offered after the dissertation course, so I do not discuss this course literature here.

Following my discussion of the mandatory literature in the degree program, I turn to the students’ dissertation research. All the students whose dissertations that I cite and discuss...
in detail have given permission for this use.\textsuperscript{3} The translations provided are my own (the preschool curriculum policy document is available in English). Since the students’ texts were originally written in Swedish, translation makes it more difficult, though not impossible, to trace this work (some of these dissertations are published online via the university’s library system). The participating students are aware of this possibility. To preserve confidentiality, I have altered some identifying details related to the students and children they write about. They are for example, the language spoken of the persons involved. A final issue relates to the views presented and the identity of the preschool teachers whom the students have interviewed in their dissertations. Though I sometimes provide direct quotes from the students’ interviews, the students have presented their interviewees anonymously in their own texts. Identifying these individual interviewees through the present article is thus highly unlikely.

Notions of Culture in the Preschool Teacher Education Curriculum

The required reading for the Early Childhood Education program related to cultural diversity and the preschool setting includes conceptual pieces (Lahdenperä 2018) and texts based on ethnographic research (Sandberg and Vourinen 2007; Lunneblad 2017; Karlsson 2016). The research data in the latter texts are mostly interviews with preschool teachers, sometimes accompanied by materials from classroom observations (ibid.). This research is published in Swedish-language, non-peer reviewed textbooks that are geared specifically towards students. As I show below, essentialism, cultural determinism, social constructionism, as well as ‘critical approaches’ to the concept of culture can be found in these texts. I now turn to examples of these perspectives from the literature.

Presenting Cultural Difference as Problematic

A textbook by Sandberg and Vuorinen (2007) concerns ways in which preschool teachers can collaborate with parents and guardians effectively. The book discusses different degrees of parental participation and engagement (from none to decision-making power); the diverse aims of collaboration such as to ensure the best interest of the child and to support parenting; how collaboration can be carried out in practice; and factors that facilitate and undermine collaboration. The book is an interesting example in that it entirely excludes an intercultural education perspective. It suggests that collaboration takes place in a context of social change, and describes this change in terms of an increasing group of middle class parents who want to participate and influence the preschool education and care. Though such demands can put pressure on preschool teachers and be challenging for them, the authors also regard engaged parents as a prerequisite for good collaboration to take place. Cultural diversity is not part of the author’s account of social change. Ethnic and national minorities’ formal rights to culture and language is excluded in the account. So is the increasingly culturally diverse Swedish population, due to labour- and forced migration, since the 1950s. Yet, the book discusses cultural differences in passing as an obstacle for preschool teachers’ ability to collaborate with parents. A ‘common framework’ or shared culture is said to facilitate collaboration. The authors’ views concerning the factors that

\textsuperscript{3} In some cases, I have not been able to reach students to ask for their informed consent because the university administration does not have their contact details. None of this work is cited.
facilitate (and obstruct) preschool teachers’ collaboration with parents can be seen in the following extract:

The main factor that facilitates collaboration is that the parent and the preschool teacher/carer can depart from a shared common framework. A common framework can entail that the parent and the personnel share thinking patterns and language and that they hold a common view of children and preschool education. It can also include the sharing of common tradition and religious beliefs; similar perceptions of time, gender roles and methods of raising children. Parents and personnel will then, by acting in a similar social and cultural context, come to share common values. They can furthermore share a common view of the parent’s and the preschool personnel’s respective roles in the child’s upbringing and nurturing. The common frame of reference is also visible in personal interactions when parents and personnel have a similar way of relating to other people. They then act according to each other’s expectations concerning greeting procedures and eye contact. (Sandberg and Vuorinen 2007: 101, my emphasis).

This text is an instance of an implicit racist discourse about the ‘Other’ linked to a positive representation of ‘ourselves’ (Hällgren 2005). Though the text is not explicit, in the Swedish context the references to greeting procedures and eye contact presumably refer to long-running political debates around the reluctance of some Muslims to shake hands with persons of the opposite sex (Nieminen and Mustasaari 2018). This textbook implies that the culture of the ‘immigrant other’ is problematic and, given that it inhibits collaboration between parents and teachers, inferior.

In a text by Lahdenperä (2018), it is also clear that parents of ‘immigrant background’ have cultural deficits from the Swedish preschool’s perspective:

For many parents with migrant backgrounds the preschool is the first contact with Swedish life, culture and views of child rearing. In the preschool, one becomes, as a parent, socialised into Swedish culture with its demands for time management and time adjustment since one has to ask for permission or inform the preschool in advance about absence and illness. One also has to adjust to the climate by dressing children with purposeful and marked clothes in relation to weather, and participate in activities at the preschool. (Lahdenperä 2018: 66)

In this infantilising depiction of parents ‘with migrant backgrounds’, we learn that ‘they’ are fundamentally different from ‘us’ not only when it comes to time-keeping, but also in their ability to label their children’s clothes. The author discusses these issues explicitly in terms of parents’ cultural backgrounds. Lahdenperä also categorises the world’s cultures into three ideal types: pre-industrial, industrial and post-industrial societies and economic systems (or cultures). Indeed, the text takes a colonising view of ‘the Other’ by ranking cultures and classifying different cultural groups according to this ranking system. The post-industrial system, which the Swedish preschool is said to represent (and to which presumably the author herself belongs), is the most sophisticated ideal type in terms of human development, while the pre-industrial system is farthest removed from the Swedish preschool’s norms, values and practices. For example, in the pre-industrial society, adults may strike at children in rage, but in the industrial society, a parent can control and regulate her emotions, and learning takes place largely through instruction rather than beatings. In the post-industrial society, Lahdenperä suggests, child rearing is individualised and child-centric. The author provides no concrete evidence in support of these claims, which seem to be based on personal impressions and opinions around the problem of the immigrant cultures for preschool
education. Lahdenperä cautions against ethnocentrism and claims that the ideal types of societal systems promote an intercultural perspective on the relationship between the preschool and the parents with migration background. The argument is that the ideal types 'problematis[e] taken-for-granted assumptions regarding Swedish ways of raising children and in this way facilitate more of an intercultural approach towards parents and guardians' (Lahdenperä 2018: 62). The 'intercultural perspective' is in this way used to legitimize a reductionist view of culture.

In the next section, I elaborate on the diversity of perspectives within intercultural education to show texts that are based on anti-racist sentiments, yet often in colour-blind and inconsistent ways.

**Colour-Blind, Anti-Racist Intercultural Education**

Karlsson (2016) (citing previous research) highlights the tendency in Swedish school settings to not regard cultural diversity as enriching for the school, but to focus instead on parents' shortcomings and deficiencies. Citing Lunneblad (2013), she points out that preschool teachers should avoid creating a social milieu of 'Us versus Them'. An intercultural approach, in Karlsson's view, is "a reflexive process in which cultures can enrich one another" and "entails collaboration between cultures where ethnic cultures, religion, way of life, cosmologies, ways of thinking and so forth enrich one another" (Karlsson 2016: 131-132). The text, based on interviews with preschool teachers, provides an account of how preschool teachers approached cultural diversity. They reflect the position that one should respect, know about and explore differences, often through close contact with parents, yet not read too much into the significance of ethnicity. Children may not perceive that they are different because they (or their parents) were born in a foreign country, and some preschool teachers regard children as having dual identities, such as both Swedish and Somali. Yet, in one instance, the text also treats culture in a less fluid and changeable sense, reflecting a particularistic and static view of culture, which appears to fuel the 'Us versus Them' perspective. Karlsson cites an interview with a preschool teacher (called Daniela in the text) who emphasizes the value of 'cultural competency' training about 'Somali and Roma cultures' that she participated in. According to the preschool teacher Daniela, knowledge about children's experiences and cultural background is a basic precondition for intercultural pedagogy. Yet in the preschool teacher's description of the lecture on cultural competency that she attended, Somali culture is seemingly discussed in a particularistic and exotifying cultural sense, detached from the particular individual children and adults of the preschool. Below is an excerpt from Karlsson's interview with Daniela:

> We have had some lectures about different cultures... She [the lecturer] knew a lot about the Somali culture and of all these different groups we have here with us. So she lectured about their customs and their ways of thinking, how they live and that, which is completely different compared to Sweden. So, for example Somali fathers who have several women, who have one woman here, who have one woman in Norway, who have one woman in Australia. It can be pretty hard to understand, why the dads, most of them, don't live together with their children and their women, but they can live for example in Norway and not in Sweden, and the mother is here with four, five, six children. But they are not all their children either, and

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4 Karlsson uses ethnicity (etnicitet) here, which she does not define, but she uses it interchangeably with origin (ursprung) and background (bakgrund).
then she explained what it is like in Somalia: One man with camels moves to different places and then he has one place here and a woman, so then he comes to a town and has another woman and children with her and then he goes to the first woman. Often when they move, then the first woman, who has highest status, she has all his children and comes for example to Sweden. Then all children go here, for example at this preschool and then the man is somewhere else and that, so for those who do not know and are not interested it is still very hard to understand it. (Karlsson 2016: 142)

Karlsson’s comment on the quote above is that there can be great differences in the families’ ways of living that are unknown and hard to understand. Training about cultural differences is one important element in the preschool work. (Karlsson 2016: 142)

In my view the ‘knowledge’ about ‘Somali culture’ here is undermining the intercultural approach that Karlsson supports. It is portraying Somali culture as frozen in time, as discrete and uniform. It seems not to trouble the author to accept the preschool teacher’s deduced stereotype and exotic view of Somali culture.

Some authors in the mandatory course literature discuss the tendency in educational settings to regard ‘Swedishness’ as the norm and gold standard against which other cultures are compared (e.g. Lahdenperä 2018). Such texts also discuss why using terms such as ‘Swede’ versus ‘immigrant’ (invandrare), terms inherited from a history of racism, denial of racism and ethnic discrimination, are problematic (e.g. Lunneblad 2017). At the same time, these same texts can reproduce the tendencies that they criticise. For example, in one text, preschool teachers and parents use the terms ‘Swede’ and ‘immigrant’ as categorically immutable groups, which is commonplace in popular discourse. The author retains these terms in the analysis, even though he finds them problematic, explaining “I would lose something of the closeness towards those people I followed if I would transform the term immigrant to a more politically correct expression” (Lunneblad 2013: 32). An employment of racist terms is here depoliticised and reduced to a discussion of political correctness (see Mikander et al. 2018). The author goes on to argue that critical race theory and critical multicultural education are not applicable to the Swedish historical and political context. The argument is that Sweden does not have a violent history of racial oppression on par with countries such as USA, Canada, United Kingdom and Australia. To dismiss the presence of racism in Swedish history in this way, is ahistoric and serves to invalidate Swedish racial minorities’ struggles for equal opportunity and political recognition, including the recent Swedish BLM protests. Such ‘intercultural’ texts sustain the dominant claims of race neutrality, colour-blindness and equal opportunity in Sweden, thus upholding the status quo of racial inequalities in Sweden.

**Students’ Observations of Preschool Practice**

Many students are critical of literature they have read during their degree programs, and of practices they have observed in preschools during their work placements. Some take a special interest in how preschools can ensure equality and equity in working with cultural diversity. These students sometimes describe situations in preschools in which ethnic minority children are excluded in everyday teaching and care practices. One of the students observed the following during work placement in a preschool, which he subsequently described in his dissertation:
The preschool had some children from the Middle East and these children seemed to not have a good command of Swedish. It appeared to me that several of these children were largely ignored by preschool teachers. It was like the teachers didn’t really know what to do with them and they were not included in the group of children like the others. It made me so sad. It seemed the preschool teachers didn’t know much about the children’s skills and abilities and did not know the children well, even though the children had been at the preschool for several months.

Another group of students argued they wanted to explore how preschools could work inclusively and in a non-discriminatory fashion with children. The following incident observed at the preschool, and presented in the dissertation, sparked their interest:

There was a small three years old girl who spoke Tigrinya, like me, and she didn’t speak Swedish. I once observed how she tried to make two preschool teachers understand her. They however did not understand what she wanted to say. After a while, they went to another section of the preschool to ask another preschool teacher for help. That preschool teacher spoke Tigrinya too. I don’t know why they didn’t ask me for help, but I was sitting with another group of children, so maybe they didn’t want to interrupt me. When they left to fetch the other teacher, the child turned to me and said: “Please Miss, can I have the toy from the shelf up there?” I gave it to her, and I couldn’t really understand what had just happened. It was such a simple situation to understand. I mean, even children who have not started to use verbal language are easy to understand. I couldn’t forget it. I wondered if the situation would had turned out differently if the child had been White.

Students have rarely discussed such issues in depth during their degree. In the first phases of supervision, I invite students to discuss observations they have made in preschool practice. I then provide them with a new body of literature to help them navigate the politicised context in which narratives of cultural diversity and difference take place. I typically suggest that students familiarise themselves with essentialist, social constructionist and post-colonial perspectives on culture and ethnicity. Students need time to read and digest this literature. As I show in the following paragraphs, it is often while discussing their own interview materials in depth during supervision that the significance of the different concepts and issues become concrete and start to make sense to them.

The sections below shed light on some of the key themes that emerge from students’ interviews with preschool teachers. When these teachers talk about cultural difference, it is frequently a euphemism used to position oneself in relation to unequal race relations in a deeply racist yet colour-blind society. As in the teacher education literature, preschool teachers usually suggest that culture plays a role in situations involving black and ethnic minority individuals. However, there is often weak evidence to that effect.

The Presumed Presence of Culture: Normative Cultural Narratives

The first theme I want to explore is how preschool teachers and students readily buy into a narrative of cultural difference when describing interactions across racialised groups. Individuals expect culture to play a role and describe social action as such, rather than necessarily being the case. Moreover, preschool teachers often rank cultures implicitly or explicitly, with ‘Swedish ways’ usually coming out on top, reflecting a deficit view of the culture of the ‘Other’ (Gorski 2008).

1 In the School of Education’s Early Childhood Education program, students write their dissertations in pairs.
In one dissertation, a pair of students carried out interviews with teachers in a preschool that had a large proportion of black and ethnic minority children. One of the students had carried out a work placement there and had the impression that the preschool teaching was inclusive of all children. She thought that the preschool teachers’ ethnic minority background could be a contributing factor. When she and her co-researcher returned to the preschool, they were disappointed to find the preschool teachers mostly talked about their work in terms of being overwhelmed by the ‘diversity of cultures’. At the same time, the students also suspected that the preschool teachers thought this was what the students wanted to hear. To quote:

It seemed like, when we turned up there wanting to interview them and write about them, they said what they thought we wanted them to say and saw us as these blond and blue eyed ‘ethnic Swedes’. They said they wanted to promote Swedish culture above all other cultures.

Some of the preschool teachers said that in working with children of ‘foreign backgrounds’, they chose to promote ‘Swedish culture’ above other ‘cultures’ because they felt that there were too many cultures to consider. To quote an interviewee in the dissertation:

Sometimes I feel it is too much hard work with many cultures involved. It is better then to go for Swedish culture in preschools. Otherwise it becomes too much. Sometimes it is just too much.

Some of the preschool teachers had the view that children with an ‘immigrant’ background often needed to be socialised to be able to conduct themselves at the same developmental level as ‘Swedish’ children of the same age. An example that they gave was that some children ate with their hands rather than with cutlery. The preschool teachers also said that they mostly observed ‘cultural differences’ in relation to the parents. For example, they said that parents did not comprehend that the preschool was a place for learning, but rather saw it as a place for care and nursing; that parents did not address and talk to their children but spoke ‘over their heads’ and preferred talking to the preschool teachers; and that children were sometimes overweight because parents gave them too much food. The preschool teachers further talked about ‘culture shock’ in relation to different ideas about gender roles and ways of raising children. One teacher said, “It is also because of culture that children are not used to dads cooking food, but only mums. When children play in the play-kitchen, one child might say, I am a boy, and I can’t cook. Then I say, well, you can try it out”.

The teacher went on

There are parents who do not want girls and boys to sit next to each other and play together. For children it works in one way in the home and in another way in the preschool. Because at home they have their ways of raising children and how things should be. Then in preschool we have another way of raising children and other values and it can become a clash for children sometimes.

In these interviews, the teachers appear to assume that culture and cultural difference are what is at stake. The ‘culture card’ legitimises grouping together differences observed among black and ethnic minority children as ‘the culture of the Other’. Using the concept of culture in this sense is commonplace and deeply rooted in Swedish society, so the teachers can talk about it as a self-evident fact. Students often think that this is a reasonable assumption as well.
When confronted by these assumptions, I encourage the students to ask whether the issues here are accurately described as cultural issues, or whether they might more specifically be about different ways of eating, different developmental stages, different styles of parenting, and different views of traditional gender roles.

Some students observed that in relation to White parents, preschool teachers were more inclined to apply an individualist perspective rather than talking about culture as an explanation. For example, teachers talked about White parents with sexist views as ‘difficult individuals’, and not as representatives of a collective (Swedish) ‘culture’.

In some cases, the ‘cultural difference’ narrative was used to conceal preschool teachers’ insecurities and manifest their good intentions, their concern ‘to do it right’ and not offend children and parents, particularly in relation to Muslim parents. In the quote below, a preschool teacher is concerned that the Swedish tradition to dress up as witches at Easter may cause offence:

*We have a family from Syria. They are Muslims. I personally don’t know much about Islam, about how a Muslim lives. I said for example [to the parents] that the girl can dress up as an Easter witch because we do that here in Sweden. Perhaps this is completely against their beliefs, because it perhaps has to do with witches. One is afraid of doing those kinds of religious mistakes.*

The interview suggests that the preschool teacher wants to avoid offending the parents, on one hand, but also that she does not want to discuss this issue with them on the other. She instead takes refuge in a cultural difference narrative. It is possible that the core issue is a lack of rapport with the parents, rather than culture, and the teacher is reluctant to engage in a dialogue with the parents because of this. Moreover, one must ask whether the practice of dressing up as an Easter witch is a symbolic religious activity, or ‘just play’. Since by law the Swedish preschool is nonconfessional, preschool teachers commonly exclude the religious aspects of traditions and focus instead on play, arts and crafts, and dressing-up (Reimers 2019). Yet talking about dressing up as an Easter witch as play does not necessarily empty the practice of religious or cultural connotations.

When I discuss these kinds of issues with students, they sometimes begin to question the analytical value of culture as an explanatory model. They start to look at their interview data in different terms and move away from accepting the cultural difference narrative at face value. For example, in their discussion of their research, two students wrote the following reflection:

*It is noteworthy and interesting that the teachers talk about situations in terms of ‘cultural behaviour’. They could have said that it is about something else, for example traditional gender roles. We maintain that the interview quotes illuminate teachers’ analyses of how parents’ behaviour should be understood and categorised. They make an analysis of behaviour as cultural and the underlying understanding of cultural behaviour is that it is generalisable and typical for a whole group of individuals of ‘the same’ ethnicity or country of origin.’*

Other students suggested in their dissertation analysis that what could be considered to be ‘culture’ in a given situation and encounter need not be pre-determined or based on preconceived ideas. Rather, it could be left open-ended and ambiguous. Their understanding is reflected in this passage from the conclusion:

*Though preschool teachers are supposed to work with promoting culture, we maintain that culture is much more unclear and not something that can be discerned and clearly ring-*
fenced – it is more ambivalent. Therefore, teachers need not decide beforehand what it means and is about in a given situation. It is something they can find out instead.

Problematising the normative narrative of culture and cultural difference in preschools can be both revelatory and frustrating for students. While it is interesting for many to explore social and political constructions of culture in relation to the preschool context, others experience racism personally and need no such ‘political awakening’. They want instead to learn about ‘good practice’ of inclusive education, for reasons of personal and professional development. I recommend that students conduct strategic and purposeful sampling, to ensure that they interview preschool teachers who are specialised in the issues students want to examine (in this case, protecting and promoting cultural diversity). By using this methodology, students procure interviews with varied perspectives on race and culture, and their dissertations often point away from culture as an explanatory model for behaviour. These students instead investigate the centrality of building personal and trusting relationships across race and ethnicity in educational settings. I turn to this theme below.

‘Super-Diversity’ Views on Culture: Inclusive and Non-Targeting

One group of students focused their dissertation research on how the preschool might provide inclusive education for newly arrived migrant children. For the dissertation, the students contacted five preschool teachers specialised in this area. Two of the teachers had written Masters dissertations on the topic, and three of them had extensive work experience with this particular group of children. In the interviews presented in this dissertation, the preschool teachers foreground what scholars have called a ‘progressive universalist’ position (Bove and Sharmahd 2020), in which education and care are focused on being inclusive of potentially marginalised groups, while at the same time being ‘non-targeting’ and ‘non-stereotyping’. In such non-stereotyping practice, the preschool teachers apparently understand culture in terms of a ‘super-diversity’ of social and cultural groups, e.g. an intersectional perspective of multiple axes of differentiation such as “country of origin, ethnicity, language, migration status (and its concomitant rights, benefits and restrictions), age, gender, education, occupation and locality” (Vertovech 2007: 1044). These preschool teachers talked about the importance of building trusting relationships and getting to know parents and children when they are new to the preschool. Said one,

You cannot work at the preschool without forming close relationships with the children. It is important to know – like, if a child is tired, it affects the entire day. If I know why and have a good relationship with the parents, I can ask them if the child has been tired and if something has happened.

These teachers emphasised treating every child equally, while finding out the individual needs of the child at the same time. One teacher talked about a child’s introduction to a new preschool as an example of how this can take place:

The introduction of a new child should entail exactly the same thing as it does for all children in the preschool. It is not that we do something extra or that a special method is needed if the child has a different language or ethnic background, but the introduction may need to go on for longer periods of time. It needs to be adjusted to the child’s needs. What is needed is a thorough introduction. And that means getting to know both the parent and the family because then they too get a sense of what we are doing here and what we work for, what our goals are, what policy documents we follow and what the preschool is for.
This preschool teacher seems to emphasise the importance of parents’ participation and the value of parents’ knowledge about their own child. Culture is portrayed neither as an obstacle nor a deficit. Indeed, the teacher does not mention culture in relation to these situations.

Some of the other preschool teachers who were interviewed considered that the preschool should be aware itself as a bearer of ‘culture’. Explained one,

The preschool has its own ‘culture’ and ways of doing things. Its own ideas of what is considered normal and not. These are important things to consider. So I don’t take it for granted that a child new to Sweden and the preschool and their parents would consider self-evident and ‘normal’ what we do around Christmas, St. Lucia and Midsummer. The important thing is to build trust so that you can talk about these things and so we know how to accommodate children in the preschool.

Another preschool teacher considered the national curriculum’s directive to counteract gender stereotypes in the preschool as an example of the preschool’s particular ‘culture’. This preschool teacher regarded culture as a relevant aspect of social interaction and simultaneously questioned culture as a collective, analytical category. To quote:

I notice that not all parents appreciate the preschool’s value and goal to work against stereotypical gender roles. You can see in the parents’ faces that they don’t necessarily appreciate that their little boys dress up in shiny, pink, princess dresses. And boys who make pretty necklaces may know it is not appreciated at home and therefore they don’t take it home with them or wear them. But it is not the most constructive to think about these issues as their culture. I mean, not all Swedes appreciate those things either, but then we don’t say it’s about culture, but that it is that particular person’s opinion on gender stereotypes and deal with it in that way.

Both of these teachers attributed culture to the preschool rather than to the parents or children. They did not regard the values and practices of the preschool as a reflection of ‘Swedish’ culture, shared by all ‘Swedes’, but rather as a top-down policy formulation.

The examples from this dissertation suggest that cultural difference and cultural ‘deficits’ are not always the conceptual framework that preschool teachers use when working with diverse groups of children. Indeed, based on this dissertation, it appears that preschool teachers who have long experience of working in culturally diverse groups of children talk instead about getting to know the individual child and her/his parents and building trusting relationships. It is within trusting relationships that preschool teachers can have a dialogue with parents and children about preferences related to gender and religious festivals.

Final Remarks: Cultural Difference as a Starting Point for Inquiry into Race Relations

While culture may be regarded as a process of “making meanings, making social relations, and making the world that we inhabit, in which all of us are engaged” (Taylor 2003: 179), it must be stressed that meaning-making in the world we inhabit plays out on an unlevel, racially-inflected playing field. The dominant intercultural perspective taught at my home institution rests upon a well-meaning, colour-blind anti-racist stance. This approach obscures the everyday racism which characterises the surrounding society, and hides or minimises the importance of major social justice struggles past and present. Colour-blind, anti-racist (and so unintentionally racist) course literature in teacher education programs causes harm to students and impedes change in the surrounding society. Swedish educational institutions,
including my home university, need to do more to respond to decades of social unrest and calls for change, including the Black Lives Matter protests in 2020. Calls to decolonise the curriculum and offer social justice education (Morreira 2017; Osman and Hornsby 2018) are not adequately addressed by promoting intercultural education, which as I have shown can inadvertently undermine the fight against Afrophobia and other forms of racism and discrimination. Based on my students’ research, it appears that all too often intercultural education in teacher education programs facilitates ‘insidious aggressive intercultural interactions’ in preschools (Valencia 2010). Narratives of ‘cultural difference’ can subtly legitimise racial hierarchies of power.

Students pursuing the Bachelor’s degree in Early Childhood Education have challenged me to consider, from an anthropological perspective, what it means to say that a particular social encounter in the preschool is about ‘cultural difference’. Though cultural differences related to beliefs, customs, and expectations about preschool can play a role in interactions between parents, teachers and children, in my experience these aspects of culture are rarely if ever discernable ‘on their own’, isolated from (often unintentional) racist discourse. In the mandatory literature for Early Childhood Education at my institution, the practice of some preschool teachers, and some student papers, ‘culture’ is often attributed more explanatory and analytical value than it should have. Often a standard narrative of cultural difference, based on common, everyday usage of the term in Sweden, is accepted at face value. However, when I interact with the students and engage in a discussion about what it means to apply culture as an explanatory mechanism for behavior, some students come to regard culture less as a self-explanatory underlying factor, and more in terms of an open-ended process.

Through my work with students to realise the spirit of the national curriculum policy, students have challenged me to put anthropology to practical use and think carefully about what an anthropological analysis can contribute to the narratives of cultural difference that are so commonly used to discuss preschool settings. In conclusion, I offer what my students’ dissertations suggest about how to think about culture in preschool practice. Their dissertation analyses support the following perspectives: 1) Notions of culture need not be predefined, but can be open-ended. Culture can be a question for investigation; 2) When narratives of ‘culture’ or ‘cultural difference’ are put to use, this is a good starting point for an in-depth inquiry into the relationships surrounding such narratives. In particular, one should ask who talks about culture, why, and in relation to whom? As one of my students pointed out, it can be useful to consider how the individuals involved might have discussed a similar event in relation to White, middle class children and parents; 3) When a preschool teacher argues that culture is at stake in particular interaction, on what evidence does she or he base these claims? Might other interpretive models of causality have equally good or better explanatory power? Is it possible for the teacher to give a precise and concrete description of what part of the particular social action is ‘cultural’? These perspectives make it possible to shift the focus away from a fixed and essentialist notion of culture. They raise questions about the operations of power, and draw attention to the potential for implicit racism to be colouring the discussion. Ultimately, they may help students recognise that ‘culture’ may be less important for preschool teachers in comparison to building trustworthy, open and inquisitive relationships.
References


Facing the Challenges of Cultural Competency in Swedish Mental Healthcare

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ABSTRACT In Sweden today, with its multifaceted and diverse population, there are increasing demands on the healthcare system to offer culturally competent care to reduce health disparities. Healthcare professionals are expected to be culturally sensitive and competent in clinical encounters to meet the diverse needs of patients/clients, who may belong to various refugee or minority groups. Based on two case studies, the Somali-Swedes and the Sami people in Swedish Sápmi, I discuss some of the multifaceted and complex challenges in Swedish mental healthcare. It is argued that an anthropologically informed approach, and the role of the anthropologist as mediator and educator, may contribute to equal, effective, and sensitive forms of holistic, non-essentialist, culturally competent mental healthcare.

Keywords: culture, applied anthropology, medical anthropology, cultural competence, mental healthcare

Introduction

In today’s world, there are increasing demands for culturally responsive, flexible, and sensitive mental health services to reduce health disparities and meet the varied needs of patients (Schouler-Ocak et al. 2015; Kirmayer 2012a). This is particularly important considering the widespread, global stigma of mental health problems (Kleinman 2009). Sweden is no exception. With its diverse population, there are great needs and challenges for the mental healthcare system. The indigenous Sami reindeer herders for example, have less trust in psychiatry and primary healthcare than the general population. According to the Swedish Sami Parliament, the reason for this is largely because of a lack in cultural competence among healthcare personnel. The parliament therefore expresses a need for culturally competent and adaptive care (Sametinget 2016; Daerga et al. 2012; see also Sametinget 2017). The Swedish Care Handbook also addresses the importance of cultural competence and states that culturally competent care means avoiding ethnocentrism and putting the needs of each individual in focus (Vårdhandboken 2018).

Healthcare and social institutions in Sweden and around the world are today developing a transcultural perspective which is commonly defined as an insight into, and consideration of, cultural perceptions of both professionals and clients in encounters and treatments as well as cultural competence, understood as an ability to apply this insight into practice and to bridge differences. There is a generally held belief that cultural competence is important when meeting people with different values, ideas, perceptions, and lifeworlds in mental healthcare settings. Many medical and nursing schools in the west offer courses and teach cultural competence. Overall, there is a growing understanding that people’s
cultural conceptions should be taken into account, especially as health care services should be ethically sound and effective (Kirmayer 2012a, 2012b; Abrams and Moio 2009).

However, this focus on cultural values and perceptions sometimes lead healthcare institutions and medical/nursing schools to understand and deal with culture in a simplistic, essentialist way as synonymous with ethnicity, nationality, and language. This is also reflected in the medical literature. Consequently, it is taken for granted that certain cultural beliefs, values, and practices will directly influence or determine individual behaviour (Kleinman and Benson 2006; Garneau and Pepin 2015; Kirmayer 2012a). The problem with this approach is that when not acknowledging the diversity within a particular group, socioeconomic and socio-political factors, living conditions as well as dynamics between communities and societal/global institutions, culture becomes something static, stable over time, homogeneous, and socially conservative. The complexities, conflicts, and uncertainties within a certain group or community are thereby downplayed or hidden. In addition, the larger societal order, including characteristics such as economic inequalities, poverty, gender relations, racial prejudice, social marginalisation, systematic discrimination, and imbalances of power, remains unquestioned and obscured. The result is a view of cultural competence as a technical skill, separated from economic, physical, political, historical, and social contexts, and with stereotypical representations of individuals and groups (Kleinman and Benson 2006; Garneau and Pepin 2015; Kirmayer 2012a; Schouler-Ocak et al. 2015).

Alternative concepts that better include trust, self-reflexivity, self-critique, power imbalances, and health inequalities in healthcare encounters, have been suggested to replace cultural competency. These include cultural humility (Tervalon and Murray-Garcia 1998), culturally tailored care (Kohn-Wood and Hooper 2014), and cultural safety (Curtis et al. 2019). Although cultural safety has been particularly useful when examining and understanding power imbalances (Josewksi 2011), it has also been criticized for emphasizing patients’ vulnerabilities instead of their strengths (Kirmayer 2012a). All these concepts including cultural competency, “draws attention to certain dimensions of intercultural work while downplaying or obscuring others” (ibid: 160).

In a non-essentialist perspective, culture is regarded as a flexible, negotiable, hybrid, evolving, and ongoing inter-human process of shared meanings. This means a focus on how an individual, who is seen as an agent in a broader perspective, interacts in many different contexts, networks, and groups (Garneau and Pepin 2015; Carpenter-Song et al. 2007; Kirmayer et al. 2014; Miklavcic and LeBlanc 2014). From this dynamic viewpoint, culture is seen as “fluid, situated and negotiable intersubjective systems of meaning and practice relevant to specific social contexts” (Kirmayer 2012b: 252). An anthropologically informed understanding of cultural competence in healthcare therefore means self-awareness and an ongoing inquisitive learning process. In mental healthcare, it implies a constant questioning of common practices and psychiatric notions with a special focus on the impact of social, economic, physical, political, religious, and existential conditions on individual mental health and wellbeing.

A special challenge in this context is refugees’ and indigenous peoples’ mental health in psychiatry and primary healthcare. This is particularly true for the Somali-Swedes, who often experience a lack of understanding and prejudices in healthcare encounters (Wedel 2011), and the Sami people in Swedish Sápmi (Northern Sweden), who suffer from high rates of mental health problems (Sametinget 2016). In the following, my aim is two-folded.
I first discuss mental health in relation to these two cases, as examples of this challenge. I then inquire into how an anthropologically informed view on cultural competence and anthropological practice, and the possible role of the anthropologist as mediator and educator, may contribute to holistic, non-essentialist, and inclusive culturally competent mental healthcare.

**Mental health among Somalis in Sweden**

Somalis are one of the largest refugee populations in the world with more than a million displaced people (UNHCR 2014). About 68,000 Somalis reside in Sweden (Statistiska Centralbyrån 2018) and many suffer from depression and anxiety (Wedel 2011, 2012a, 2014a, 2014b). During my eleven months of anthropological fieldwork in the north-eastern parts of Gothenburg from 2010-2011, I encountered considerable variation regarding people’s health-related ideas and perceptions. For many, religion was of major importance and people generally found religiosity and spirituality, and especially Qur’anic reading, to be of significance when making sense of, and dealing with, mental health problems (cf. Mölsä et al. 2019; Johnsdotter et al. 2011). Some male teenagers were however less enthusiastic about religious therapies. One young man rejected Qur’anic reading by religious leaders, but added that he could not express his opinion openly as he feared that people would distance themselves from him.

In general, there was considerable stigma surrounding mental ill-health and a fear of being labelled as “crazy” or “mad” within the Somali community, especially if diagnosed with depression or other mental health problem (cf. Mölsä et al. 2010). I also found several non-Western illness explanations, such as jinn (spirit) possession, isha (the evil eye), sixir (witchcraft) and inkaar (imprecation). Moreover, people used various indigenous concepts for describing different stages and forms of mental distress. The most common were welwel (stress, worry, depression), murug (stress and anxiety; often related to social problems), buufis (severe depression; often related to longing and unfulfilled migration), qalbijab/niyadjab (“a broken heart”, depression, despair; commonly resulting from failed attempts to bring relatives to Sweden or because of being denied a Swedish permanent residence permit) and waali (insanity, spirit possession). These concepts were more or less unknown to the Swedish healthcare personnel (Wedel 2011, 2014b).

In addition, stress and worries were often related to economic obligations towards relatives in Somalia or the diaspora, or difficulties in finding work because of perceived racism in the job market. A man also complained that Swedish gender values could cause loneliness and depression for some men: “If you are a real Muslim, you should not live alone.”

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1 The first case study focuses on ideas and experiences concerning mental health problems and healing among Somali-Swedes in Gothenburg, Sweden. Data collection, which took place during 11 months from 2010-2011, was based on participant-observation and included open and semi-structured interviews. These lasted from half an hour to an hour. A total of 25 Somali men and women were interviewed. Some of them were newly arrived, while others had lived most of their lives in Sweden. In addition, six biomedical health professionals (two medical doctors and four nurses) and two social workers were interviewed. The second case study focuses on ideas and experiences concerning mental health problems and healing among the Sami people in Swedish Sápmi. This study was based on a literary review as well as data gathered during two short field trips to Sápmi in 2019. Field data consisted of informal interviews with 11 Sami men and women. The interviews lasted from 15 minutes to an hour. One of the interviewees was a medical doctor and two were nurses.
You have to get married to avoid problems. The problem is that here in Sweden the women have a higher status and importance. They sometimes kick out the men” (Wedel 2011: 76).

When suffering from mental health problems, many of those I met during fieldwork expressed the importance of reading the Qur’an. A woman explained: “We live in Sweden where the soul doesn’t count and where people don’t believe there are forces that affect us, that can make us ill. But these forces exist. To become healthy we must work with the soul and read the Qur’an which can heal. These are incredible forces” (Wedel 2014b: 2353; see also McMichael 2002; Tiilikainen and Koehn 2011). A woman who was a refugee having left her two children in Mogadishu, also talked about reading the Qur’an to overcome her worries and problems:

Each day on the news, we hear about the chaos in Somalia. You hear about someone in another family who has lost her son or daughter. If I would sit and think about that every day I would become crazy [waali]. I don't have the power to bring my children here today, but I wait and have patience. I read the Qur'an to gain strength. [In the Qur'an] there are stories about people who have gone through great difficulties and who overcame their problems. If you are strong in your faith, you know that all problems come and go. (Wedel 2014b: 2350)

People would often ask an imam or a sheikh, religious expert and healer, to read the Qur’an in the Arabic language, as they are experts in Qur’anic reading. In serious cases, an imam or sheikh and a group of people would recite the Qur’an in a mosque to expel troublesome spirits, jinn, from the patient.

Many Somali-Swedes mentioned prejudicial treatment in Swedish healthcare units and that it was common with misunderstandings. They also felt a lack of trust in clinical encounters and said that physical problems were sometimes diagnosed as “stress” or a demanding life situation, instead of being examined properly. A woman explained:

‘There are a lot of prejudices against Somalis. People have heard that Somalis are difficult, complicated and strange. If I am mentally ill and behave completely crazy, they will say it’s a ‘Somali thing’ or a ‘Somali woman.’ … [Somali mothers] never reveal how many children they have so that the doctor won’t think they are sick because of their children. They are told to do gymnastics, drink water, meet people and that they have too many children. (Wedel 2011: 75)

Another woman discussed a case with a boy who was sent to Somalia for Qur’anic reading after being diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) in Sweden: “He was medicated. He became calm. He became different. But he wasn't crazy. He was over-active and rowdy and just needed to grow up” (Wedel 2014b: 2350).

In particular, Somali-Swedes felt that Swedish healthcare workers had little understanding for Somali views, perceptions, illness explanations and treatments, such as Qur’anic reading and jinn exorcism, when facing mental distress. For example, Qur’anic readings were sometimes interrupted when the hospital’s visiting time was over, and the reader had to leave. In one case, a man had let his wife suffering from a psychosis, to listen to recordings of Qur’anic verses in the hospital where she was treated. The man related: “When she listened, she cried. The doctor said ‘no, no, no, she's crying. You should let her listen to classical music’. The psychiatrist did not understand what was happening to my wife” (Wedel 2014b: 2355).
Many Somalis whom I met during fieldwork were also of the opinion that psychological or psychiatric treatments were ineffective or even harmful. A woman explained “…we Somalis don’t believe in psychologists. That is especially true when one, for example, hears voices [which may be a sign of jinn possession]” (Wedel 2011: 76). In a similar vein, a man said that he did not expect a Swedish psychologist “to understand him or his culture”. He expressed concerns that the psychologist’s questions “could make it worse”, that antidepressants had worrisome and unwanted side effects and that psychiatric treatment could lead to being locked up in a psychiatric institution for years (ibid.).

Swedish healthcare personnel, on the other hand, were struggling to understand their Somali patients and give a correct diagnosis. They described how Somali patients exaggerated their physical symptoms in order to get the physician’s attention. Physicians and nurses often understood these symptoms as related to a general stressful life situation. They also complained that Somali-Swedes were stoic and seldom showed any sign of pain when they were examined, and that this made it difficult to make a diagnosis and find a solution to the patient’s problem. Overall, it was a common opinion among Swedish healthcare personnel that Somali-Swedes were culturally different and difficult to deal with, that they often denied their psychological problems, and that they tended to avoid Swedish mental healthcare services (Wedel 2011, 2014b).

**Mental health among the Sami people in Swedish Sápmi**

The indigenous Sami population in Sweden consists of 20-30,000 people, and about 10 per cent of them are reindeer herders (Daerga 2017; Stoor 2015). Overall, the Swedish Sami experience high rates of mental health problems. Every other young woman has had suicidal thoughts. About half of the male reindeer herders suffer from anxiety disorder. No less than one in three of the young Sami reindeer herders and one in five of the adults have considered taking their lives (Omma 2013; Sametinget 2016; Kaiser et al. 2010; Omma et al. 2013). Factors such as high predator pressure on reindeer pasture land, climate change, land conflicts, and powerlessness in connection with exploitations all create feelings of stress, hopelessness, and worries about the future. Young adults particularly are concerned about the conditions for continuing with reindeer herding and about losing their Sami identity (Daerga 2017; Kowalczewskia and Klein 2018; SANKS 2017; Omma 2013).

Many young Sami experience ethnic discrimination in Sweden, which may result in increased stress and mental distress. There is a lack of understanding concerning Sami mental health issues in healthcare institutions and people may feel that they have to defend their Sami identity when seeking healthcare, or hide their needs. There is also a lack of confidence in governmental institutions in general, mainly because of historical abuses and limited self-determination (Omma 2013; Sametinget 2016). Religious repression, displacements, nomadic schools, racist ideologies, environmental degradation, and the gradual loss of the Sami language has contributed to what has been defined as historical trauma (Sametinget 2016; SANKS 2017; Lindmark and Sundström 2016; Labba 2020).

Having particularly low trust in healthcare institutions, some reindeer herders use their own remedies before turning to medical healthcare institutions. They “have confidence in traditional medicine and household remedies, which might conflict with the evidence-based medical approach of the Swedish health care system” (Daerga et al. 2012: 521). Many Sami also feel that healthcare personnel lack knowledge about Sami culture and lifestyle (Daerga
2017; Stoor et al. 2015). In addition, mental ill-health can be stigmatising from a Sami perspective and to talk openly about one’s own illness is considered inappropriate and can be experienced as exposing oneself to others. People may therefore instead use an indirect and coded language, as if speaking in riddles (Daerga 2017; Miller 2015; Sametinget 2016). Discussing these issues with a female nurse of Sami origin who worked in a primary healthcare centre in a small town in Sápmi, she claimed that expressions of mental health problems are today changing among the Sami:

Reindeer herders really have the toughest job in the world. A family needs to have two incomes, one from reindeer herding and one from another job, to make ends meet. When it comes to mental ill-health, there is a culture of silence and you should never complain. It’s the same for both men and women. On the other hand, this is changing now among the youth. They have begun to say, “we don’t feel well”. Now they are talking about [the problems with] suicide. That was not the case a few years ago.

The traditional Sami health concept has a broad meaning and is related to other family members, fellow members of the Sami village, domestic animals, reindeer, and nature in general. The extended family generally plays an important role for wellbeing, as well as Sami cultural identity. The nurse quoted above explained:

Sami culture is important. It keeps us together. It’s the language and all the stories we have heard from family members, and handicraft, especially the making and the wearing of the kolt [traditional dress]”. Yoiking [singing/chanting] is also important. Through yoiking you can also express how you really feel. It can be sorrow. It can be happiness.

She also claimed that among some reindeer herders, well-being was dependent on good relations with spirits in nature known as “the little people,” who were also the protectors of places:

To have reindeer luck, to be sure that the reindeers will thrive and grow, you have to respect småfolket [“the little people”]. You cannot just throw away things in nature. It’s bad luck. Bones and offal should carefully be placed in the forest. In the old days, you had to ask småfolket before you built a house in a certain place.

Especially among Sami reindeer herders, a healer, known as reader, gunsttar, guvlar or noaidi/ nåejtie, who may use telephone conversations, prayers and various physical techniques and objects, including neo-shamanic practices, may well be the first choice when facing mental or bodily afflictions. People are generally reluctant to talk about these healers and their healing methods with outsiders and biomedical personnel (Daerga 2017; Eriksson 2018; Langås-Larsen et al. 2018; Miller 2015; Helander-Renvall 2010; Skott 1997). A female physician who worked in a healthcare centre in Sápmi, and who was of Sami origin and spoke the Sami language, said that it was common to use alternative, non-biomedical treatments:

This is Norrland [Northern Sweden]. People go here and there, but it’s nothing they talk about. I grow up here. I know what’s going on and I know that some look for alternative treatments. Sometimes people tell me. I don’t decide over anyone and I reject nothing. But it’s not anything I record and register. I just say, “it’s your choice, do as you please”. The reason that people don’t want to talk is also because of all the bad [historical] things that have happened here. Some researchers talk about a cultural trauma.
Among the Sami, there are various non-scientific explanations for illness, particularly among some reindeer herders. A person for example, may lose his/her soul and may die if a “death bird” (guottalvis) picks up one of his/hers personal belongings, such as hair, a piece of clothing or shoe bands, and carries it to the graveyard (Beach 2001: 113). A force known as the evil ear, onda örat, which is said to exist everywhere, hears if someone jokes about illness and may cause illness or other affliction if a person says something disrespectful about someone else (Skott 1997: 210f). Illness may also be the result if a person has “provoked an affliction on someone” or “satt ont på en”. In addition, people sometimes have experiences that can be seen as indications of mental ill-health from a non-Sami perspective. Some may experience foreboding, see and hear deceased persons (Stoor 2015: 32), and develop relations with spiritual beings known as katniha or gufttar (Skott 1997; Helander-Renvall 2010). The Sami nurse quoted above said that foreboding in particular was common:

Many Sami experience foreboding. My mother had it. She was warned when something was going to happen. She could hear a tree falling, but it did not fall. She could see black shadows running. The spirits warn you that something is going to happen. It’s not strange or scary. If a Sami patient who suffers from mental ill-health tells me this, I will understand. I could ask “did you invite them [the spirits]”. A [non-Sami] psychiatrist would just say that the patient is mentally ill.

Possible Interventions: The anthropologist as mediator

The two case studies discussed here highlight the complexity of mental ill-health and how meanings, perceptions, and ideas concerning illness causation and health are interrelated with, and affected by, larger societal forces and conditions. The cases also point to the multifaceted, holistic, and interrelated approach needed to face mental health issues relative to interacting with social, historical, political, and economic processes.

In the case of the Sami people in Norway, researchers have identified social and extended family networks, Sami language competence, yoiking, knowledge of reindeer herding, ecological knowledge, and involvement with nature as protective factors and as contributions to wellbeing and resilience among Sami youth (Nystad et al. 2014), and there have been attempts in the direction of more holistic healthcare methods. The Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse, SANKS, has developed miljöterapi or environmental therapy, which takes place in people’s home or at the workplace such as in the reindeer corral, with an emphasize on physical activities, seasons changes, and Sami values and identities. These activities may also be part of more targeted efforts on suicide prevention and programmes to limit the exposure to violence and discrimination, and to strengthen identity, self-determination and diversity (SANKS 2017; Mikkola 2019; Finnmarkssykehuset 2019).

Generally speaking, the two cases discussed above show the need for an anthropologically informed, holistic, non-essentialist, and inclusive approach to cultural competence that takes into account the effects of existential, religious, social, physical, historical, political, and economic processes and their effect on individual mental health. This also includes how these processes are interrelated. Healthcare units wanting to work with this kind of holistic approach will benefit from having stipulated, feasible, and inclusive institutional policies of diversity, equity, social justice, anti-discrimination, anti-marginalisation, and anti-racism. To
build trust and reduce stigma attached to psychiatric institutions particularly, the healthcare infrastructure should be flexible and adapted to meet the needs of individuals.

In both psychiatric institutions and primary healthcare, this would imply an anthropologically informed, explicit power-sharing policy where minorities, indigenous people, ethnic communities, religious, and secular organisations and congregations are involved in policy making, decision-making, planning and the delivery of mental health services (Garneau and Pepin 2015; Kirmayer 2012a). Moreover, adapting mental healthcare to the needs of patients would include practical efforts. This could be for example, to allow flexible visiting hours in psychiatric clinics/wards to facilitate group praying, or making space for prayer or healing, as well as creating flexible opening hours at primary healthcare clinics.

The Swedish Psychiatric Association in Sweden has published guidelines in transcultural psychiatry, including information about training resources and courses (Svenska psykiatriska föreningen 2018). Some caregivers in transcultural psychiatry also use the Cultural Formulation Interview, CFI, which is included in the DSM-5 (Diagnostic and statistical manual of mental disorders, 5th Edition, American Psychiatric Association 2013). This patient-centered, transcultural interview guide consists of a number of open-ended questions focusing on the patient’s experiences, perceptions, expectations, and networks. The CFI is recommended by the Transcultural Center, Stockholm County Council (Transkulturellt centrum 2020; see also Bäärnhielm and Mösko 2012). However, according to Bäärnhielm and Sundvall (2018: S11), in actual practice, there is seldom time to work with the CFI in a proper way and clinicians cannot fully “grasp the meanings patients give to illness and life situations and their expectations of care. … time is often considered too short for a proper assessment, especially an assessment involving the patient’s perspectives”.

To take advantage of the CFI, primary healthcare clinics and mental healthcare institutions may use cultural mediators. They have been known to play an important role in therapeutic encounters (Schouler-Ocak et al. 2015; Kirmayer 2012a; Kirmayer et al. 2014). These mediators may advantageously be anthropologists as they are “guided by multiperspectivity, which allows them to make sense of the world from the point of view of various actors” (Podjed et al. 2016: 61). Moreover, in clinical settings the anthropological focus on context and lived experience have shown to be important for understanding the patient’s health behaviour and the patient’s ability to understand health information (Lane et al. 2017). Anthropologists working with clinicians may also improve healthcare in general by creating knowledge of, and an understanding for, multiple perspectives and mixed research methods (Deitrick et al. 2010).

Given sufficient time and resources, an anthropologist who takes the role of a cultural mediator may create the conditions for effective, trustworthy, responsive, inclusive, and individualised culturally competent mental healthcare that does not stereotype patients. He/she may also timely organize culturally competent techniques and therapies and an open safe space for encounters, dialogue, critical thinking, mutual understanding, and reciprocity. In this role in a primary healthcare clinic or psychiatric ward, the anthropologist may cooperate with clinicians and patients to promote healing, resilience and hope, create patient-centred and power-sharing healthcare encounters, mediate between different perspectives and treatment options, and take advice from religious/spiritual practitioners and healers when needed.
By working together with the anthropologist as cultural mediator, clinicians would also be supported to develop open, humble, and respectful ways to tailor mental healthcare to individual needs. The caregiver, patient, and anthropologist may thereby personally and jointly participate in a sensitive therapeutic relationship, learn from each other, and discuss religious, spiritual, existential, social, political and economic issues. With this engagement in the patient’s life-worlds, clinicians may also broaden their horizon concerning their own values and perceptions. In so doing, they can develop self-reflexivity, empathy, and an awareness of differences and similarities concerning notions, expressions, and explanations for mental distress (Kirmayer 2012a; Garneau and Pepin 2015; Schouler-Ocak et al. 2015).

In this model, the anthropologist as cultural mediator works together with the patient and the caregiver to understand and make sense of afflictions from an emic, insider’s, perspective, with a particular focus on illness perceptions, family, work and social networks, and in relation to larger socioeconomic and socio-political forces and processes. Furthermore, with this holistic and eclectic approach, there is an emphasis on engagement in the patient’s life-world and an aspiration to inquire into what is at stake for the patient and what matters most, with an awareness that cultural processes are diverse, ongoing, flexible and inseparable from religious, political, social and economic conditions (Kleinman and Benson 2006).

Working together with the CFI, cultural mediators/anthropologists, clinicians and patients can also jointly develop the patient’s narrative/life-story. With a focus on ideas, perceptions, and meaning, they may discuss, together and on equal terms, individual or group health-promoting resources involving for example, community and diasporic networks. This dialogue may also include illness explanations, symptom presentations, non-biomedical alternative treatments and healing, psychosocial stresses, the effects of migration, discrimination and racism, and the importance of family and social networks. In cases where religion or spirituality seems particularly important in the patient’s life, the clinician, patient, and mediator could also together find out ways to integrate religiosity and spirituality into the treatment plan to enhance recovery, healing, and resilience.

Possible interventions: The anthropologist as educator

Anthropological education, with its focus on anthropological theory and ethnographic methods, may be a valid and useful complement to existing Swedish transcultural psychiatric educational efforts (Svenska psykiatriska föreningen 2018; Bäärnhielm and Måsko 2012). This is especially true for primary healthcare clinics and psychiatric wards that want to promote a holistic, self-reflexive, and non-essential view of cultural competence. Such initiatives could include a series of occasional lectures at the workplace, or possibilities to take part in more extended university courses in anthropology (ideally through workplace authorized paid leave).

As such lectures and courses emphasise openness, flexibility, and self-awareness, they will also encourage the caregiver to reflect upon his/her own identity, attitudes, and perceptions. Consequently, as the clinician gradually occupies an open-minded, reflective, and curious position, an awareness of his/her own prejudices, biases, and stereotypes is acquired. Teaching that includes role-playing, drama, ethnography, and fictive patient encounters can be particularly useful in this context (Skott et al. 2013).

Mental healthcare policymakers may also benefit from the suggested lectures and courses. They would acquire a more holistic understanding for policymaking which in turn
will make them better equipped to understand policies in relation to issues such as mental health inequalities, racism and intolerance. Consequently, they would also be better prepared for unexpected and unintended consequences of policies and interventions (Bernstein and Razon 2019; Farmer et al. 2013).

Mental healthcare practitioners and policy-makers would particularly benefit from lectures and courses in medical anthropology as they commonly focus on a broad understanding of illness, health and healing, as well as both emic (insider’s) and etic (outsider’s or comparative) perspectives. Over the years, I have myself been teaching medical anthropology at healthcare units, workplaces, and universities in Sweden and abroad, focusing on illness and health in a comparative perspective as well as on how illness perceptions influence and shape the experience of health and illness in relation to social, economic, religious, and historical processes. Teaching has also included how historical injustices and structural discriminations may generate social, political, and economic inequalities in relation to inequalities in health. This has also included factors that contribute to good mental health (Kirmayer 2012a, 2012b; Garneau and Pepin 2015).

In the educational efforts for mental healthcare practitioners outlined here, participants would acquire an insight into indigenous worldviews, which in turn could help them to question taken-for-granted biomedical and Western concepts, including models of the body, self, soul, and social relations. Students may thereby begin to critically reflect on how mental health is understood and how mental health problems are treated in biomedicine and psychiatry, and acquire an understanding for healing in a broader perspective and “universal logics of causation (jealousy, magic, sorcery, contagion, possession, etc.)” (Miklavcic and LeBlanc 2014: 123; cf. Kapferer 2003).

By using patient/client-centred teaching material and case studies that encourage empathy, sensitivity, respect, curiosity, and wonder, a non-essentialist and non-stereotyping view of cultural competence is promoted. This may contribute to a more holistic understanding for issues such as religion/spirituality and non-western medicine/healing, and encourage the empowerment of patients. Accordingly, this may also help to develop an understanding for healing, religion, and spirituality as resources to promote resilience, hope, perseverance, and agency (Whitley 2012; Schouler-Ocak et al. 2015; Kirmayer 2012a, Kirmayer et al. 2011; Wedel 2004). Using a theoretical framework based in medical anthropology, this also contributes to an ongoing two-way learning where biomedical and psychiatric notions and practices may be discussed, problematized, and challenged. Critical concepts and ideas in this educational process may include the individualisation of mental ill-health, morality in caregiving, mind-body dichotomies, caring vs curing, healing of illness vs curing of disease, placebo/nocebo effects, medicalisation, ethnocentrism, and the universal validity of psychiatric categories (Good 1994; Kleinman 2012; Moerman 2002; Gadamer 1996).

**Concluding remarks**

In this article, I have discussed how an anthropologically informed view of cultural competence may contribute to addressing mental distress and offer appropriate mental healthcare in diverse settings using two case studies on mental health from Sweden as examples. Acknowledging the differences and variations in people’s values, attitudes, and behaviours, as well as in relation to the larger social order, I have argued against an oversimplified, undifferentiated, and essentialist view of cultural competence in mental
healthcare. Moreover, by giving suggestions on how an anthropologically informed, holistic, inclusive, non-essentialist, non-stereotyping, contextual, flexible, and multifaceted approach to cultural competence in mental healthcare may deal effectively with patients from various backgrounds, I have envisioned how an anthropologist may help to mediate between perspectives and contribute to reflective teaching and education in mental healthcare.

The two ethnographic cases discussed here which are based on the experiences of the Somali-Swedes and the Sami people, not only show the need for a culturally competent, sensitive, and holistic approach to understand and deal with diverse mental health problems; they also indicate the importance of bridging the gap between biomedical and non-Western perceptions, explanatory models, and notions of illness causation (Wedel 2009; Kleinman and Benson 2006).

The concept cultural competency has been criticised and sometimes understood in an essentialist and simplistic way in mental healthcare. If the term is to be used in the future, it should be understood and applied from an anthropological standpoint and based on a holistic, non-essentialist perspective, and a critical self-reflective position. Used in this way, it also encompasses the term cultural safety and related concepts as it emphasizes self-reflection and listening to patients, as well as the complex social, historical, political, and economic circumstances creating and contributing to power imbalances and indigenous and ethnic inequalities (Curtis et al. 2019; Kirmayer 2012a).

Acknowledgements
Research was funded by Ekhagastiftelsen, Åke Wibergs stiftelse, and the Swedish Research Council for Health, Working Life and Welfare.

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Rapid and Focused Ethnographies to Decrease Tensions in Guinea’s Ebola Crisis

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ABSTRACT This article is based on the personal experiences of the author as an anthropologist working for the WHO during the West African Ebola Virus Disease (EVD) outbreak between 2013 and 2016. As in earlier outbreaks in Central and East Africa, interventions by local and international institutional actors to control the EVD outbreak in West Africa faced resistance from populations, thus contributing to the spread and persistence of the epidemic. Distrust of health workers – sometimes resulting in aggressive attacks – presented an extreme challenge to the Ebola eradication initiative. Faced with a highly volatile situation, various international organisations decided to employ social scientists and particularly applied anthropologists, to help facilitate communication between the EVD response teams and the affected populations. By describing specific cases where anthropological methods – specifically, rapid and focused ethnographies – contributed to the progressive subsiding of reluctance to EVD interventions in the prefecture of Kindia, Guinea, the author demonstrates how these tools can be effective methods for anthropologists to contribute to managing severe public health emergencies.

Keywords: Applied anthropology, rapid and focused ethnographies, Ebola, public health emergency, Guinea

Introduction

During the Ebola outbreak in West Africa from 2013-2016, the response from the anthropological community was one of the most rapid and expansive anthropological interventions made to a global health emergency in the discipline’s history (see Abramowitz 2017; Venables and Pellecchia 2017). As in earlier outbreaks in Central and East Africa (Hewlett and Hewlett 2007), interventions by local and international institutional actors to control the outbreak in West Africa faced resistance from populations, thus contributing to the spread and persistence of the epidemic. Distrust of health workers – sometimes resulting in aggressive attacks – presented an extreme challenge to the Ebola eradication initiative (see Niang 2014; WHO 2015; Coltart et al. 2017; Chandler et al. 2015). Faced with a highly volatile situation, various international organisations (e.g., WHO, UNICEF, Médecins Sans Frontières [MSF]) decided to employ social scientists and particularly applied anthropologists, to help facilitate communication between the Ebola Virus Disease (EVD) response teams and the affected populations (see Niang 2014; Anoko 2014; Amalaman et al. 2017; Wilkinson et al. 2017).

The overall aim of the article is to show the usefulness of applied ethnographic methods when there is a demand to produce results and useful advice during a very short timeframe. The fieldwork methods known as ‘rapid and focused ethnographies’ (cf. Trotter et al. 2015; Vindrola-Padros and Vindrola-Padros 2017; Gove and Pelto 1994) carried out by the author...
during the EVD outbreak in 2015, are the particular focus of this article. I will first provide a short introduction to the problem and the field site, and then discuss the methodological challenges and how the methods were applied during the Ebola crisis. I used these methods as part of a consultancy assignment carried out for the WHO on social mobilisation and community engagement in controlling the EVD in Guinea. As I will show, I consider rapid and focused ethnographies to be effective and workable methodological tools during a severe public health emergency. I base this argument largely on two cases where anthropological methods contributed to the progressive subsiding of reluctance to EVD interventions in the prefecture of Kindia, which is in the center of Guinea (Figure 1).

Background

The largest EVD outbreak in history severely affected three West African countries – Liberia, Sierra Leone, and Guinea – from 2013 to 2016. By March 2016, there were more than 28,646 official cases of EVD and over 11,323 deaths worldwide. On June 1, 2016, the WHO declared the end of Ebola virus transmission in Guinea. Guinea was the country in which the outbreak (2013–2016) originated. By June 2016 Guinea had 3,355 confirmed and 456 probable cases, including 2,544 deaths (Keita et al. 2017).

During the first three months of the EVD epidemic, between late December 2013 and March 2014, the disease was new and unknown to the local communities, and many people started to attribute it to occult-related forces (i.e., sorcery, retaliation of ancestors) and curses laid on the affected families (Ouattara and Århem 2020). Initially, health workers investigating the deaths in the village of Meliandou where the outbreak originated, wrongly concluded that there was a cholera outbreak in the village (Ouattara and Århem 2020).
When the inhabitants of villages surrounding Méliandou started to accept that it was in fact the Ebola virus that was causing the deaths, they started to fear Méliandou and its inhabitants. The neighbouring villages interpreted Méliandou’s misfortune as something that the village had brought upon itself and cut off many of the roads and bridges to the village (see Fairhead 2016; Ouattara and Århem 2020).

After the formal declaration by the Pasteur Institute in France on 21 March 2014, that these deaths were caused by Ebola, the discourse stemming from the authorities rapidly became focused on the epidemic (see Faye et al. 2016). The NGO Medicines Sans Frontiers (MSF) helped Guinea’s Ministry of Health to establish an Ebola Treatment Center in the village of Macenta. People showing symptoms were transported to this location. As a result, youths in Macenta demonstrated en masse and attempted to destroy the MSF installations and attack the fifty or more expatriates working there, some arguing that Ebola was false or spread by outsiders (Anoko 2014; L’Obs 2014).

The discrepancies between professional/governmental, international institutions, and NGOs views of the epidemic and those of local populations initially led to some tragic events. In the village of Womey (see figure 2) eight members of an EVD prevention team were brutally murdered in September 2014 (see Bizot 2014). Resistance also escalated in the capital Conakry and the nearby prefecture of Forécariah and Kindia. Two members of the Ebola response teams were killed in Conakry in January 2015, as well as two police officers accused of spreading Ebola in Forécariah. In sum, an atmosphere of fear existed during the initial months of the outbreak in Guinea, and the EVD response team had two ‘enemies’ to face: first, the EVD; and second, the tensions and interpretations surrounding the Ebola response.

![Figure 2](image_url)
In this atmosphere of health crisis characterised by the fear and mistrust of the local population, anthropologists were deployed to facilitate communication between the EVD intervention teams and the affected communities. In other words, the goal was that the anthropologists would help to quickly find solutions for diminishing the resistance. This became clear as soon as I arrived at the WHO’s local office in Conakry. My supervisor, who was the Coordinator of Social Mobilisation and Community Engagement for the World Health Organization (WHO) in Guinea, said: “Syna, we are not asking you to offer us anthropological theories. What we need is practical solutions that can help stop the epidemic”.

Given the need to produce results and practical advice within a short timeframe, long-term participant-observation was not possible. It was necessary to put in place a method that suited the short timeframe and objectives of the intervention. I now turn to the methods used, namely rapid and focused ethnographies.

**Rapid and Focused Ethnographies**

In 1988, anthropologists Susan C. Scrimshaw and Elena Hurtado asked, “Must one spend a year in the field collecting ethnographic data in order to make useful recommendations for a health program?” (Scrimshaw and Hurtado 1988: 97). Since then, applied anthropologists have responded to the limitations of both surveys and classic ethnographies by developing ethnographic methods which are highly focused and intended to produce systematic data in a short period of time. These approaches aim at generating data which are easily accessible to development programme planners. They include rapid ethnography (see Beebe 2001; Reeves et al. 2013; Isaacs 2013; Trotter et al. 2015; Vindrola-Padros and Vindrola-Padros 2017) and focused ethnography (see Gove and Pelto 994; Higginbottom et al. 2013; Andreassen et al. 2020).

Rapid ethnographic research, broadly understood, is an approach whereby fieldwork is undertaken in a short and well-defined timeline (Reeves et al. 2013). Rapid ethnography (RE) consists of short cycles of in-depth interviews and observations at key time periods. The following terms indicate RE in applied health research contexts: ‘quick ethnography,’ ‘rapid ethnographic assessment,’ ‘rapid assessment response and evaluation,’ ‘rapid assessment procedures,’ and ‘focused rapid ethnographic procedures’ (see Isaacs 2013; Trotter et al. 2015; Vindrola-Padros and Vindrola-Padros 2017; Sangaramoorthy and Kroeger 2020).

RE requires extensive prior knowledge of the cultural setting and the social, political, and economic context, as well as prior knowledge of all of the important sectors contributing to the problem, from which researchers can draw representative samples of key informants and focus group respondents. This assessment can be made either by ethnographers familiar with the setting or by an interdisciplinary/intersectoral team responsible for the study and its uses (Trotter et al. 2015).

Challenges facing RE approach include the need to develop an accurate understanding of the problem and its context in a relatively short and cost-effective time period, the need to have systems for transforming the data into satisfactory solutions, and the need to produce socioculturally acceptable solutions (see Trotter et al. 2015). Rapid ethnography within applied health research have been criticised for reducing ethnography to a series of observations and not engaging the socio-political dynamics of knowledge production deeply (see Ingold 2014; Jowsey 2016).
Focused ethnography (FE) refers to a specific methodology that was developed initially at the WHO for the Programme for the Control of Acute Respiratory Infections (Gove and Pelto 1994). FE emerged as a methodology to answer specific sets of questions that are required by agencies, policymakers, program planners or by project implementation teams, in order to make decisions about future actions regarding social, public health, or nutrition interventions, and for public–private partnership activities (see Roper and Shapira 2000; Vougioukalou et al. 2019). Unlike classic long-term ethnography, FE explores a specific phenomenon, issue, or problem within sub-cultures and among small groups of people and is often used as an applied research approach to open up strategies for problem solving (Roper and Shapira 2000; Andreassen et al. 2020). In FE, the preparation phase is relatively long. Extensive background research prior to entering the field is essential as a relatively short time is spent in the field and observations have to be focused (Higginbottom et al. 2013). Thus, focused ethnography is a suitable tool for researchers who have prior practical experience or are otherwise embedded in the locality of the research (Andreassen et al. 2020: 298).

In focused ethnography, interviewing becomes a way to get participants’ perspectives on what is happening. FE implies confirming observations through interviews, as well as collecting data on issues and phenomena that cannot be or have not been observed, including attitudes and feelings (Higginbottom et al. 2013; Andreassen et al. 2020). As in classic ethnography, the analytical steps in FE are characterised by identifying, collecting, and classifying the data and then progressing and creating generalisations and explanations of patterns. However, whereas classic ethnography makes use of a very open and exploratory analytic approach (Reeves et al. 2013), focused ethnography entails finding answers to the specific problem-oriented research questions posed by a governmental or non-governmental organisation, with the goal of offering specific recommendations (see Roper and Shapira 2000; Andreassen et al. 2020).

As I note above, both RE and FE are ideally based on extensive prior knowledge and research experience. In addition, many social scientists consider rapid ethnography and focused ethnography complementary, each method making up for the limitations of the other (Whyte and Alberti 1983; Inhorn and Brown 1997). Finally, RE and FE have also been subject to scholarly critique. For example, anthropologists Cecilia Vindrola-Padros and Bruno Vindrola-Padros (2017: 8) suggest that “future rapid ethnographic research needs to develop more robust processes for the reporting of study designs and findings and place greater emphasis on reflexivity”.

The Guinea EVD Mission
My main responsibility was to support the EVD Response Teams in the Prefecture of Kindia through the application of ethnographic methods to understand the factors that drove the spread of EVD in Guinea and resistance to EVD interventions. The terms of engagement for my three-month assignment stipulated:

In collaboration with the Ministry of Health, under the supervision of the WHO Country Office and the WHO team leader of the outbreak response team, the medical anthropologist will conduct the following activities: Join a medical intervention team and assist in efforts to control the outbreak; carry out investigation that will help to better understand the local cultural attitudes toward Ebola; identify beliefs and practices that may amplify or help control the outbreak; identify and incorporate local beliefs and practices into appropriate and
safe patient care and response efforts; contribute to conducting ecological studies in relation to primary cases, if possible, to identify the natural source of the Ebola virus; investigate social and anthropological issues that would support a better understanding of the outbreaks of Ebola; investigate cultural and social norms within communities that will contribute to developing better rapport and trust within the community; and support the Ministry of Health in documenting the anthropological aspects of the Ebola outbreak.

In other words, the expectations surrounding my contribution to a better understanding of and response to, the outbreak of Ebola were very high, especially considering the short time that I had for my assignment. To provide practical recommendations, it was necessary to quickly find answers to the following questions: What do affected populations think and feel about the EVD and its response teams? What beliefs and practices in the communities amplify the outbreak? What practices in the communities can enhance the efforts to control EVD? What beliefs or practices of the EVD response teams amplify the outbreak?

**Outline of the Mission Methodology**

The WHO mission was conducted in several phases. The first step was documentary study and exploratory interviews in Conakry (2 days) and in Kindia (1 day). Here the most important steps were: first, planning of the fieldwork in the affected communities; second, fieldwork and data analysis; and third, presentation of the results at the Prefectural EVD Coordination Cell daily meetings.

Planning the fieldwork in the affected communities included identifying key trusted community leaders in the study location, such as leaders of local government authorities, communal authorities, healthcare facilities, socio-cultural organisations, traditional and religious organisations, youth associations, women’s associations, etc. This was followed by presenting the purpose of the mission to these trusted community leaders, to get their
approval of the mission. After this, a date for conducting the fieldwork was decided. Meetings with these leaders also included discussions on expected support from them for carrying out the fieldwork. Overall, the duration of planning for fieldwork varied from 2 to 7 days.

The fieldwork involved interviews and observations. I used both RE and FE, which included formal, informal and semi-structured interviews. The fieldwork aimed at identifying the reasons behind peoples’ unwillingness to comply with the efforts for EVD control, community health needs, and community health facility use. Determining which specific villages and communities were at a high risk of being reluctant to interventions was important, as was targeting interventions in the early stages of the EVD epidemic and developing a rapid assessment tool so that these communities could be prioritised for prevention programs. I conducted in-depth interviews with members of affected communities, as well as with several members of the Ebola response teams to understand their perceptions of affected communities’ reactions, and the difficulties they faced.

A key element to this rapid and focused ethnographies approach was involving local researchers and actors who understood the realities “on the ground” and could provide useful information concerning the affected communities. I worked with two local sociologists (female and male) as assistants in the field, both of whom had a Master’s degree in sociology and spoke the main local language (Susu). They also spoke Malinké (which I also speak fluently), which was another of the languages spoken by several of our respondents in the field. The interviews were held in Susu, Malinké, or in French, depending on the language spoken by the respondent. I led the interviews, and the assistants took notes. In the cases of Susu, the assistants interpreted. Both of my assistants had been trained in rapid and focused ethnographies methods by one of the WHO’s senior anthropologists. They also had previously worked with the EVD response for UNICEF. When I arrived in Kindia, they were already working with the WHO EVD response teams. They had knowledge of the EVD response as well as local knowledge, which was very helpful. These RE and FE studies varied in duration from 1 to 3 days per setting.

Given the health emergency and insecurity in the country, all WHO staff were asked to be on site in Kindia city before 18:00. Each day, I left Kindia city with my team for fieldwork in villages after the WHO morning meeting, which ended around 7:30 a.m. We had to return to present the results and concrete recommendations at the Prefectural EVD Coordination Cell daily meeting in Kindia, which started at 16:30. This required very rapid and focused fieldwork, and data collection occurred concurrently with data analysis. During the first stage of the analysis, my assistants and I read and discussed the transcription of each interview at the end of each workday. These discussions helped us to build and revise respondents’ explanatory models for EVD and its response efforts as a team. Through this procedure, we were able to understand the problems from an emic, insiders’ perspective, and to prepare the results at the meetings.

The daily meetings provided opportunities for regular acquisition and transmission of information, especially on the planning activities with a special focus on the difficulties encountered by the EVD response teams in the field. At each meeting, the chairperson allocated speaking time systematically to me, for the daily fieldwork results and for anthropological discussions and analyses. These presentations also included the recommendations of the day. At these meetings we generally presented our daily findings in the form of quotations (on 1
to 3 slides) from key informants’ interviews, and images from the field. These results were useful for strengthening risk communication and further developing the response efforts.

As mentioned, I was deployed in the prefecture of Kindia which has nine sub-prefectures or sous-prefectures. I worked in all these sub-prefectures, although I spent most of my time in the sub-prefecture of Samayah. The main reason for this was that at the time of my deployment, the community’s resistance to the EVD response teams was greater in the Samayah sub-prefecture than in other Kindia sub-prefectures. I will mainly focus on my work in Samayah, which is located 44 km from the urban commune of Kindia.

Before conducting fieldwork in affected communities, I found it important and valuable to carry out in-depth interviews with several members of the Ebola response teams. My aim was to rapidly get a general overview of their perceptions of the affected peoples’ reactions and the difficulties they faced. This data informed my more-focused fieldwork in affected communities. Below, I present some voices from these in-depth interviews. The respondents mainly focused on communication problems and lack of transparency regarding what was taking place in the Ebola Treatment Centers. This was especially a problem during the initial months of the epidemic.

Voices from Some Members of the EVD Response Teams in Kindia

I focused my first interviews on staff who had extensive experience in the EVD response. During my first interview with my two assistants, who were members of the social mobilisation and community engagement team, one of them pointed out that the EVD was not the problem but rather the way it was managed. He explained:

Communication was faulty from the start. People have been told there is no cure or vaccine for the EVD. So, they say to themselves, if the disease is incurable, why should I go to a hospital or ETC [Ebola Treatment Center]? When you enter an ETC, you never come out alive. He continued:

The staff of the Red Cross was well received at the beginning of the EVD. But everything changed in a bad direction after there was a hostile situation between them [the Red Cross] and local communities in Forested Guinea [Figure 4]. There was a death in a village and the villages contacted the staff of the Red Cross. They came and initially said that it was not a case of EVD, and the family proceeded to the burial. Two days later, they came back and said that it was a case of EVD and that all members of the deceased’s family had to be quarantined. There was panic in the village! Some members of the deceased’s family fled, and those who were taken to the ETC did not return at all [i.e., they died in the center]. But those who escaped [the Red Cross intervention effort] came back safely to the village.

These problems with early communications, contradictory messages, and missteps were among the factors that made people distrustful and fearful of health workers and ETCs. Fear and mistrust of healthcare workers and the ETCs negatively affected the EVD efforts. A nurse who worked in an ETC reported that in the initial months of the epidemic most of the EVD patients refused to consume the drugs prescribed to them. They also refused to eat the food, as they thought the drugs and the food were contaminated and that the ETC personnel wanted to kill them by poisoning them.

Interviewees also mentioned the lack of transparency regarding the ETCs – people simply did not know what happened to relatives taken to the center. This lack of transparency created distrust between affected communities and the EVD response teams. A doctor who
worked in an ETC stated that at the beginning of the EVD, people were not allowed to see the bodies of their loved ones who had died from Ebola. He also explained that often, bereaved families were not even informed about the location of the buried corpses.

A hygienist told the following story:

A woman from the city of Faranah, Upper Guinea, was admitted to the ETC. When her brother came to enquire about her health condition, he was told that his sister was dead. He asked them to inform him about when the Red Cross agents would bury her and went home. However, the ETC staff forgot to inform the Red Cross agents about this. By the time the man returned to the ETC with a cross to place on the grave of his sister, the funeral was already finished. The saddest part was that no one could show her grave to him, so he left the ETC frustrated.

People did not know what happened to their relatives who had been taken to the centers. Doubt and distrust also emerged when people did not see the bodies of their loved ones and did not know where they were buried.

Using RE and FE, I quickly listened to several key persons and gained important insights into the interrelated problems. These could be summed up as the following: first, faulty early communication and missteps; second, lack of information to affected communities about ETC and caregiving to EVD patients; third, lack of transparency concerning several activities of the EVD efforts (such as a safe and dignified burial); and fourth, lack of confidence in local authorities and EVD response teams, which probably contributed to the creation of mistrust and fear. Mistrust and fear contributed to the resistance of the
affected communities against the EVD response teams and a lack of trust led some affected persons to avoid seeking medical help for suspected EVD. There was reluctance to engage in surveillance and contact tracing, as well as avoidance of the WHO’s ‘safe and dignified burial’ activities (described in WHO 2017).

Case 1: Applying Rapid and Targeted Methods to Rebuild Trust Through Stakeholder Engagement

In Samayah, nurses working in the sub-prefecture had been chased away by the inhabitants of the village and the sub-prefecture was ‘cut off’ from the rest of the world. The community’s resistance to efforts to prevent and response to EVD was particularly acute and required rapid solutions.

Before my deployment in the field on March 2015, an EVD Response Team went to the village of Samayah on December 31, 2014, to undertake a ‘safe and dignified burial’ of the body of a suspected Ebola victim, following the WHO burial protocol (WHO 2017). A group of young people chased the team away from the village. After this incident, Samayah and several villages in the sub-prefecture were in a kind of self-quarantine. The inhabitants of numerous villages including Samayah controlled all the entrances and exits to and from their villages. This caused the Guinean Government to install two mobile security teams and reinforce prefectural security to protect the EVD response teams (OMS 2015). However, after three months, the national newspaper *Guinée Matin* reported:

The two health workers who served in the Samayah sub-prefecture were hunted down and attacked by the population who considered them ‘accomplices’ of the Ebola awareness agents. Their motorbikes were confiscated by the mob. The health workers were able to escape and ‘take refuge’ in the town of Kindia. (Guinée Matin, 2015, my translation)

Faced with persistent active resistance in Samayah, the coordinator of the Kindia Prefectural EVD Coordination Cell asked the team of WHO anthropologists (led by me) to intervene. Given the urgency of the situation, we used rapid and focused ethnographic methods to investigate. The purpose was to listen to the community leaders and quickly find an adequate solution that would mitigate the reluctance of the local population to allow EVD work.

We began by locating and interviewing the two health workers from the sub-prefecture who had been attacked by the inhabitants. After this, and in collaboration with the mayor and the prefect of the city of Kindia, we identified and contacted (by phone) several key persons (the sub-prefect, the mayor, the heads of districts, and the customary leaders) in the sub-prefecture to organise a “mission” to Samayah. One of the conditions demanded by all these key persons was that the security forces (police, gendarmes, or military) should not escort us (my two assistants and I) to the sub-prefecture. We agreed to this demand. During my conversation with the sub-prefect concerning the mission, I asked him to describe the balance between the different social groups. A sample matrix with a list of social characteristics (e.g., districts and the customary leaders, traditional medicine practitioners, hunters, religious leaders (Christians and Muslims), schoolteachers, women leaders, youth leaders was created by the sub-prefect.

Upon arrival in the village, I first conducted an interview with the sub-prefect and the

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1 A contact is any person who had physical contact with a case (alive or dead) or the bodily fluids of a case within the last three weeks. A contact has no signs of the disease. Physical contact includes sharing the same room/bed, caring for a patient, touching bodily fluids, or closely participating in a burial (WHO 2014).
During this interview, the sub-prefect emphasised the widespread disbelief among the villagers, telling us, “I believe the disease exists, but a large part of the population does not believe, because they have never seen an Ebola patient”. After our meeting, we were taken to the public square by the mayor, where 32 persons of different ages, genders and sociocultural groups (10 male and 22 female) were waiting for us. The composition of this group reflected the fact that most of the resistance towards EVD efforts in the prefecture of Kindia was led by women and youth.

I started the conversation in French (translated into Susu by one of the assistants) with questions about income-generating activities in the sub-prefecture, followed by questions focused on socio-cultural activities. After a general overview of the economic and socio-cultural activities, I focused on local understandings of the Ebola epidemic, prevention, and control of the EVD; accounts of the way public health interventions to control the epidemic were perceived; rumors concerning the EVD; and (concrete) proposals for a rapid eradication of EVD. I began the discussions about Ebola with the following words: “We want to know, what do you think about the Ebola problem? What makes you angry, hurts your dignity and what are your deepest feelings? What the EVD response teams done or said that shocks you?”

Most of the participants claimed that EVD probably did not exist, because there had never been a case of Ebola in Samayah. For example, a woman alleged:

No one can tell me that Ebola exists. My father massaged and fed my brother-in-law when he was sick. He was later declared dead from Ebola by the EVD response team. My father also washed his body. My father and I, as well as all the other members of our family, have been living without any EVD symptoms, or any illness for about two months.

One of the religious leaders stated, “This epidemic is the result of divine anger toward humans because humans are increasingly abandoning their beliefs in God. To give us a warning, God has sent a force that sows psychosis and death among us”. A hunter added, “We believe that bush meat cannot be the cause of Ebola because our parents and great grandparents have always eaten this meat without ever getting Ebola”. Another hunter stated, “I am a hunter, my family subsists on that [hunting] and it is through hunting that I make an income. It is this meat that we live on, both for direct consumption and for sale in the market for money”. A traditional-medicine practitioner also related the epidemic to income-generating activities, declaring:

The EVD response teams told us not to receive or treat patients. How do they want us to live without the help that the patients give us? Those who tell us not to work, don’t they work? We know that all members of the EVD response teams, even you [nodding at me], receive money, and lots of it.

A youth leader added:

Even though Samayah houses the two largest hydroelectric dams in the Kindia prefecture, it has never benefited from that: the sub-prefecture is not electrified. There is a lack of potable water. There is no Ebola here in Samaya. What we are fighting for now is water and electricity. Ebola is not a priority for us.

One of the youths asked, “Is the Ebola virus natural or is it created by humans”? Another immediately responded by saying, “It’s a virus created to harm people. The evidence is that
the government has said that in 60 days Ebola will end. So, if the government can specify the end of the epidemic in the country, it means that they control the situation”.

Another area of resistance that participants brought up concerned burials. Community leaders insisted upon dignified funerals. Nobody saw any reason for carrying out burials according to the burial policy stated by the Health Ministry. As one leader of a women’s association emphasised, “We do our funerals as usual”.

In sum, there was a deep lack of trust and numerous respondents did not believe that EVD existed. Several respondents argued that the EVD was a divine punishment for violating traditional values and that it was God alone who could decide the end of the epidemic. EVD was perceived by many as a disease created intentionally by the government in order to make people suffer and for monetary purposes. People described this as “Ebola business”. The official position that Ebola would end in 60 days caused people to see Ebola as a human creation. The lack of electricity and potable water in the sub-prefecture had already created a crisis of confidence which was amplified during Ebola and created a divide between the communities, on the one hand, and the EVD response teams and the country authorities’ representatives (the mayor and the prefect of the city of Kindia, the sub-prefect, and the mayor of the sub-prefecture of Samayah), on the other.

RE and FE are intended to lead to interventions. One of my first recommendations was to continue the ethnographic investigation in all the villages of the sub-prefecture, in order to better understand the causes and factors associated with the lack of trust, reluctance, and denial of the EVD. Together with my assistants, I proposed: firstly establishing ‘listening sessions’ with representatives from several different social/age/gender groups, including women, midwives, and youth; and secondly organising consultation sessions with the customary leaders, to discuss and understand the difficulties that affected communities and make relevant recommendations that would reduce or circumvent reluctance toward cooperation with the EVD response teams. I also recommended undertaking a broad sensitisation and mobilisation program concerning the EVD in this sub-prefecture, with various themes such as safe and dignified burials, management of visitors from the outside, and referral of patients to health facilities. These recommendations were endorsed by the Prefectural EVD Coordination Cell. Samayah was now ‘opening up’ to the EVD response teams.

Case 2: Doing Rapid and Focused Ethnographies in a Hostile Context

The rapid and focused ethnographies methods that my assistants and I used became particularly vital and critical when we decided to go to the village of Maléa on July 13, 2015 to explore the community’s EVD awareness. At the entrance to the village, the road was blocked with a tree trunk and some large stones. As soon as our vehicle stopped, we saw young people coming out from the forest with stones, machetes, cutters, pieces of wood, axes, and batons. They blocked the road and told us to stop our car. Seeing these excited and angry young men, we stopped our car and asked what was going on. One of them explained: “We got a phone call from Conakry saying that the Red Cross agents are coming to our village to spread the Ebola virus”. At this point, we wanted to turn around, but they told us, “No, you cannot turn around. We are going to kill you”.

SYNA OUATTARA | RAPID AND FOCUSED ETHNOGRAPHIES TO DECREASE TENSIONS IN GUINEA’S EBOLA CRISIS

80
This was no idle threat. Other cars belonging to EVD response teams had been burnt in several villages in Guinea. In the village of Womey, eight members of the EVD response teams had been murdered.

To defuse the encounter, we identified the leader of the group and asked him to search the vehicle to verify that we were not from the Red Cross. He did not find anything that could be associated with the Red Cross, and so reassured the others that we were not the real target. We were then allowed to enter the village and to meet several community leaders. At that point, we did not dare to speak about EVD. Instead, we talked about other issues, such as income-generating activities, socio-cultural activities, schools and education, and common diseases in the district. After a while, the villagers began to tell us about EVD and their concerns about the epidemic reaching their village. This allowed us to explain the real purpose of the mission in the village. We presented the customary cola nuts (figure 5) to the village elders (i.e., the customary leader, the district president, the imam, and other local elders) as a way to get their permission to work with the community. The imam then welcomed the team to the village, saying:

We are very sorry for our attitude toward you and, in particular, how our youngsters behaved toward you. We know that you are not from the Red Cross and that you are not doctors who have come to harm us. We know you are here for us and not against us. We are isolated here, abandoned by the sub-prefect; all development projects designed in our district are diverted by the sub-prefect. You have seen the state of the road between our village and Samayah yourself; even on a motorbike, it is difficult. Our children have not gone to school for months because of teacher shortages. You may feel at home here and may work here without any problems. I speak on behalf of the whole district.

The youth leader then told us, “Since his nomination, the sub-prefect of Samayah has not once set foot in our village and our community has never benefited from any development project”. The meeting ended with an exchange of phone numbers between our team and several influential people in the community (such as the head of the female organisations and youth leaders in the district) and a plan to set up an anthropological investigation in the village. My team and I left Maléa and drove back to Kindia.

In this community there was a deep ‘divide’ between the sub-prefectural administrative authority and the populations. Locals felt abandoned, excluded from development projects. Risk communication concerning the EVD was particularly difficult to deliver to the youths and women, due to the very low health literacy in the community. The prevailing attitude in

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2 In several West African countries, cola nuts are given as a symbol of hospitality, friendship, and respect. Cola nuts are also presented to guests at important social events such as weddings, funerals and infant naming ceremonies. Additionally, they are used for medicinal and divination purposes (Ouattara 2008).
the village could be described as a denial of the existence of the disease. No EVD response team had visited the village since the advent of the EVD in Guinea.

In this context, RE and FE became particularly valuable for building trust between the community and the EVD response teams. I recommended continuing anthropological studies to better understand the root causes of the local reluctance and denial and made proposals together with the district inhabitants to overcome the hindrances and ‘open up’ Maléa to the response teams. One of my main strategies was to be discreet when visiting an affected person, a family, or a new locality. Discretion had saved us from violence when entering the village of Maléa. The vehicle we used was neutral. It did not have a logo from an organisation responding to the EVD such as the WHO, UNICEF, or the Red Cross. We also did not have vests or WHO badges. As in the case of Samayah, the Prefectural EVD Coordination Cell approved these recommendations. Maléa was now also opening up to the EVD response teams. As required by the village residents, the EVD response continued in the village without the involvement of the sub-prefect. Two days later, I returned to Maléa with my two assistants and an UNICEF awareness team who distributed kits.

**Case 3: Using Rapid and Focused Ethnographies in Contact Tracing**

The two preceding cases were primarily focused on reducing resistance in affected communities, (re)building of trust between the local communities and the frontline EVD response staff and strengthening community mobilisation and engagement in the EVD response. I now turn to some specific methodological contributions in contact tracing, as this was vital in the effort to combat the spread of EVD.

During an EVD outbreak with established person-to-person transmission, new cases are likely to emerge among contacts. All potential contacts of persons with suspected, probable, and confirmed Ebola cases must be systemically identified and put under observation for 21 days (the maximum incubation period for the Ebola virus) from their most recent contact with the case. Potentially infectious contacts with signs and symptoms of the disease must be immediately evacuated to designated treatment centers or to the nearest healthcare facility in order to prevent high-risk exposure during home-based care, ordinary burial procedures, and other social activities. Rapid contact tracing is one of the most effective outbreak containment measures but must be implemented prudently (WHO and CDC 2015). Involvement and full cooperation of affected communities are critical for successful contact tracing (WHO 2014).

Contact tracing must also be considered in relation to stigma. Fear of EVD-related stigma was a key factor causing peoples resist the EVD response efforts (see Hofman and Au 2017). Fear of stigma negatively affected the involvement of affected communities in the EVD control activities and particularly contact tracing. One respondent in the sous-prefecture of Friguiagbe in the Kindia prefecture highlighted this issue:

> The way in which 4x4 cars drove into villages to take away the dead bodies shocked and dishonored us. They are driving at full speed in a large procession supported by a siren that warns the entire neighborhood. People go out and look at the family, who are experiencing pain and shame. As a result, family members are subject to stigma and extreme exhaustion. We would like the Red Cross’ removal of the bodies to be more discreet. These cars arrive unexpectedly with too much noise and cause fear and anxiety.

Several affected people, including contact persons, ran away from these large white 4x4 cars. The vehicles were associated with EVD, even becoming known as ‘the Ebola vehicles’ (**Les
véhicules d’Ebola). Identifying the need for changes in the use of these vehicles was one of the first findings we made with RE and FE.

We also used RE and FE in relation to other problems with contact tracing. At the daily WHO meetings between EVD response teams and the Prefectural EVD Coordination Cell, the contact tracing team often reported how many contact-persons they could not find during their daily mission. They had not tried to find out the reasons why these contact-persons did not follow the confinement procedures. It was our team of anthropologists who investigated this at the request of the Prefectural EVD Coordination Cell.

When investigating why contact persons or households did not follow the confinement measures, we discovered that socioeconomic issues negatively affected contact tracing. All the EVD patients (positive cases) who were recovering from the EVD were supposed to receive a sum of money per month. Additionally, all contact persons were also supposed to receive food, an amount of money for cooking expenses and a hygiene kit (hand-wash basin, soap, bleach and individual sprayer) for the 21 days of confinement (see Greiner et al. 2015; Desclaux et al. 2017). We met several individuals (EVD patients, survivors, and contact persons) who had not received in full what they were entitled to. This was particularly common among contact persons. The result was reluctance to agree to confinement procedures. Another problem we identified was that these measures in and of themselves could contribute to stigma, as EVD patients and contacts could not maintain routine activities. The stigma associated with this failure occasionally led to contact persons fleeing from follow-up or being ostracised from their communities (Greiner et al. 2015: 5).

Our reports on these socioeconomic issues created tensions between the team of anthropologists and those responsible for managing the funds allocated to the victims of Ebola. Nevertheless, we had the support of the lead coordinator of the WHO EVD response teams in the prefecture as well as the chief of the Prefectural EVD Coordination. As the terms of my employment stipulated, one of my main responsibilities was “to identify beliefs and practices that may amplify or help control the outbreak”. It was clear that a failure to deliver economic support complicated contact tracing and could amplify the outbreak.

Another factor that negatively affected contact tracing concerned so-called community watch committees. The National EVD Coordination Cell created 1,150 Community Watch Committees (Comités de Veille), which were expected to perform early warning and surveillance tasks and facilitate communication with people on how to quell the epidemic. There were five committee members per village. Each of these received a remuneration of US$50 per month (in local currency), a considerable amount by Guinean standards. Ideally, the members of these committees should have been elected from the bottom up by the community. However, RE and FE in several villages in the Kindia prefecture showed that in reality, most of the Comités de Veille were selected by (and thus loyal to) the government. They were not functioning as intended in many villages. We recommended to National EVD Coordination Cell that all social groups be involved in the community watch committees and each village be allowed to choose who should be part of this committee. The Prefectural EVD Coordination Cell approved this recommendation. All Comités de Veille were identified and reorganised in the Prefecture. It was now up to the village residents themselves to decide who would be included in the Comités de Veille.

3 These funds and kits were managed by the Direction préfectorale de la santé (DPS)/ Prefectoral Health Department.
Conclusion
In this article I describe how rapid and focused ethnographies (RE and FE) were useful research methods during an acute public health crisis (such as the Ebola epidemic) when prompt and highly focused interventions are required. Given the need to produce results and practical advice within a very short timeframe, long-term participant-observation was not an appropriate method. As an applied medical anthropologist working with an acute health problem where poor decisions could literally mean life or death, I had to rapidly develop ethnographic insights that could inform the containment practices and suggest solutions that could be accepted by both the EVD response team and local villagers. To this end, RE and FE approaches were useful methods for gathering affected people’s views and concerns about the epidemic and the outbreak response activities. RE and FE allowed me to keep focus on issues relevant to program planners, as well as work within the extremely short time between data collection and final report/recommendations. Based on my experience, I argue that RE and FE are highly effective tools in responses to local and global public health emergencies.

RE and FE highlighted a lack of information about Ebola Treatment Centers, a lack of transparency, and a lack of confidence in local authorities and EVD response teams, which contributed to the creation of rumors and suspicions as well as mistrust and fear. This led to a reluctance among affected populations to the EVD response teams. In the localities where I worked, attentive listening to the affected communities and taking into account their daily precautions, made it possible to improve EVD interventions. Strengthened community engagement (re)built trust between the local communities and the frontline EVD response staff.

The inclusive and participatory approaches that we employed, combining scientific and local knowledge, were vital to avoiding negative reactions, fear, distrust, stigmatisation, and even violence (Hewlett and Hewlett 2007). RE and FE were reliable, rapid research techniques that gave affected people a voice in how the disease was managed. We helped facilitate communication between the affected populations and the EVD response teams, which diminished resistance to public health interventions. RE and FE are useful methods for applied anthropologists operating in public health crises who seek to develop local response and resilience strategies, mobilise community engagement and increase collaboration between affected populations and health care actors.

Acknowledgements
I would like to express my deep gratitude to Maris Boyd Gillette, Lisa Åkesson, Johan Wedel and the two anonymous reviewers for kritisk etnografi for their careful reading of the manuscript and their insightful comments and suggestions. I would also like to thank my respondents, the WHO team of the outbreak response and the National EVD Coordination Cell for their assistance during the fieldwork.

References


Harnessing the Unruly: Anthropological Contributions in Applied Reuse Projects

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ABSTRACT This article discusses the experiences of two anthropologists working on two applied collaborative projects, both with a focus on sustainable consumption, and both spin-offs from a more conventional academic research project on second-hand and reuse. Although different – one focusing on the reuse of office furniture in the public sector, the other on co-creating an exhibition at a state-run museum – both entailed interventions aiming to stimulate a transition to less damaging ways of living and consuming. Collaborating with a municipality, a state-run museum and a reuse design company, as well as various professional stakeholders in the sector, the anthropologists outline how being ‘unruly’ – probing deeper into seemingly self-evident questions, recontextualising issues, and making associations between domains – allowed them to provide new perspectives and formulate alternative understandings of how to meet the challenges. The main contributions of anthropology in applied settings are often said to be the methodological tools and techniques of the discipline, but in this case, insights from posthumanism significantly shaped the outcomes of the two projects. The authors argue that abstract theoretical insights can play an important role in providing solutions or understandings in concrete, applied situations.

Keywords: sustainable consumption, applied anthropology, collaboration, reuse, circular economy, posthumanism

Introduction

One of the major global challenges of our time is the question of how to transition to more sustainable and less environmentally damaging ways of living. The ecological footprint of consumption in Sweden is estimated at four times what is considered a long-term sustainable level (WWF 2016: 74-79). Swedish material consumption is still on the rise landing at a 9% increase from 2016 to 2018 (Naturvårdsverket 2018: 21; Sveriges Miljömål). Furthermore, quantities of waste are expected to increase by over thirty percent in Sweden by 2035, and two thirds of greenhouse emissions in Sweden come from consumption within households (Naturvårdsverket 2018: 11, 21). How then, can we find more sustainable approaches to the way we accumulate, live with, and discard things – the kind of stuff that overflows our everyday life and has become so central to our lifestyle – and in what ways can anthropology contribute to this?

As two anthropologists, working on a research project on consumption of second-hand and reuse objects that began in 2014, we found ourselves increasingly preoccupied with this question. The focus of the project was on the circulation of aging material culture in second-hand markets as an alternative form of heritage making (see below for details).
Through fieldwork in second-hand shops, flea markets and private homes we explored everyday practices of care for old things and were intrigued by the complex and sometimes contradictory ways that people live with and relate to their belongings and to their physical process of aging (Appelgren and Bohlin 2015, 2017; Appelgren 2019b; Bohlin 2019). As issues of environmental degradation, climate change, and sustainability became increasingly prominent topics, not just for us, but for our interlocutors, we began to recognise that these ways of relating to material culture offered important perspectives on the ‘throw-away society’ of mass consumption and consumerism often depicted and lamented in media and the academy (see Gregson et al. 2007 for a critique of the notion). We also found that our anthropological focus provided knowledge that various groups of professionals in the field considered not merely interesting, but in fact useful. Faced with increasing pressure to get staff, customers, or citizens to adopt new and more sustainable practices or modes of thinking, these professionals were keen to learn more about how people behave and think, and to find appropriate conceptual tools for communicating the changes that they considered necessary to implement. As a result, what began as a small-scale collaboration with a municipal museum, as part of the original research project, rapidly extended into a number of applied spin-off projects, where we collaborated with professionals in city management, interior design, and the heritage sector in order to address concrete problems related to private, corporate, and public consumption and global sustainability.

The sheer magnitude and urgency of the larger issue – the future of life on the planet – not only propelled us into applied collaborations outside institutional academic research, but also threw us into normative engagements which, unlike our previous academic research, did not stop at understanding, interpreting, and critiquing what we saw, but ultimately aimed at influencing and changing the way people think and act. Despite generally adhering to the common stance in anthropology of deferring moral judgments on social-cultural practices and norms encountered in the field, we became involved in projects where the stated goal was to transform human thinking and behaviour – in small and partial ways; here, to reuse more – to achieve a transition to less damaging ways of living and consuming. In what follows we reflect on these experiences and discuss how developments and challenges in the field resonated with processes within the academy. Like the Australian environmental humanities scholar, Gay Hawkins, we found ourselves “...working at the interface between interesting conceptual intellectual work and applied engaged research that’s tackling a global crisis” (Hawkins et al. 2019).

Applied anthropology is often thought of as the practice of enrolling anthropology in order to address human and societal problems (van Willigen 2002: ix). Methods, perspectives, and knowledge emerging out of the discipline are used for utilitarian purposes where “[t]he primary goal is getting things done” (Nolan 2017: 33). ‘Solving problems’ then, is central to applied anthropology, sometimes even to the point of defining it. But what is a problem and what does a problem do? The word ‘problem’ derives from the Greek word proballein, which in turn breaks down into pro, before, and ballein, to throw (Oxford Dictionary of English 2015). In other words a problem can be seen as something that is thrown before us: something that we find ourselves facing and which we need to consider and respond to. In what follows, we will outline how we used anthropological knowledge and tools to address problems in two applied projects. It will become clear that rather than merely accepting how the problems had been defined and offering solutions to them, what we did was primarily
to ‘throw’ the problems differently. Through being ‘unruly’ – probing deeper into seemingly self-evident questions, recontextualising issues, and making associations between domains – we tried to encourage critical thinking and reflection in order to formulate alternative understandings of how the challenges could be met.

The following account will draw on a longer history of collaborative work that we undertook in relation to our original research project, but the main focus will be on two distinct applied projects. The first, here called ROF (Reuse Office Furnishing), was a collaboration with a municipal department and an interior design company specialising in reuse interior design and furnishing.¹ From the City administration, we mainly worked with the Department of Sustainable Waste and Water, which housed a pilot project aimed at exploring ways of making the entire municipality more sustainable, both in terms of its citizens and in terms of internal administration. Together with the project leader and staff members from this initiative, and the owners of the interior design company, we wrote an application for funding for an eight-month project, which was granted by the Swedish Energy Agency. The aim of this project was to facilitate large-scale reuse of furniture and furnishings in public offices, using the City administration as a case study. Our motivation was that transition to sustainability is generally far easier to achieve within the private sector, which tends to be more flexible and more easily adapts to changing circumstances, than in the more rigidly structured and controlled public sector. If we could show that transition to increased reuse is possible within the City, then, we argued, this could set an example that others – for example, other cities, regional administrations, and private companies – could follow.²

The project was designed around exploring a series of obstacles or barriers to reuse. We had identified a number of such barriers that we believed would be useful to study, and part of the undertakings within the project was a series of workshops and think tanks, where we invited various stakeholders (architects, caretakers, sustainability officers, furniture producers and sellers, removal specialists, etc.) to discuss these barriers, as well as add more. The project thus had an open and inclusive approach built into its design in order to maximise its value to, and relevance for the users.

The second project, here called LwT (Living (with) Things), was undertaken with a state-run museum. We had approached the director of the museum, saying that we were interested in exploring possibilities for collaboration, and as it happened, the museum had just begun the planning of a major new exhibition on the theme of consumption and sustainability. After an initial meeting we decided to apply for separate funding for this collaboration, with the aim of jointly designing a physical component of the upcoming exhibition using findings from our research project, but also to implement a citizen science component in the exhibition feeding data into our research. In total, we had monthly or bi-monthly planning meetings for two years, and also held two workshops at the museum where we tried out prototypes for the exhibition with two focus groups from the public, one school class, and one adult choir. The result was a demarcated section of the exhibition called Living (with) Things which contained three visitors’ activities and formed part of

¹ The results of this project were published in a report (Appelgren et al. 2018).
² Relocations and reorganizations in both the private and the public sector routinely involve disposal of old furni-
ture and purchase of new resulting in massive waste. In Sweden alone, office furniture is manufactured to the value of approx. 5.1 billion SEK ($550 M) annually (TMF 2020: 7). Annual disposal is more difficult to measure.
the overall exhibition *Human:Nature. An exhibition about consumption and the future of the planet* that opened in February 2019 and will close in Stockholm in 2021. In addition, we helped design, and during 2019, participated in an experimental outreach component of the exhibition in the shape of a mobile, ‘pop-up’ exhibition that travelled to a number of locations throughout the city to meet new publics. Simply put, this ‘pop-up’ was a tiny caravan, entirely built from scrap material, peddled by a tandem bike. It contained informational material, miniature versions of some exhibits from the main exhibition, and a range of interactive material, used to engage passers-by. This was a new form of outreach that the museum had never tried before, and the theme of the ‘pop-up’ was based on our component of the main exhibition.

Both ROF and LwT came about as a result of activities within the cross-disciplinary research project *Re:heritage. Circulation and Marketization of Things with History*, funded by the Swedish Research Council, 2014-2019.

### Reuse and circular economy

Before outlining the details of how we worked with anthropological knowledge and methods in the two projects, some words need to be said about the broader field that we came into, and how our approach differed from some of the dominant ways of thinking.

At the time that we began exploring reuse and second-hand consumption, discussions on the promises of the ‘circular economy’ (CE) had begun to emerge in Sweden. The concept circulated in national media, and in Gothenburg where we were doing fieldwork, various meetings, workshops, and lectures on the topic illustrated the growing interest in this new way of conceptualising the economy. Indeed, the City administration pilot project we collaborated with was called Circular Gothenburg. In short, CE thinking takes a systematic approach to the economy that should benefit industry, society, and the planet by disconnecting growth from resource exploitation. Inspired by the restorative and regenerative powers of ecological cycles in nature it argues for closing the loops of material flows in order to reduce resource extraction and waste production. In symbiotic networks corporations are supposed to turn waste and by-products into resources for production. Design for disassembling and recycling is crucial in this, as is design for care and repair in order to extend the lifespan of things before being returned for another production cycle (McDonough and Braungart, 2002; Webster, 2017). CE has received criticism, not least in regard to the limited evidence of large-scale practical CE cases (see Gregson et al. 2015; Blomsma and Brennan 2017; Valenzuela and Böhm 2017; Corvellec et al. 2020), but overall has been met with enthusiasm from industry, policy makers, and social movements and is being increasingly adopted as an imagined solution to sustainability challenges in Sweden. This is reflected for example in the way that the Swedish government sees it as a cornerstone of the sustainable consumption strategy (Ministry of Finance 2016), recently formed the Swedish Circular Economy Delegation (Government Offices of Sweden 2018) and ambitiously stated that “Sweden will develop the resource-effective, circular, bio-based economy” in its latest Government Declaration (authors’ translation, Government Offices of Sweden 2019: 6).

Although initially attracted to CE, particularly in the way it resonated with our previous work on the circulation of material culture, care and repair, and the interconnectedness of humans and things, we realised that our research findings spoke of issues that could not easily
be reconciled with CE thinking. First, it became clear that CE thinking, still in the process of formation, tended to take the perspective of big and established actors, leaving little room for small entrepreneurs. For example, discussions on the importance of being able to track furniture and their parts in order to recycle and reuse them became overshadowed by large corporations’ wish to retain control over the entire process to the point of claiming and maintaining ownership over materials and disenfranchising the user from the right to repair.

Second, despite all the talk about the importance of all the different ‘re-’s, i.e. reduce, reuse, repair and recycle, the dominating discourse of CE prioritises recycling, since this is where the economic interest of the main actors lies, and the economic gains are most easily made (Alexander and Reno 2012; MacBride 2012). ‘Reduce’ uncomfortably conflicts with growth, while ‘reuse’ and ‘repair’ in general are considered too specific and messy for an economy of scale (Crocker and Chiveralls 2018; Isenhour and Berry 2020; Norris 2017). This despite the fact that recycling is burdened by costly and energy consuming infrastructures (Corvellec 2019). Third, and the most important divergence however, was how mainstream CE thinking by being concerned with recycling, tended to prioritize resource efficiency, faster loops, and the dissociation of materials from their users. CE thus becomes more of a conceptual continuation of the modern linear production system – promoting the core values of efficiency, reduction, and detachment that led to an extreme form of planetary resource depletion in the first place – than a break with it. It shares much of its foundation with ecomodernism in its reliance on technological innovation and market capitalism for its operation (Genovese and Pansera 2020: 9).

Many of the professionals we came into contact with, during both ROF and LwT, were well versed in the CE thinking, were often motivated by its core principles, and tended to be relatively uncritical of it. Given that our own research pointed in directions that contradicted or were incompatible with many of the aspects of CE theories, when entering this field, we often sought to recast issues and suggest alternative interpretations. On the one hand, then, our ‘unruliness’ consisted in critiquing some of the main assumptions and dominant ways of thinking, a well-established mode of academic engagement that will be further described below.

On the other hand, we also went beyond this mode of critique and criticism. As will be shown below, in both projects we collaborated with partners around a series of co-hosted events, as well as co-produced more tangible, physical artefacts – a jointly authored ‘furniture guide’; a jointly designed exhibition – that can be likened to the ‘fieldwork devices’ discussed by anthropologists Adolfo Estalella and Tomás Sánchez Criado (2018: 2). These are creative interventions that “…turn the field into a site for epistemic collaboration” (Estalella and Criado 2018: 2). As they point out, when anthropologists do fieldwork in distinct sites with ‘epistemic communities’, such as experts, scientists, public servants, or artists, this often leads to collaborative relationships where the counterparts become epistemic partners and involve a distinct ethnographic modality that differs from the traditional trope of participant observation (Ibid 2018).

The main reason why we ventured into such experimental collaboration however, did not come from within anthropology, but from the emerging set of theoretical approaches and methodological tools often labelled under ‘posthumanism’. We had become interested in such perspectives because they offered us conceptual tools for thinking about ethics and responsibility that go beyond care for humans to also consider things and non-human
processes, such as, in our case furniture or household belongings (Appelgren 2020; Bohlin 2020). Yet, we also found inspiration in the way that posthumanist approaches explicitly encourage combining critique with constructive and speculative approaches. Political philosopher Jane Bennett for example, discussing the relationship between humans and things, argues that there is a need to move beyond ‘demystification’, a critical mode which aims at exposing, revealing, and denouncing human, often exploitative or oppressing, intentions (2010: xiv). Besides broadening our view to also consider how non-human forces affect our lives, she argues, we need positive formulations of alternatives, since ethical political action “... seems to require not only a vigilant critique of existing institutions but also positive, even utopian alternatives” (2010: xv). In a similar move, philosopher and feminist Rosi Braidotti (2018) argues for an affirmative critique that is both critical and creative. She and other scholars associated with posthumanism and feminism have long emphasised how analysis is performative: how when we describe what we find, “wording”, becomes “wording”; in other words, we co-produce reality by describing it. For this reason, one way of bringing about the change we wish to see is to “write it”; to put it into words (Åsberg 2012: 15). For us, such arguments gave us theoretical license to step outside of the usual mode of critique associated with academia – a mode we were used to – and engage more creatively and constructively in the “collaboration, sharing and co-thinking” that is emphasised by Nolan (2017: 33) as key characteristics of applied anthropological work. Such a stance also resonates well with recent anthropological work that emphasizes how creative, improvisational, speculative, and participatory techniques may have the potential to significantly contribute to and intervene in contemporary worldmaking activities (Pink and Salazar 2017: 3).

Three ways of being unruly

Recontextualising and reframing

What, then, did being unruly entail, and what did it result in? One illustrative example is from the ROF project. In the beginning of the project, other project members had drawn up a graphic model of how we should divide the work between us, which the project leader showed on a PowerPoint presentation. The focus of the project was what we called ‘bottlenecks’, various kinds of organisational obstacles that we had identified as preventing reuse of office furnishings. In the model, such obstacles were broken down into boxes, each focusing on a constituent part like traceability (of the material that furniture is made of), safety (for example, toxicity of materials, or fire hazards), juridical aspects, or logistics. For each box, aspects such as ‘knowledge’ or ‘information’ would be investigated, for example, how can information about available used furniture in an organization be made more accessible, or how can knowledge about traceability be improved? There was also a box for ‘attitudes’. Unsurprisingly, this was the box that was assigned to the anthropologists – our task was to investigate what role ‘attitudes’ played for decisions on whether to reuse or buy newly produced office furnishings.

We considered this conceptualisation of the project to be problematic for two reasons. First, we had reservations about the idea of treating attitudes as distinct from information and knowledge. Not only are these inseparable we argued, but they are also intertwined with other aspects such as social relations, desires, and emotions – all factors that need to
be considered when understanding how decisions are taken. Second, it made little sense to treat ‘attitudes’ as a distinct phenomenon from, and on par with, the other obstacles, such as legislation or logistics. Surely these would all be related, given that stakeholders would have attitudes in relation to precisely those obstacles – to fire hazards, legislation, or economic incentives?

While this kind of compartmentalization of various “cognitive” aspects had been useful in one phase of conceptualising the project, we argued that it was important to see how everyday decision making was grounded in a range of interrelated aspects. Emphasising the ‘composite’ character of what our collaborators called ‘attitudes’, we argued that decision making processes unfold in entanglements of practices, information, knowledge, desires, emotions, social relations and so on. In other words, our unruliness consisted in questioning the basic conceptualisation of the project: a recontextualising and reframing of the issue. In this case, our suggestion led to a revision of the planning document. The separate box of attitudes was removed and was replaced by an understanding that each of the other subthemes – logistics, safety etc. – would need to be investigated in terms of how it depended on knowledge, routines, expectations, norms, desires and so on.

This way of being unruly, through recontextualising issues, also happened on other occasions. One that ended up having a significant impact on the project was when we suggested a shift from focusing on the critical phases of disposing of and acquiring new furniture, to the less noticeable but important phases in between, of ongoing everyday usage and care. This was initially met with some hesitation: why discuss everyday usage and care of chairs and tables when we should talk about facilitating the transition from new purchases into reuse? Yet, by reframing the issue this way new fruitful questions emerged, such as why and how the need to purchase furniture emerges. If purchase is partly related to the ways a piece of furniture has been maintained on an everyday basis, should we not think more about care and repair? In this way the scope of the project broadened to consider more fully how decisions to change furniture can be delayed or avoided. Eventually this led to a concrete proposal of establishing a new profession in public management, such as a furniture consultant or furniture caretaker, who on an everyday basis manages and cares for the furniture and interior of a workplace – a janitor with extended authority to see to “the best interest” of the furniture, safeguarding its wellbeing, assessing its vulnerabilities and capacities and matchmaking it with the needs of the organization. Whether or not this will lead to the creation of such a profession we don’t know, but we included the recommendation in our final project report.

The shift from insisting on interrogating critical phases of discarding and buying new, to assessing the ongoing everyday interaction between people and furniture, was partly a case of the classic anthropological technique of reframing and recontextualizing. By casting the established main question in a different light, new aspects, relations, and associations were made visible and conceptually approachable. We used the Swedish words for reuse, återbruk, and use, bruk, to illustrate this shift. While bruk usually translates to use, it also has connotations to cultivation as in jordbruk, farming, or literally “cultivating the soil.” Bruk can be understood as the linear gradual erosion of a thing, through use, until it is used up, förbrukat, but we emphasized how bruk also connotes the responsible and sustainable management of productive resources. However, this reframing did not only come about as a result of a play with words and their deeper meanings. The CE perspective of our
collaborators influenced how they focused on ‘the problem’ of getting persons in decision-making positions to choose reuse, rather than the less sustainable option of new purchases – the whole ‘bottleneck’ issue arose from the aim of getting people to change behaviour in critical phases, i.e. when purchases are being made. They were simply put, primarily concerned with “closing the loops”. Our suggestion of shifting the focus from reuse to the phase of bruk, use, was grounded in our critique of CE, which, in turn, was inspired by the posthumanist concern with care in relationships between humans and non-humans, as well by its foregrounding of processes of change and becoming. Thus, while it is often said that the main contribution of anthropology in applied settings is the methodological tools and techniques, this illustrates the important role that theory can play, showing how abstract theoretical insights can provide solutions or understandings in concrete, applied situations (Pink, O’Dell and Fors 2017; Stull and Schensul 2018).

A third example of how we recontextualised issues concerned the matter of safety of reuse. After some meetings and team-labs with other stakeholders, including various professions such as “mainstream” (as opposed to those specialising in reuse) interior designers, architects, janitors, procurement officers etc., we noticed how a common way of framing the decision to buy newly produced furniture instead of reusing was to claim that this decision was based on considerations of health and safety issues. Partly, the argument went, furniture production has overall become safer and much more strictly regulated, and toxic or fire-prone materials, paints or varnish that were commonly used in the past are now forbidden. In contrast, there is often a lack of information about old furniture, and reusing it involves taking risks of exposure to toxins or fire hazards. Yet, in this way of framing the issue the focus was strictly on the user, imagined to be an employee in an office in the Gothenburg region. If we broadened our focus, we argued, and included the phases of producing the furniture, considering the places and people involved where this takes place, as well as where the furniture is transported from (e.g. the global South), the overall net effect is not necessarily that the newly produced is less harmful or more healthy, indeed, the opposite may be true. This recontextualisation of the health issues pushed the discussion in new directions, and a representative from the procurement department of the municipality later told us that this discussion had led her to include this broader conceptualization of health issues in a policy document for procurement, aimed at facilitating the buying of reuse products and services.

In the LwT project we used similar techniques of recontextualising and reframing. This project was more firmly framed, as the ultimate goal was to produce a part of a museum exhibition with a set opening date and a relatively strict working plan up to that day. Meetings with museum officials, including an exhibition designer and pedagogical staff, took place over an extended period of two years. The collaboration was thus initiated from two different starting points: the museum’s, with the task of developing and concretizing and overarching exhibition, and ours, which was to contribute with knowledge from our research. The process was one of gradually understanding each other’s positions and possibilities for contributing to the process, and slowly converging in a common conceptual idea. This turned out to be a winding journey, where two different creative approaches met – one more closely tied to the overall conceptual scheme and the concrete task at hand, the other more unbound, unwieldy, and unruly. One reason for the different approaches was the museum staff’s expertise in the field of exhibition design, something we lacked.
times, when we would offer creative ideas, they put these into perspective by pointing out that they had already been tried before, in a different exhibition, and were therefore not novel enough, or that they were unsuitable for practical reasons, for example wheelchair access demands. Another reason concerned how the overall exhibition concept evolved, and the strict deadlines the museum staff were tied to, while we were freer to pursue ideas on their own merits.

Yet, once the different temporalities had been aligned, and the blind spots we might have had for each other’s work processes identified and addressed, overall this collaboration became creative and fruitful. The techniques of recontextualising and reframing proved particularly useful when trying to develop innovative and thought-provoking ways of illustrating human-thing relationships and the dynamics involved in consumption. For example, whereas the overall exhibition focused on a critique of mass consumption and unsustainable production methods, our partners and we agreed on the need to recontextualise the role of objects by counteracting this negative narrative of mass consumption with one that emphasises our ability to form close relationships with things, something that will be further discussed below. Furthermore, given that this collaboration was designed to be a creative and explorative one – albeit within the given overall goal of producing an exhibition – the format of the process was in itself conducive to precisely such techniques.

Among other things, we tried out prototypes of the exhibition components with focus groups, or test panels. These were immensely valuable events for finding out how potential visitors would understand and react to our ideas. One example was when we had prepared a mockup of what we planned would become a citizen science component, which involved visitors answering questions about certain household belongings that they had kept for a long time. Our aim was to stimulate reflection on why we throw things away, and to recontextualise objects that had remained with us for a very long time, for example in attics or basements, from being regarded as “junk” or “clutter”, to something to be proud of. Yet, because of the way that we had phrased certain questions and also the order they were asked, members in the focus group consisting of adult choir members, reacted in the opposite way. One man expressed shame that he had kept an old broken tennis racket even though he knew it was not good to play with anymore, and a woman said that she felt guilty about all the junk that she never had the time to go through. We had to go back to the drawing board and reframe and recontextualise our questions to ensure that they better reflected what we wanted to communicate.

These joint focus groups are a good example of the kinds of material and social interventions that Estalella and Sánchez Criado argue (2018), transform the field into a site of epistemic collaboration when doing fieldwork with communities of professionals. During these events, our partners and we engaged in joint epistemic explorations, where we together designed the focus groups, and were equally unknowledgeable about what would come out of the activity and how this would affect the next step of our process.

See Tinius and Macdonald (2020) for a discussion of the challenges involved in what they term the recursive relational modalities between anthropology, ethnography and curating.
**Probing deeper**

Another way of being unruly is what we here call *probing deeper*, in other words to go beyond the seemingly obvious by contextualising an issue or simply seeking more information (for a similar argument, see Pink, Morgan and Dainty 2017). One example from the ROF project was when we probed deeper into what the issue of safety involved. We discovered that different administrative units and companies prioritised this issue very differently, even though their activities and business were very similar. One example was a unit that had recently moved offices. During the process of planning the move, the issue of chemicals, particularly airborne ones that could be measured had played a crucial part in discussions and was a topic that according to one of the staff members, had absorbed much time and energy. In contrast, a staff member from a similar unit reported that during their recent move, the question of chemicals had not been prominent at all, but instead discussions about the costs of transports had dominated the process and shaped decisions. Similarly, different units had very different ideas regarding how important the risk of fire hazards is, or to what extent they should consider acoustic concerns. The different evaluation of these and similar factors did not seem to reflect actual differences in needs between the units, but rather a degree of arbitrariness and serendipity in terms of which issues happened to be influential.

We also discovered that issues of toxicity and fire hazards were sometimes used rhetorically to establish buying newly produced furniture as the better and safer alternative. For example, an oft-repeated comment from those hesitant about reuse – for example, those whose profession was heavily invested in structures geared towards buying new furniture – was the risk that children would chew on the furniture, even though the offices in question were not frequented by children. Similarly, another common phrase when wanting to keep reuse furniture at an arm’s length was “What happens if this enters a pre-school or a hospital?”. Given that few people willingly wish to harm children, such arguments tended to invoke feelings of uneasiness about the unknown and were efficient ways of miscrediting reuse and defending established routines of buying newly produced furniture. One example came from one of the project workshops when participants were divided into small groups discussing the possibilities of reusing furniture in offices belonging to public administration. In one group, an interior designer said that it was irresponsible to reuse furniture, asking in an agitated voice how we could possibly be sure that tables and chairs in a school did not originate from Chernobyl, full of radiation. Another participant with expertise in reuse went quiet, but later told us that she had felt criticized by the comment. The examples show the importance of not treating toxicity as a demarcated “box”, isolated from attitudes, or to treat “knowledge” as separate from the field of social relations or power struggles. Discussing this helped our collaborators to question the use of certain discursive labels and deconstruct how such labels were used to achieve certain ends.

Another example of probing deeper, which partly was a result of the recontextualization described above, was when we formulated a question for stakeholders to discuss during a team lab: “Why do offices get to be refurbished other than the obvious reasons such as moving, or change of activity, or business?” Until then, we had simply assumed that offices are renewed or changed mainly because of straightforward, functional reasons, not least because of the hard budget reality of many organisations. Yet during the subsequent discussion we realised that the motives for changing office furniture were often far more
complex. Two interior designers spoke of their frustration at managers who did not listen to their advice, the typical scenario being that the manager wanted a large number of flexible workspaces (i.e. desks not assigned to any one individual), despite them explaining that far fewer of these kinds of spaces are usually needed than expected. Sure enough, they said, when they later visited the refurbished office, they would see the flexible workspaces, kitted out with brand new desks, seats and lighting, standing empty and unused. A janitor pointed out that managers often order new ergonomic chairs, adjustable table or double computer screens for their employees, not because the employees actually need them or even ask for them, but because the managers wish to show that they care about their staff. This, he said, was particularly clear when the leadership changed, and a new manager wanted to leave his or her mark. In this way, simply asking a why-question, rather than starting from the notion that one knows what is going on, revealed a range of relevant social dimensions for understanding decisions to renew offices.

Probing deeper in this way also relates to the issue above regarding recontextualizing the critical phase of choosing to reuse before buying new. We realized that if purchases of office chairs, height-adjustable desks, and computer screens were indeed expressions of status, symbols of progress, techniques of conflict management, or acts of acknowledging individual employees, then our idea to shift focus from instances of purchase to everyday use would miss the point. If purchasing was more related to social processes than material needs, then we needed to do yet another reframing exercise. Again, this led us to focus on what happens outside the critical phases of purchases – the phase of ongoing use. This time however, the discussion revolved less around everyday use of furniture and more about how human relations are being cared for and maintained and how this can take other forms than consumption of new office furniture.

In the ROF project, probing deeper often resulted in surprising insights or information given that the project was based on a number of assumptions that were relatively unquestioned, i.e. that toxicity or fire hazards were measurable risks that impact different administrative units in the same way and are therefore treated the same way, or that such units changed their office furnishings for straightforward, functional reasons. The results of such probing were particularly useful for one of the concrete outcomes of the project, a “furniture guide” which was a simple flow chart that we jointly designed in order to facilitate decisions about whether or not particular pieces of furniture would be suitable to reuse (Appelgren et al. 2018). Without being based on knowledge about how stakeholders perceive and frame the topic of reuse or understanding the issues that are relevant to them, such a guide would lack relevance.

Compared with the ROF project, the LwT project was more explorative in its setup, and both our partners and we used “probing deeper” as a kind of unspoken modus operandi. Nearly every meeting we had involved trying to move beyond or beneath obvious ways of conceiving and doing things in order to find new, playful, or provocative angles on the exhibition theme. As such it is more difficult to pinpoint precise examples of insights that it yielded, but as a general technique it was of fundamental importance to the project.

Making associative links between domains
The third way of being unruly is a technique familiar from anthropological literature: to make associative links from one domain to another. Well into the ROF project when we had
worked with the techniques discussed above, reframing problems to find new angles and productive perspectives and to probe deeper, beyond the initial layers of appearances, there was something of a turning point in the way that we conceptualised and communicated issues. Basically one of us got the sudden idea to liken office furniture to fellow colleagues, or staff members. This idea came during one of the workshops with stakeholders in the reuse furniture field and was triggered by the notion of “resources”. Immersed in the CE-discourse that permeated many of the PowerPoint presentations and the debates, our thinking had been trained to associate furniture and materials with resources. When the discussions moved on to managing and caring for staff in organizations and at workplaces however, the concept of human resources came to mind providing a linkage between furniture and humans. Similar to the intervention mentioned above about shifting focus from reuse to use, this association was also inspired by posthumanist theory which encourages thinking of parallels and links between humans, animals, plants, things, and materials, rather than of differences and incongruences, as well as how it seeks ways to level the hierarchy often assumed between them.

At a later workshop we included this juxtaposition in a PowerPoint presentation, and from then on the comparison became widely used, both within the project and in our communication with stakeholders. We asked what would happen if the management of a public or private organisation approached furniture and furnishing in the same way as they approached their staff. What would it mean to think of furniture and interiors as kindred non-human resources? If a staff member starts to perform less well than expected, the usual route is not to end that person’s contract but to provide supplementary training, change something in the work environment, or perhaps give him or her different tasks. Firing somebody is seen as a costly and administratively complicated last resort, to be avoided. Could one change attitudes, policies, and regulation to create similar routines when it comes to tired or malfunctioning office furniture? By phrasing the issue this way we opened up the possibility of thinking of pieces of furniture as subjects of the workplace as much as people, having equal rights to be valued, cared for, and nurtured. While far-fetched, the idea was effective in communicating a conceptual shortcut to a rethinking of taken-for-granted perspectives.

In the LwT project, we also played with the posthumanist notion of things not as objects but as subjects and used the technique of drawing associative connections between different domains. This time we played with the parallel between the relationships that humans have with their belongings and those that they have with each other. Together with our project partners, we formulated an idea that the exhibition could encourage visitors to view their relationships to things as they are used to thinking about relations with human beings. Indeed, why not take this one step further to structure this part of the exhibition as a narrative of a long-term love relationship between a human and thing, with phases such as initial romantic attraction, established and stable everyday togetherness, and relationship crises?

This idea proved fruitful and eventually shaped our contribution to the exhibition. The theme of sudden attraction and faded feelings were illustrated by mugs and cups standing on a table. Each had been donated by a member of the public, and when pushing a heart-shaped button next to the mug, the visitor could hear a voice telling the story of how the previous owner had fallen in love with the mug, and how the strong feelings of attraction for various reasons had faded. Then there was another part dedicated to long-term relations
with things, a wall full of objects that we had bought from a second-hand shop and included a screen with the citizen science component. A final section explored broken relationships and mending, for example containing a bowl mended with the Japanese technique of visual repairing, *kintsugi*. Here the visitor could go to the “thing therapist”, a mannequin doll dressed up as a therapist, giving recorded questions and advice modelled on those one expects when in a relationship crisis, such as can the relationship be repaired, or is it time to part ways? By casting relationships to things in this way, the idea was to encourage visitors to think about why they fall in love with stuff, how it is to live with trustworthy and faithful things and what makes us get tired of our belongings and want to get rid of them. The aim was to draw attention to our capacity to form strong bonds with objects and to care for them, as a counterbalance to other parts of the larger exhibition which were explicitly critical of consumption.

**Room for unruliness**

Reflecting on the different collaborations with non-academic partners that we have undertaken, both as part of *Re:heritage* and in the various applied projects, certain patterns emerge. Put simply, the level of success of a project seems to depend on two interrelated issues: first, whether there are good and trusting relationships between the collaborating partners; and second, whether the anthropologists are given room to be “unruly” (and of course, that partners regard this unruliness as beneficial). The two are intimately connected. As is clear from the above discussion, what is referred to here is not unruliness or disruption in a social sense as in being rude or impertinent, but rather in terms of cognitive strategies and ideas. Even so, to articulate an alternative way of conceptualising something in a meeting, or to insist on abandoning an established typology or way of classifying phenomena, might not work very well unless good relations have been established.

One of the lessons we had learned from previous collaborations, which we brought into the cases discussed here, was the importance of making sure to provide ample opportunities to get to know each other preferably outside of the conventional meeting format. This meant being ready to quickly respond to opportunities that presented themselves; for example, in the case of the ROF project, an invitation to go on a day trip to a town known for its many furniture factories and reuse initiatives. Despite not being sure what the exact purpose of this visit was, we had learned the value of doing something concrete together as a group. Chatting in the rented car trying to find the way, keeping each other company when the train turned out to be many hours late, and visiting a range of reuse initiatives indeed helped to consolidate the group and establish trust. The concrete tasks that needed to be solved along the journey pushed us all to step out from our professional roles and to relate to each other in a more relaxed and informal manner. Similarly, once the project was underway, collectively hosting “team labs” events for invited stakeholders, with all that this entailed in terms of practical planning such as sending out invitations, preparing coffee and snacks, getting stationary, and cleaning up afterwards, further strengthened relationships in the group and created good conditions for productive forms of unruliness.

Finally, a note on the conditions for such collaboration to be successful. In the cases discussed here, we were fortunate that two funding agencies supported our projects, meaning that our and our collaborators’ labour was paid for and we had the time to build solid relationships. Had this not been the case, and we had lacked the possibility of laying the groundwork for these relationships, it is possible that the same unruly interventions
that proved successful here would have been received very differently and our input into the processes might have been more limited.

Conclusion

When we began our initial research project Re:heritage, the field of reuse and second-hand was dominated by debates on structures, regulations, policies, and big actors that were often disconnected from the experiences and perspectives of ordinary people and everyday social life. Discussions on recycling and CE seemed to miss what was so clearly visible in our fieldwork: how ordinary household belongings are used to express identities, negotiate social relationships, and form an intrinsic but often unacknowledged part of people's lives. In our experience, CE thinking tends to disregard the inherently complex layers of material, historical, cultural, and social values and meanings of things in order to isolate and exploit their material resource value in new production cycles. This reductive process is in itself wasteful as important socio-cultural qualities of the thing are neglected and lost (Appelgren 2019a). In addition, CE thinking encourages further dissociation of materials and things from humans. By giving the control of the resources of production to corporations, even during the consumption phase casting consumers as users rather than owners and providing a function rather than a commodity, people are set apart from things. Ultimately their engagement in things becomes watered down, as practices for reinforcing relationships to things, such as ownership, care, and repair are undermined by corporate control.

In contrast, in both the applied projects discussed here we sought to engage in a critique of wasteful and unsustainable practices that was combined with a more nuanced understanding of the multifaceted and complex role of objects in people's lives, whether in private homes or in offices. Here we were able to draw on posthuman insights that stresses relationality, coexistence, and material vitality and on insights from critical heritage studies that acknowledge the layers of significance of things to be actively valued and cared for (Appelgren and Bohlin 2015, 2017). Instead of further dissociation of humans from things and from the material implications of life, a sustainable economy needs to stress interconnectedness and interdependence as well as the importance of staying in vital relationships even when they cause troubles and inconveniences (Haraway 2016).

These insights inspired our involvement in both projects. In the ROF project, it meant that whenever we could, we tried to counteract the large-scale, abstract concepts and logic of CE language that we often encountered with attention to actual, situated human-thing relations, highlighting how social, cultural, and material processes come together. In the museum project, LwT, these ideas inspired us to steer away from the initial focus on reuse and circulation as a solution, instead concentrating on not sending things into circulation, but rather to keep them for as long as possible. The process was different in each project, with a clearer division and separation of labour in the ROF project, which meant a greater freedom for us to conduct our part, and a stricter and more structured format in LwT, but where we, to a larger extent than in the former, shared an explorative and creative approach with our partners. In both projects, however, we often experienced that we were “unruly” in the sense of asking questions or coming with suggestions that were clearly not expected, and that sometimes threw the process in entirely new directions.

Going back to the issue of what a problem is, the etymological origin of the word highlights that a problem is far from a gap or an empty void that can simply be filled.
with a solution. In contrast, it is something thrown before us; it has substance, much like an obstacle on the ground in front of us, bringing our onward movement to a halt. If we understand problems as things thrown in particular times and spaces, the techniques that have been discussed above – probing deeper into issues, recontextualising them, and drawing unexpected associations between separate domains – may create new understandings of the ‘then’ and ‘there’ of a particular issue. Rather than removing the obstacle as quickly as possible, the task of the anthropologist is to throw it differently, and to harness the possibilities and energies emerging from the different notions of “then” and “there” that may thus become accessible.

The particular benefit of bringing in an anthropologist in an applied project, then, is not so much to get the problem solved, as to have the problem thrown differently before the stakeholders in order to engender reflection and consideration. The challenge for the anthropologist is to stay with the issue broadly defined, but not be limited by a preconceived or premature framing of the problem. When we ask what happens if office furniture is seen as valuable by staff and fellow colleagues, or when thing-relationships are modelled on human romantic love, we put anthropology to work by engaging in the kind of speculative acts Tim Ingold identifies as central to the discipline (2017). These are occasions for exploring possibilities – other ways of being and other worlds – that may contribute to the articulation of new and unexpected alternatives and solutions.

Acknowledgements

We would like to thank the editors of this special issue, and the two anonymous reviewers, for the thoughtful and constructive comments they provided on earlier versions of this text. We also gratefully acknowledge the Seedbox initiative, Linköping University, and the Swedish Energy Agency, for funding the two applied projects and the Swedish Research Council for funding the main research project (VR 421-2013-1923).

References


A Living Intervention – Anthropology and the Search for Person-centred Teamwork in a Hospital Ward in Sweden

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ABSTRACT This article draws on a long-term, team-driven project in a Swedish hospital ward to provide an ethnographic description how anthropology can be used in practice to support healthcare providers in their everyday work. I argue that ethnographic research, by affording participants in the ward an outsider’s view of their workplace and routines, can facilitate healthcare providers’ own process of reflection, communication, and the development of solutions to problems. The project aimed at facilitating change in relation to three challenging circumstances identified by the hospital ward management and staff: better-functioning communication on the ward, closer and more collaborative inter-professional teamwork, and deeper and more respectful integration of the patients in what was termed person-centred care. As an anthropologist I moderated a series of workshops in which I presented fieldwork insights, organised small-group work, and facilitated dialogue. The workshops enabled co-learning and collective reflection across professional boundaries, empowering the healthcare professionals to identify steps for better teamwork and patient care.

Keywords: facilitating change, collaborative reflection, healthcare, Sweden, teamwork, person-centred care

Introduction

Drawing on a long-term, team-driven project, initiated by the nurses’ ward management leader at a medical emergency ward in a Swedish hospital and carried out by anthropologists in collaboration with the management and various healthcare professionals, this article gives an ethnographic description of how anthropology can be used in practice to support healthcare providers in their everyday work. I argue that ethnographic research, by affording participants in the ward an outsider’s view of their workplace and routines, can facilitate healthcare providers’ own process of reflection, communication, and the development of solutions to problems. The project aimed at facilitating change in relation to three challenging circumstances identified by the hospital ward management and staff: better-functioning communication on the ward; closer and more collaborative inter-professional teamwork; and deeper and more respectful integration of the patients in what was termed person-centred care. The method developed in partnership between the ward management leaders and the research group entailed arranging drama workshops for collective reflection and learning and three sets of follow-up workshops on communication, teamwork, and person-centred care.

1 Thanks to the anonymous reviewer for this formulation, that neatly describes my argument in this article.

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Since the drama workshops have been described elsewhere (Skott et al. 2013; Dellenborg and Lepp 2018), I focus here on the follow-up workshops held on staff days, in which the management and the staff worked to improve communication, teamwork, and person-centred care on the basis of the results from the drama workshops and the long-term collaborative project. In these workshops, I as an anthropologist had the dual role of researcher and moderator, which presented some challenges, described below. The workshops sought to raise awareness of the structures that influenced everyday work on the ward, and help participants to see the workplace from the perspectives of the various healthcare workers. By means of collaborative action and reflection, the researchers and participants went through an open-ended learning-process together.

The setting

The medical emergency ward was divided into an intensive care unit for the most critically ill, and a post-acute unit for patients who were in rehabilitation or whose condition had been diagnosed as not critical, although many of them were old and very sick and their status could quickly change to critically ill. The ward was a high-tech environment, prioritizing a biomedical perspective and marginalizing a care-giving perspective. The treatment regimen included full supervision of the patients and readiness for emergency intervention by the personnel. The ward had high numbers of patient admissions and discharges. Coupled with daily rotation of staff and high turnover rates of different care professionals and students, this meant many people passed through the ward on any given day. Both healthcare providers and patients experienced communication challenges due to this high circulation.

The healthcare providers and professionals in the project were nursing assistants (NAs), registered nurses (RNs) and senior and junior physicians. A senior physician is a specialist. A junior physician, called a resident, might be a medical student practicing to gain their licence, a newly certified physician or a physician in specialist training. An NA has two years of high school education and in this ward, did the ward’s ‘household chores’, such as the linen, ordering and serving food, and making beds, and performed most of the caring, although caring (Sw. omvårdnad) is the RN’s professional competency (Leksell and Lepp 2019). In Sweden, RN is a legitimation earned after three years of academic study. In this ward, an RN was expected to be well-informed about vital signs and the patient’s medical problems and treatment, and technically skilled in reading electrocardiograms and recognizing various heart rhythms and respiratory problems with a stethoscope. As described elsewhere, the nursing perspective received little attention in the ward, which made the RNs uncomfortable (Wolf et al. 2012).

There were many other healthcare professionals working in this setting, such as physiotherapists, occupational therapists and dieticians, and cleaners. At the time, the three first-mentioned were not considered to be members of the team, but functioned as ‘consultants.’ Cleaners were not even seen as part of the ward’s work force, although they were present all days of the working week and their task was crucial for the hospital (cf. Messing 1998).

Teamwork and professional boundaries

The healthcare professionals worked in many different teams. The RNs and NAs worked closely in a nurse team, and the physicians (specialists and residents) in a physician team.
Every morning on the ward round, they met in a multi-professional team consisting of two RNs and two NAs caring for ten patients, a senior physician, and one or two residents caring for the same ten patients in the ward. In the multi-professional team, each profession performed their tasks parallel to each other or in sequences. During the project, the clinic wanted more intensive and collaborative inter-professional teamwork.

Inter-professional teamwork unlike multi-professional teams, entails a collegial and equal relationship between the participants, with shared decision-making procedures (D’Amour et al. 2005). In the hospital setting, it demands a fundamental change of professional relations and ordering of knowledge, and moving away from parallel work processes. The circumstances complicating teamwork in the ward were three-fold: first, the social construction of biomedicine as the primary knowledge of healing (cf. Good 1994; Lupton 2007); second, physicians who were trained to be autonomous decision makers (cf. Baathe and Norbäck 2013), contra nurses who were trained to cooperate (cf. Leksell and Lepp 2019; Coombs 2003); and third, healthcare organizations that were operationalised in terms of the medical gaze, and awarded physicians the authority to define and solve problems in the treatment of patients (cf. Wikström 2008).

The biomedical perspective is based in a disciplinary knowledge tradition according to which physicians are trained to discover the illness in the patient’s body, separate it, name it, and correctly treat it using a medical gaze (Foucault 1975). Epistemologically, biomedicine focuses on “the solitary body of the individual sick person” (Kleinman 1995: 37), thus constructing the patient as someone experiencing illness in a vacuum of social relations. While medicine concerns the pathogen perspective, nursing also considers the salutogenic perspective (Antonovski 1987), focusing on health and the possibilities for maintaining health and understanding illness holistically, in the wider context of a person’s life situation (Jansson 2010).

Healthcare’s hierarchy of “hospital workers with curing (doctors) at the top, followed by caring and healing (nurses, therapists, and attendants), and hygiene (cleaners, sterilizers, and launderers) at the bottom” (Messing 1998: 168) is well-documented. However, although the biomedical perspective was prioritized in this ward, and the physicians located at the top in their team status, the physicians did not experience themselves as being in a power position. They felt seriously curtailed agency in relation to their hospital management’s healthcare organization (Dellenborg et al. 2019) and the general hospital steering system, New Public Management (NPM). With its prioritization of efficiency and economical aspects of care, NPM has turned healthcare towards increased administration and manual control (Bornemark 2018: 14, see also Kaufman 2005).

At the same time, the physicians’ status was visible through their understanding of themselves as the ones responsible for a patient’s life and death. Medical responsibility was constructed as the decisive responsibility, even though research stresses the importance of nursing knowledge (Aiken et al. 2014; Griffiths et al. 2016) and professional collaboration in teams (Lyubovnikova et al. 2015) for reducing patient mortality. This hierarchical polarization between care and cure has a long history; the professions are socialized into these epistemologies and identities (Wikström et al. 2018; Coombs 2003). The different value attached to the disciplinary knowledge traditions in contemporary healthcare is detrimental to care, and creates conflict in the healthcare team (Wallström and Ekman 2018). Making visible these structural dimensions of professional identity and disciplinary knowledge in the healthcare organization was an essential first step for improving teamwork.
**Person-centred care – a contested concept**

Parallel to inter-professional teams, the hospital was implementing person-centred care. Researchers define person-centred care as an ethic that urges healthcare professionals to change the focus from the disease within the person to the person with the disease (Edvardsson and Nay 2008; McCormack and McCance 2010; Ekman et. al. 2011; Zhao et al. 2016), an approach that has been shown to increase care quality and decrease the length of stay in hospital (Ekman et al. 2012; Olsson et al. 2009). Fundamentally, medical signs and the ill person’s experiences of symptoms should be considered as equally important in person-centred care (Wallström and Ekman 2018). Care decisions should be made in partnership between the person with the disease and the care providers (Ekman et al. 2011). This challenges the priority given to the biomedical perspective and the physician as the main decision-maker, and the generally hierarchical relations between patient and healthcare practitioner (McCormack and McCance 2010).

In this ward, the concept of person-centred care evoked strong emotions. The meaning of person-centred care differed both between and within the various healthcare professions, and caused confusion and frustration that complicated everyday care practice and relations in the team. The physicians particularly questioned the hospital management’s aim to implement person-centred care, wondering if their motivation was patient empowerment or cost effectiveness, as management emphasized person-centred care as a way of reducing the number of hospital beds in use and length of stay (Dellenborg et al. 2019).

**Practicing anthropology on the ward**

Our practice of anthropology during this project was informed by Ingold’s vision of anthropology (2017) and Kiefer’s of action anthropology (2007). Ingold writes that anthropology is generous, open-ended, comparative and critical. It is generous because it helps us understand other people’s way of living from their perspective and encompasses gratitude on the part of the researcher for having been let in, often generating a desire to give back. It is open-ended because it does not seek final solutions, comparative because nothing is given (life can be lived in many ways), and critical because we cannot be content with things as they are (Ingold 2017: 58-59). Ingold sees change as central to anthropology, and widely critiques the modern era, focusing on ecological aspects, and discrimination against local knowledge. He also emphasizes participant observation as a learning process with the ability to be transformative. More than a method, it is “an ontological commitment” (ibid.: 23), about learning with, not about, people.

Kiefer describes action anthropology as “far more than just a technical skill. It is, in a very real way, a moral position…” (2007: 201). The action anthropologist is an “outside helper in promoting the process of empowerment” (ibid.: 200), one who “helps people create the conditions for self-discovery and independent action” (ibid.: 202). The "goals are set by the community under study, and the results of [the anthropologist’s] work are made available to the community to use as they see fit” (ibid.: 200). Like Ingold, Kiefer sees the learning position as central. The anthropologist is a student who learns from those whose life situation they aim to understand, not an expert on others’ life situation. The research participants are the experts and teachers. Kiefer sees curiosity and courage as central to action anthropology. Courage means putting yourself in situations where you might be
seen as clumsy and inappropriate. I would add that this opens up the possibility of being transformed through a process of critical questioning of your own pre-understanding.

**Methods**

Fieldwork for this project stretched over eight years, from the end of 2009 to the beginning of 2018. Long-term fieldwork, entailing long-term relationships, understanding the context for change, and understanding resistance to change (Tax 1975; see also Loup 2005), was crucial. I conducted participant observation with, and interviewed all three categories of healthcare providers in the team: RNs, NAs, and junior and senior physicians, plus the management leaders and patients. Data included fieldnotes, formal and informal interviews, and group discussions that were transcribed verbatim, photographs of architecture, machines, devices, signs, and consenting staff, and drawings of the professionals’ and patients’ position in the room during rounds and care encounters that I used for reflection in interviews and workshops. As the medical anthropologist Kaufman says of her fieldwork in American hospitals, the field was broader than the physical setting of the hospital. It was also “found in the structural fabric of the health care system and its institutions, the powerful and tenacious values and traditions that support individualism and biomedical progress, and the taken-for-granted, everyday activities that constitute bedside medicine” (Kaufman 2005: 328).

The project involved a cycle of planning-acting-observing-reflecting-re-planning, with critical reflection as an important step in each cycle (Kemmis and McTaggart, 2005). The team of anthropologists planned action along with the ward management, who were themselves trained nurses and physicians. We co-created the workshops together and co-owned the results, albeit not the data. I was the field-working researcher building relationships with the staff and the management, and therefore the one appointed as moderator at the workshops. As such, I facilitated bridging between researchers and practitioners and between the different healthcare professionals. In this context of strong professional boundaries, my dual role as field-working researcher and facilitator of change was at times challenging.

In classical anthropological research, the anthropologist follows various social actors and dynamic processes in the field. As one seeking to facilitate change, I also had to respond to, and act in relation to these to “make things happen … or at least be catalysts” (Tax 1975: 515). This demanded a high capacity for improvisation and serendipity (Watson 2019).

Every set of workshops was conducted twice, as one part of the staff had to stay in the ward taking care of the patients, and the others went to the staff day. In the workshops, I presented preliminary research findings and guided the inter-professional discussions. These discussions could become rather heated, demanding sensitive navigation on my part as the moderator. The staff presented results from group discussions on large sheets of paper and in verbal presentations that I tape-recorded and transcribed. I took fieldnotes which, along...

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2 The fieldwork was divided into two research periods. The first involved intensive fieldwork including participant observation on all working days of the week for one year and two months (December 2009 - February 2011) and then periodically from March 2011 to December 2012. The second entailed shorter periods of fieldwork conducted between October 2013 and January 2018.

3 The study comprised five action research cycles starting in 2008 with focus groups on communication in the ward. For a detailed description of the first four action research cycles (see Dellenborg and Lepp (2018). Both the nurse and the physician management leaders were exchanged in this period: the first-mentioned twice and the latter once. These changes in management did not cause us any problems since all showed great interest in the project.
with the transcribed staff presentations, I subjected to analysis before presenting them to the research group. After each set of workshops, I wrote a report that was first discussed in the research group, then given to the management for comments. After reworking, the management leaders asked me to circulate the report in the ward, present it at different staff meetings, and at times to the hospital management. Observation was conducted in each encounter with the practitioners and reflection was an essential part of the whole research process.

**Building confidence**

To facilitate the staff’s reflections and dialogue in the workshops, I had to study communication, teamwork, and person-centred care from the perspectives of each professional group. Creating confidence and acceptance and attaining access were methodological challenges, given the strong professional identities and boundaries. I had to use my role as researcher flexibly, depending on the profession with which I was performing participant observation. I had to place myself in this hierarchical order and negotiate my own belonging there, in order to gain trust with each profession, and at the same time retain the trust of all. This demanded that I chop and change, and not stay consistent, rather like a trickster (van Meijl 2005). Because building the confidence of all four groups of healthcare providers was crucial for the project (cf. Tax 1975), I describe the process in detail.

The nursing staff were a relatively stable group working closely together in the ward. It was relatively easy for me to enter this group. Each time I arrived, the nurse management leader welcomed me publicly and announced to the nurses in the morning meeting that I was to spend the day in the ward. Frequently, one or several nurses invited me to be in their team, or I asked the one closest to me if I could join them during the day. To be recognized as someone who genuinely wanted to learn about the nurses’ working conditions, I had to work in close proximity to the patients. This included comforting, washing and drying patients, combing their hair, fetching plasters, water, food trays, blood-pressure cuffs, bedpans, blankets and clean clothes, sorting and folding washing. It was not possible for me to participate in the RNs’ more specialized work, such as administering medication, documentation, care planning, and contact with relatives; I could only “shadow” and observe them. Nonetheless this gave me significant understanding of their everyday situation.

Gaining acceptance among the physicians was harder. Unlike the nurses, the physicians moved around the clinic and often worked alone. I had to approach them one at a time. I could only follow the physicians around in their daily work; I couldn’t examine patients, listen with a stethoscope, make diagnoses, decide upon or carry out treatments, write or respond to referrals, approve medications, or lead rounds. However, I could fetch blankets, hold an anxious patient’s hand, and actively listen to the physicians’ discussions. Through this I learned a great deal. I noted the hope in a patient’s eyes as they looked at their doctor and later asked them, “What do you do with all the hope that is pinned upon you in your professional role?” I understood that physicians, like nurses, are subject to many expectations. I emphasized my role as researcher among the physicians. I discovered that many physicians knew about anthropology and were interested in the subject, which opened doors.

Learning from all professions in the team gave me the opportunity to explore misunderstandings and gaps in communication. By following first nurses and then physicians, I gained bodily experience of these gaps and the professional boundaries became visceral
to me. For instance, before I began participant observation with a physician, I had only met physicians during the ward rounds. These were organized according to a strict pattern in terms of both embodiment and speech. Working with a physician, I now saw myself positioned in this structure: the physician's body in front of the rest of us, a silent cluster, the physician's body turning back to us to say something. I realized that I must demarcate myself from the rest of the silent group if I was to earn the physician's trust as a researcher. If I dressed as the nurses commonly did, in blue, I would be associated with the 'other side'. Yet if I began dressing in white, would the nurses regard me as a deserter? Fieldwork in this setting was a balancing act. In hindsight, I realize how revealing of the clinic's professional hierarchy my worries were. Maintaining the trust of the various groups of professionals required delicacy. The way in which they viewed one another and pulled together depended upon the context. Privileges were always pointed out by those who lacked them: NAs in relation to RNs and physicians, nurses in relation to physicians and, after I had earned their trust, junior physicians in relation to their seniors.

When I shifted groups, conflicts of interest between the physicians' and the nursing staff's duties became clear. Time and space took on entirely different meanings. For instance, when I was with the physicians, the round just suddenly seemed to happen. With the nursing staff, I would already have been on the go for many hours when the round started. Further, the nurses mainly stayed with their ten patients in the ward, while the senior physicians' duties spanned the whole clinic. Marching quickly through the clinic with the physicians gave me a feeling of autonomy, and the physicians' better-fitting clothes made me feel slimmer. When I was with the nurses I often had to bend over for long periods of time in a single place – over a bed we were making, over a patient we were washing, while a patient was sitting in bed having blood tests taken, while we picked up the washing, took clothes from low shelves in the cupboards, prepared trolleys, fetched food from the fridge, or helped a patient to get dressed.

The junior physicians were in-between the nurses and the senior physicians, attending different tasks in the clinic and staying for long times in the ward. This middle position frequently put them in difficult situations. They had a great deal of responsibility in the ward but were dependent on the senior physicians for decisions on treatment or discharge. Waiting for these decisions created a work ‘bottleneck’, which gave rise to irritation in the team and often set nurses against junior physicians.

In spite of these differences, I noted an embodied solidarity among the staff on the ward. Emergencies, severely ill patients, and anxious relatives all prompted a cooperative spirit. At staff parties, there was laughter, dancing, and fun activities. Professional boundaries became more blurred, and a sense of common belonging to the ward more pronounced. Some of the nurses told me they thought the parties had a positive effect on teamwork in the subsequent week. “But then it's gone and we're back in this formal division again”, one nurse said gloomily.

Fieldwork demonstrated the extent to which the work environment enhanced the hierarchical order (cf. Messing 1998). As noted, the physicians did not experience themselves as prioritized; they often expressed feelings of powerlessness in relation to the healthcare organization and its management. They often found themselves facing the nurses’ violent criticism regarding a lack of communication or routines not being followed. A young junior physician told me, “I have tried to tell [the nurses] why, but they accuse
me of defending myself, they are not interested in my situation…” At the same time, the nurses clearly experienced a strong hierarchy in relation to the physicians, and felt that their time, duties, and knowledge were not valued. Patient overload and financial cutbacks only strengthened the hierarchical relationships between disciplinary knowledge bases and between professions. The staff experienced tension in the team, yet the organisational and structural aspects creating the tension were usually invisible to them. They were seldom given time for reflection and feedback, and conflicts and misunderstandings were rarely addressed. Making these circumstances visible to the management and the staff became our main approach to improve communication and teamwork in the ward.

The workshops on communication, teamwork, and person-centred care

The three sets of workshops on communication, teamwork, and person-centred care followed inter-professional group discussions and drama workshops on various aspects of communication and teamwork in the ward. Co-developed with the management leaders, the workshops intended to bring about change by helping the healthcare workers to ‘see’ themselves, to discuss what they had learnt, and develop their own solutions. The research team never presented solutions that we developed based on our research; the staff were the experts in their working environment and best suited to finding solutions to their problems. My role was to give an outsider’s view on their working situation and support them in problematizing what they took for granted. I now turn to the three sets of workshops, presenting them in chronological order.

Workshop on communication: All encounters are cultural

The first set of workshops were in late 2010. At the time, I had been doing fieldwork for over ten months and had held several drama workshops. I saw presenting professional relations and the complexity of the working environment without misrepresenting any of the professions as ethically challenging. I had observed their actions, choices, and communication patterns in situations of great uncertainty, in delicate and often painful encounters, and in emergencies, when any posturing in front of the observer was lost. After weeks of torment, in reflection with my research colleagues, I finally found support in the ethnographic stance itself: the non-judgmental, profound curiosity, and relativistic approach of truly wanting to understand what is going on ‘on the ground’ (D’Andrade 1995; Kiefer 2007). Remembering this ‘ontological commitment’ (Ingold 2017) helped me clarify my role in this new, and sometimes awkward situation of being both anthropologist and facilitator of change.

I started my presentation by describing the workshop as co-operation between researchers and healthcare workers, with the aim of finding solutions together for problems they defined. I explained my role as an outsider observer who was seeking to understand their situation, not as an expert who would tell them what to do. This statement raised interest in the staff, and many nodded their heads in approval. To link my presentation to the learning process, I reminded them that we had taken the first step in 2008, when

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4 The results from the group discussions that focused on transcultural care and communication in the ward are described in Dellenborg et al. (2012), and the drama workshops with the healthcare providers in Skott et al. (2012), and also in Dellenborg and Lepp (2018).
the ward management and researchers had arranged for a workshop where the staff had discussed communication in transcultural care in the ward, in inter-professional groups. Most present remembered that day well. I explained that we would continue this work on improving communication in the ward, but with focus on the staff as ‘the other’ this time. To help them think of themselves as ‘the other’, I compared my fieldwork in Senegal, West Africa to my fieldwork in the ward. I showed pictures of what I had initially found exotic and unfamiliar in Senegal and then in their ward, explaining my journey into learning the local norms in both settings. I intentionally took time to describe cultural practices, norms, and perceptions that I needed to learn in order to understand and adjust to Senegal, and how it had been confusing at times, but also a beautiful, fun, and surprising experience. My purpose was twofold: to familiarise the group with the anthropological methodology of fieldwork and participant observation and to help them get to know me as a person better, not as a detached researcher. My presentation was also an icebreaker, helping the participants focus on something other than their workplace for a short while.

After the pictures from Senegal, I showed the participants pictures which were more familiar to them. First was a photograph of the ward round being done. I asked them to reflect briefly on whether their positions in relation to each other might influence communication patterns. Next came a photograph of the naked hospital corridors and another of devices in the ward. I joked that I had expected R2D2 from Star Wars to come around the corner at any minute, and commented on how tired I was initially because of all the sounds. I talked about the different beeping tones, and how curious it was to see that different categories of staff reacted to different alarms. I showed them a list of medical terms that had flooded over me, saying that it had taken me weeks to be able to hear anything else during the round, so overloaded was I with this eccentric medical lingo. I intentionally used words such as “rituals”, “altars”, “sacred space”, and “secret language” when describing pictures of the staff’s familiar milieu. They laughed at how this classic anthropological terminology made them sound exotic.

I ended the presentation by saying, “All human encounters are cultural; we constantly interpret each other’s words and body language”. I clarified that we usually take our own cultural context and its codes and norms of behaviour for granted; we rarely perceive ourselves as cultural beings. If misunderstandings happen in transcultural encounters, we tend to explain these as the other being cultural, strange, and complicated. In making the group exotic to themselves I hoped to support them in self-discovery (Kiefer 2007) and break down the perception of differences between Us and Them that was the main finding from the 2008 discussions (Dellenborg et al. 2012). Their laughter and comments revealed an amused recognition that the organization of people and relations, language and practices in the hospital actually were quite special.

Next I presented the results from the transcultural communication discussions and the drama workshops. There, the staff had highlighted difficulties in communication with patients and their families, as well as between healthcare providers, and had pointed to difficulties within the team and the organization of care. The results showed how staff struggled to do the right thing, following their conscience and conviction, and that they did not always succeed because of stress, routines, language difficulties, lack of communication, misunderstandings, and hierarchical relations that silenced them. I made sure to give examples of situations that they could identify with and emphasize the staff’s strong ambition
to provide good care. This included demanding themselves to solve problems autonomously (Dellenborg et al. 2012; Dellenborg and Lepp 2018).

The staff listened attentively, with the nurses smiling and nodding, and posing short questions. I felt they were with me, but the physicians’ silence made me uneasy. I could not figure out whether they recognized the situations, or whether my presentation interested them, surprised them or made them critical or uncomfortable.

After a break, I divided the participants into inter-professional groups. Each group was given a theme that we had construed from analysing the drama workshops and asked to develop three suggestions for improvement to present to the entire group. I urged them to be constructive, to work as anthropologists, and take the opportunity for curious inquiry.

The response

The staff were intrigued by the outside perspective on the ward and themselves. They described the pictures and comparisons as a revelation, spurring reflection on how they worked and how they could work differently; for instance, how they needed to be more patient with new junior physicians and nurses on the ward. They reflected on the difficulties for patients and their families to navigate the hospital, realizing that signs were often confusing. Months and years afterwards, the staff repeatedly told me how this presentation had affected them and made them see themselves and the care environment with different eyes. Two junior physicians I met much later laughed at the fact that the hospital staff did not greet each other in the elevator. Reflecting about the atmosphere that this promoted, they commented that the hospital being a big work place was no excuse – tram drivers, for example, greet each other as they pass, and there are hundreds of these drivers spread around the city.

During the first workshop day, mostly physicians reported from the small groups. I realized this was because I had given the paper with the written instructions to the physicians. On the second day, I therefore handed out the instructions to the NAs in each group. This time, rapporteurs came from all the professions. They identified barriers to good healthcare encounters and teamwork, such as lack of knowledge about the individual patients due to high circulation of staff and a lack of documentation, and the need for extra physicans in the team and a greater presence of the senior physician in the ward. An area of concern was the lack of patient perspective and how to involve the patient in the care process from the start. They also realized that they were unfamiliar with each other’s tasks and daily work. One suggestion to remedy this was for the different categories of care providers to “shadow” each other during a working day. At times the discussion became heated, typically when nurses complained about physicians being unprepared and late for the round. As the moderator, I tried to open up the discussion by providing arguments for “both sides” from my observations, but the physicians mainly remained silent.

When the day ended, I was unsure of how the physicians as a professional group had received my presentation. Afterwards, however, several physicians expressed interest in my research and those who had not attended had heard from colleagues about the presentation. One senior physician commented, “It’s fun to be cartooned – it makes you recognize yourself.” Although pleased, I noted the word *cartooned* with ambivalence. Nevertheless, my presentation seemed to have achieved something among the physicians.

1 The themes were: improving teamwork, routines and flexibility, the patient’s voice, improved relationships with patients’ families, improvement of communication, and transcultural encounters.
Based on the staff’s suggestions, several routines were changed. A simple routine that facilitated teamwork was to write the phone numbers of the physicians on duty that week on the whiteboard, as well as the number of the nurse coordinating places for incoming patients. Another change was organising checks, such as taking the temperature of all patients every morning, and checking patients who were simply waiting to go home. The NAs told me this was an important change in care practice, as it freed up time to be with the patients. Still another new routine entailed adding a brief period in the afternoon for nurses and junior physicians to give feedback and reflect on the day’s work.

Workshops on teamwork

For the second set of workshops, which took place in 2012, the management leaders were interested in formulating ethical guidelines for conduct in the ward and the team. Initially, they asked the anthropology team to formulate these. We argued that a key approach in action research was seeing the staff as the experts. The staff needed an opportunity for deeper conversation about what they saw as the aim of teamwork, and the opportunities and barriers they faced in fulfilling this aim. On the basis of such a conversation, we suggested, the management could formulate ethical guidelines for conduct, or let the staff do it. The management leaders agreed it could be a good idea to explore the team’s aim and their scope for teamwork before writing rules. We drew on our experiences from the communication workshops to rethink how to stimulate productive dialogue. We wanted to avoid, for instance, silence on the part of the physicians. This time, we organized the workshop participants into profession-specific groups, with the aim of providing them a safe space to explore opportunities and obstacles to teamworking in their profession, and to consider how to promote inter-professional teamwork.

As during the communication workshops, I started with a presentation of preliminary research results from fieldwork and a short recapitulation from earlier interventions. I then talked about teamwork and started with a comparison with general knowledge from transcultural studies: when people from different parts of the world work together, they need to learn about each other's background, norms and perceptions; this awareness makes us more open-minded when misunderstanding and conflict occur. Teamwork researchers argue that this approach is needed in multi-professional healthcare teams as well, as the members have different professional formations, with different historical background, epistemological traditions and ontologies, and perspectives on the patient. I reminded the participants that they had discovered this in the 2010 workshops; one of their suggestions to improve teamwork was to shadow one another during a working day. I then gave a short lecture on different theories and definitions of teamwork, identifying as a challenge that organisations and enterprises often take for granted what teamwork implies. Using Lind’s and Skärvad’s (2004) playful metaphors of different sports to illustrate different healthcare teams, I described how teams ideally should be organized differently depending on aim, and that the team aim is one of the fundamentals of successful teamwork (Otis-Green and Cohen Fineberg 2010).

On the whiteboard, I wrote down the different teams they were actually working in, i.e. the multi-professional team that met each morning, a separate nurse team and physician team, and teams for competency development, among others. I drew pictures illustrating that in the competency development teams, the same people were working together over
time. For care teams, however, functions were represented and these were rarely occupied by the same person for any length of time. Each of the care teams consisted of one senior physician, one junior physician, two RNs and two NAs with shared responsibility for ten patients. Although the management aimed to keep the same individuals in a team for as long as possible, nurses were commonly exchanged every two or three days, and senior and junior physicians every Monday. Team members were not considered persons with relationships to the patients and to one another. Patients encountered so many different care providers during their hospital stay that they mixed them up. I gave examples of how this organization caused discontinuity and fragmentation in care, breaches in communication and increased tension in the team. I highlighted the nurses’ frustrated catch phrase, “Where is the physician?” as symptomatic for the tension in the team and the tendency to confine organizational problems to a single profession. To further illustrate structural and organizational aspects that influenced teamwork, I used pictures of communication flow during the round which I had drawn during observations, illustrating that time was mostly consumed by physicians’ internal interchange, with nurses briefly responding to physicians’ direct questions. I asked them to reflect on the implications this had for communication and relations in the team, as well as knowledge of the patient. In this way I prepared them for small group discussions, laboriously urging them to consider ward structures and how these structures influenced them. I asked them to be specific and to give examples – simply saying “more resources” or “improved communication” was too vague.

The response

Again, the staff appreciated the outsider view of the different teams in the ward. There was instant emotional recognition of the illustration of team members as functions rather than persons. One participant reflected on the absurdity of being expected to work with person-centred care without themselves being considered persons in the organisation. The sport metaphors prompted laughter and were pedagogical: the staff used them frequently in their presentations to make visible for themselves how they worked differently in different teams. Some structural and organisational factors that impeded teamwork were highlighted; others seemed too complex to formulate in the moment. The participants pointed out the extent to which the nurses and the physicians worked parallel to each other rather than in cooperation, noting that this was neither bad nor good but depended on the aim of the particular team. The nurses said it was important to make the patients members of the team, while the physicians preferred to talk in terms of a holistic understanding of the patient, and identifying patients’ needs.

This set of workshops was a real breakthrough. Power dynamics and hierarchy that I had identified during fieldwork and that made the healthcare providers uncomfortable when I brought them up, were suddenly formulated in plain words when participants reported from their group discussions. The senior physicians, who were understood by all as the undisputed team leaders, pointed out an impossible situation: they could not be team members as they had too many missions outside the ward. The physician management leader then explained that the senior physicians were actually scheduled 60% in other parts of the hospital. Suddenly, the nurses’ frustrated question “Where is the physician?” was answered. The senior physicians were lacking support ‘from above’ in providing continuity for their patients and the team. The junior physicians reported that the absence of senior physicians
in the ward meant that they bore significant responsibility for the running of the ward. They identified a lack of communication with the senior physician and with the nurses, which complicated their task.

The NAs expressed difficulties in ‘being heard’ and ‘being seen’, with several talking in terms of ‘not daring to speak’ during the round. They pointed out their competency was omitted from the team. When I asked one NA what hindered NAs from speaking, she said hesitantly, “I don’t know what’s medically relevant or not”. The RNs also reported ‘not being heard’: they were obliged to repeat themselves to get the physicians’ attention, and their knowledge was not valued. These reports produced disagreement among the nurses. As soon as one mentioned ‘not being heard’, another protested emphatically, declaring that it ‘depends on the person; I say what I have to say’. This resulted in the nurse who raised the problem falling silent. Further, the senior physicians did not understand why the nurses felt this way. They emphasized the importance of nurses’ perspectives on the patient and underscored that they expected the nurses to speak up during the round. Ultimately, the nurse reports led to a common conclusion that they needed competence building in verbalising caring perspectives. To me, this was yet another example of individuals and professional groups being blamed for structural circumstances. The nurses’ complaints mirrored the biomedical culture on the ward, where ‘the voice of the lifeworld’ was generally inhibited by ‘the voice of medicine’ (Mishler 1984).

Given the opportunity to discuss their situation without having to explain or defend themselves, the healthcare providers had formulated core barriers to fulfilling their roles in the team, and an important discrepancy in the aim of the team, i.e. to provide patients with the best care based on the competencies of all involved professions. When it came to discussing these reports together, tensions rose. Evidently, the issues were sensitive and occasionally explosive; they stirred emotions in all of us. Most of the participants, not least the physicians, spoke hesitantly, searching for words, anxious not to step on any mine fields. All the professions tended to disguise their meanings between the lines, which made my task as moderator trying. I had instructed them to give examples and not to be abstract. Reading the transcriptions, I can see that I unwittingly put the participants in an uncomfortable situation, as I urged them to put their experiences into plain words.

Reception of the report
The management leaders appreciated the report, and I was invited to present at various levels and in different situations in the ward and in the hospital. The physicians’ management leader commented with satisfaction that although some of the suggestions were impossible to follow because of inadequate resources (for example, the senior physicians’ situation and the discontinuity this caused), much could be adjusted. They incorporated the report in an information sheet for patients and their families concerning what they could expect from care and how the staff worked in teams. The report later led to the junior physicians being scheduled two consecutive weeks in the ward for better continuity, instead of one as with the senior physicians. Finally, the nurse management leader used the report to help formulate ethical guidelines for the ward.
Workshops on teamwork and person-centred care

The last set of workshops on teamwork and person-centred care occurred in a different context than previous occasions. This time, I had conducted fieldwork periodically and was less anchored in the participants’ everyday context. I was worried that this might lessen the staff’s confidence in me, as circumstances change quickly in hospitals. All the senior physicians and the majority of the nurses knew me from before. There were however quite a few junior physicians that I never had met. In addition, after two years of implementation work in the ward, there were still voices questioning the feasibility of person-centred care, especially among the senior physicians. The majority of the nurses expressed the importance of providing person-centred care, and many of the junior physicians also saw a value in that approach. I expected heated discussions.

As with previous workshops, I began by highlighting how the work on person-centred care was part of a long-term effort to improve teamwork and include the patient's voice. I recounted that I could see improvements since I first entered the ward in 2008. I then presented the concept of culture and the possibility of changing the structure, followed by a few words on the challenges of work according to their own definitions of the team aim from 2012. I spoke about the epistemological differences between biomedicine and nursing, the priority of medical aspects in the team and the nurses' experiences of not being heard.

In presenting my field observations on their work to implement person-centred care and formulate care plans together with the patients, I highlighted the finding that patients generally appreciated being more well-informed. The NAs witnessed that patients now took more interest in and responsibility for their own treatment. RNs and NAs felt that the plan gave them greater independence in fulfilling their tasks. However, physicians reported a heavy increase in work. In-bed time had been reduced, causing more work for the already overburdened junior physicians. I also reported that my interviews with patients indicated that they went home with big questions unanswered. For example, one elderly woman wondered why the heart problems that she had been experiencing for many years had now suddenly worsened. Was it because her husband was suffering from dementia and this made her home situation difficult? I knew the physicians had answered her question several times, but always standing during the bedside round, with other patients waiting and the whole team around them, and never in dialog in a calm setting.

Drawing on the success of the last set of workshops, I divided participants into groups separated by profession. They were given the same questions as in the previous workshop about the team aim and their role in the team, plus a new question on how their profession could promote the patient perspective.

The response

The presentation and the theme for discussion spurred the healthcare providers’ interest. They participated energetically in the small group discussions, and came forward with interesting insights. My worry that they would lack confidence in me proved groundless. During the breaks, the junior physicians in particular sought me out to continue the discussion. Presentations in the larger group were animated, and the atmosphere was mostly friendly, although there were some heated moments. For example, it emerged that the junior physicians and the nurses had different strategies for handling the round, which complicated teamwork and presented barriers to good care. A marked difference from the 2012 workshops
was that both junior and senior physicians raised concerns about the patients’ perspectives and experiences, and stating that they needed more time with the patient. In 2012, the physicians had not addressed the patients’ perspectives, only the nurses. Now the physicians complained about the lack of time and space for a real conversation with the patient. They identified problems with the lengths of the various rounds. They explained that the overall ground situation was not suitable for conversation, standing as they were by the patient’s bed, surrounded by the team and other patients in their beds. As one physician exclaimed, “There isn’t even a chair for me to sit down on!” Ever since my first fieldwork, the physicians had complained about lack of time with patients, and of course, the added question on how their profession could promote the patient perspective influenced the discussion. However, the emphasis on the patient’s experiences and also the focus on “real conversations”, both of which can be said to be central to person-centred care (i.e. patient experiences and narrative, see for instance Ekman et al. 2011), were new.

Clearly counteracting the ethics of person-centred care was the lack of inter-professional co-operation and co-production of knowledge about and together with the patient. The physicians talked in terms of the other team members giving them information so that they themselves could form a holistic picture of the patient as a basis for the medical decision. Significantly, the most important relation for the physicians was with the patient, not as a team member, but as their patient deserving the best treatment. In contrast, the nurses focused on the patient as a team member, and the importance of improving relationships between the professions in the team and the collaboration of different disciplinary perspectives for the best care. In other words, the physicians promoted a multi-professional team with themselves as the decision-makers, whereas the nurses (as in the previous workshop) rather promoted an inter-professional team and the co-production of decisions. The workshops revealed staff engagement with the patient, but strong professional boundaries within which medicine remained the prioritized knowledge, and the other team members’ competency was understood as information adding to biomedicine, not as knowledge in itself. Further, the patient was understood by the physicians as ‘theirs’, not the whole team’s responsibility. Overall, the participants in this process realized that their efforts to achieve their ideal of person-centered care were impeded by aspects of their own institutional organization, such as the division of labor, spatial and temporal organization. In various ways, they put the hierarchical ordering of relations between members of different professional groups (nurse assistants, registered nurses, senior and junior physicians and also the management and the administration) into words.

**Conclusion**

Better communication, improved inter-professional teamwork, and person-centred care in the ward require epistemological and ontological changes. The healthcare providers’ efforts at positive transformation were hampered by circumstances they could not control, such as the senior physicians working 60% outside the ward, staff cut-backs, and reduced time for care. As described elsewhere (Wolf et al. 2012), Sherry B. Ortner’s (1996) concept of serious games can be used to understand the possibility for change in hospital organizations. Social life can be understood as a game with rules that limit action, but the rules may also be stretched and interpreted differently. In addition, there is never only one game, but a “multiplicity of games in play, both at any given moment, and across time” (Ortner 1996: 20). Participants
in these serious games play with “skill, intention, wit, knowledge [and] intelligence” (ibid.: 12): we are neither completely tied down by the structure, nor completely autonomous agents, but act and are constructed by multiple simultaneously-existing games. From this perspective, critical collective reflection and raising awareness are important strategies for inducing change. How every individual healthcare provider acts in relation to patients and their families, and in relation to colleagues and other team members matters.

Still, if there are no efforts made to change the context, transformation through collective reflection and learning cannot reach its full potential. Change within healthcare is also a question of curriculum; how nurses and physicians are trained into conventional professional identities that create boundaries, rather than as team members co-producing knowledge (McCormack 2018). Significantly, in the current era of NPM, with its focus on efficacy as the prime objective for care, a change in hospital organization for improved communication, inter-professional teamwork and person-centred care is a societal issue and a question of political will.

I recently met one of the management leaders at a conference on person-centered care. She told me that whenever they as management leaders are asked how they work for a person-centered care in the ward, they present their many years of collaboration with anthropologists as a method for improving the conditions for person-centeredness such as communication and teamwork. Of course, I was delighted to get this confirmation that anthropology in the clinic matters. Like the action anthropologist Mark K. Watson, I see anthropology’s most important contribution to the ward as being “a more complex and nuanced awareness for the context in which action, conflict, life occurs” (2019: 27, emphasis in original). As I have described, the healthcare providers and management leaders often got stuck in a pattern of blaming individuals or individual professions for problems caused by structural and organizational circumstances. The workshops gave them the opportunity to conduct a “collective self-reflexive enquiry” (Kemmis and McTaggart 2005: 1) into their circumstances of communication, professional identity, teamwork, and patient care, making reflexivity a social practice (Watson 2019).

Research colleagues who have worked in this same ward referred to my role there as “a living intervention” and say that its echoes are still found in staff discussions of ward circumstances. The anthropologist’s intensive presence in the everyday life of the ward prompted staff reflection; posing questions had incited dialogue on things sometimes so ordinary that they did not see them until the anthropologist poked her finger at it. Our collaborative reflections during the workshops allowed the staff to identify new perspectives that supported them in their work for change. Our collective reflections particularly allowed us to transcend professional boundaries, at least to some extent. These moments of co-learning and co-producing knowledge are at the heart of what anthropologists can contribute to healthcare professionals’ work for transformative change. They are what enables ethnographic research to become “a living intervention”.

Acknowledgements

The author is grateful to the healthcare professionals and the management staff for their co-operation in this action study, and also to the action research group: Associate Professor Carola Skott, Professor Margret Lepp and Dr. Kristina Nässén. The author would also like
to thank: The Centre for Person-Centred Care (GPCC: http://gpcc.gu.se ) at the University of Gothenburg, Sweden for funding. Thanks are also extended to the two anonymous reviewers whose valuable comments improved the text.

References


Bricolage
What Can Anthropologists Offer in Applied Settings?

Maria Padrón Hernández | PhD in Social Anthropology

One of the things I love most about my profession as an applied anthropologist is that it helps me to go back and forth between the messiness of life and the clarity of analysis. I believe ethnographic methods are the best way to truly capture the former, while the latter is the only way to use this knowledge, be it for research, analysis, or practical action.

While writing this essay, I have reflected upon those important questions that were left unanswered during my academic studies in anthropology. The experience that I have gained since I started working outside of academia has allowed me to answer the question: what can an anthropologist bring to the table in an applied setting? More specifically, what can anthropologists offer to their potential employers or communities that only few others can? I address these topics here.

My answer is of course, coloured by my specific experience. I trained as an anthropologist in Sweden and completed a PhD in 2012 before leaving academia to work first as a consultant doing external evaluations of projects run by Swedish municipalities, then as a teacher for youth in an underprivileged community, and most recently as a program officer in a Swedish NGO that tries to build international solidarity. Working in such different settings allowed me to see contributions that I made wherever I worked which were valuable to the people I worked with and for. I use experiences from my current position as program officer for the Swedish solidarity organisation BjörkåFrihet, to exemplify such contributions.

BjörkåFrihet was founded in 1965 as a socialist workers’ collective gathering second hand clothes, furniture, books, and so on, to send abroad as material support or sell in Sweden. The organisation supported liberation movements and the anti-colonial and anti-imperialist struggle in the Middle East, Africa, and Latin America. Today we continue collecting second hand goods but instead of sending much of it to other countries, we sell it in the five stores run by the organisation. The revenue is used to support organisations working against contemporary colonialism and occupation in Palestine and Western Sahara.

The anthropology that I engage with in my current position is intended to facilitate processes of change. BjörkåFrihet wants to know what type of interventions they should focus on, what organisations to work with, and how partnerships should look. They want to know about the context that these organisations work in, determine the risks (for staff, for financial transfers, for the organisations receiving the money) and make sure to do no harm (as development work has often caused more harm than it has solved). I am responsible for making sure that the organisation’s strategy is implemented in the best possible way and ultimately, that the gifts we receive from our donors and the money spent by customers in our stores are also used in the best possible way. BjörkåFrihet as well as donors and customers...
want to know how ongoing projects are progressing, how the resources have been used and what are the effects of interventions. In turn, the partner organisations with whom we work want to see how we can cooperate to address a problem. Yes, they are looking for funding to carry out activities that they want to do, but they are also looking for networks of solidarity, avenues to conduct advocacy, and new ideas on how to change the lives of their communities for the better.

Working as a program officer requires me to leave my office and engage with the messiness of life and the turbulent waters of societal and cultural change as a deeply participatory participant-observer. My work is political and moral and considering anthropology’s (and the development sector’s) history of compliance with colonialism, it is risky, scary, and sometimes angst-inducing.

As a program officer I participate in a closed loop, from study to intervention to evaluation, and the cycle from messiness to contemplation and back is extremely fast. This can be compared with the work of a consultant working for a client. Consultants use the knowledge gained in conversations, interviews, and focus groups to write a report. They transform a complex reality to the simplification of a written product. This kind of report is then used by others to inform their decision, but the decision itself is completely out of the consultant’s hands. In my case however, my end goal and our collective end goal, is always to do something, to change something. I can influence the whole organisation’s direction, the way their long-term strategy is formulated and the way it is implemented. Ultimately, however, all decisions lie in the hands of our members and the board they elect.

BjörkåFrihet’s fast pace and lack of opportunity to take a step back and devote more time to analysis and contemplation is a typical problem for many organisations. However, the focus on action and the insistence on the applicability of knowledge is as exhilarating and rewarding as it is challenging and frustrating. It is exhilarating because many times my work leads to tangible results. It is frustrating because change takes time and sometimes I work for years before I see anything significant happening.

At the same time, it is not me making the changes happen; I am very rarely at the centre stage. If there is a successful campaign to change a law or the way that a business operates, I am typically the one who makes sure that the activists have access to the necessary resources. I am backstage rather than on stage, my name is certainly on a pay slip but never in the spotlight. I work to facilitate change, but the change itself is a collective effort.

**Anthropological Skills in Applied Work**

Based on this kind of experience, I am convinced that anthropologists who work in applied settings offer specific skills that are highly valuable. I want to focus on two of those here: first, the capacity to handle complex data; and second, the ability to redefine where knowledge can and should be found.

I think most anthropologists know that the data we collect is complex, but I also believe that few anthropologists within academia recognise just how specialised this skillset it. I think anthropology lecturers could do more to make sure students know that this is one thing that they can offer a future employer. Let me explain with a comparison.

I know a researcher who works in the biomedical field, mostly focusing on proteins. He gets dizzy thinking about the complexity of working with cells – molecules, he argues, are already complex enough. As anthropologists we handle data that is far more complicated
than either cells or molecules! It is important that applied anthropologists know this and let others know about it too.

Here is another example. I have spoken with applied anthropologists who have been contacted to interpret the comments at the end of a survey questionnaire, where people are asked to express what they think rather than tick a box. These anthropologists tell me that their employers have needed them because none of the people who carried out the surveys knew what to do with that information.

My point is that anthropologists can collect data which few others are able to and then interpret it in a way that can be useful for others. We do this by moving from the messy, contradictory, complex life of human beings toward analytic simplifications needed to find meaning and applicability. Our methods, our perspective, and our ways of generating knowledge are adapted to handle this. They help us strike a balance between complexity on the one hand and usefulness on the other. Participant observation prepares us to find as much and as important data during a lunchbreak, as during an interview. We are trained to take into consideration not only what is said during a focus group but also the dynamics in the group. When looking at interview responses we not only look for what people say but also which words they use, how they may resist certain questions, or the words that the interviewers have chosen to describe something. We are attentive to power in a nuanced way, considering how power shifts minutely depending on context. When bringing together representatives from organisations in different parts of the world for a meeting for example, we not only carry out workshops and organise activities but pay attention to the dynamics of the group. We examine our role in it, always attentive to how our position of power can be used to create a less-hierarchical dynamic. We are attentive to how the different organisations relate to each other, trying to create an environment of cooperation and mutual help rather than competition. The relativism inherent in the anthropological perspective and our capacity to take the perspective of others helps establish rapport and build a deeper understanding. All of this gives us access to nuanced and complex data.

We then make this data usable by simplifying it. In applied anthropology the analysis is all about making a set of data useful for a specific purpose. The question that the anthropologist asks herself, when deciding what to keep and what to leave out of a report, is if it is relevant for the specific purpose of the job. What data is useful for the client to know? What data has guided us to make the recommendations we present?

Most readers of this journal know how to do this already. It is a basic component of academic writing. Yet in my experience we rarely tell students that this is a valuable skill which they can use for other things than writing papers. Even more rarely do we tell students that this is a skill that many other professions do not have – at least not to the same degree – and that it is thus something they as anthropologists have to offer.

The second skill I want to discuss is our ability to redefine where knowledge can and should be found. Our anthropological capacity to handle messy data also leads to a daredevil approach to collecting data. We conduct research among people who are often far removed from decision-makers and whom decision-makers have a hard time approaching or establishing honest communication with. We excel at conversing with the target group, the end users or whatever you want to call them. In other words, anthropologists work with people beyond ‘the usual suspects’ when it comes to applied research.
Let me give you an example. Michael Agar is a veteran in applied anthropology. He once told me an anecdote about another applied anthropologist who was hired to find out why so few patients used a clinic that had just opened in a working-class neighbourhood in the USA. The management wondered why people insisted on crowding the old clinic when the new one had an almost empty waiting room; had they failed to see the municipality’s information campaigns? The anthropologist went to the old clinic and asked a couple of people who were sitting in the waiting room. The next day he could deliver the answer: there was no public transport to the new clinic. Apparently no one had actually talked to the patients about their needs.

Anthropologists dive right into the messy, the contradictory, the complex details that many others avoid. Sometimes when we take this dive we find the simplest answers, as in Agar’s story above. But even when the answers are not so simple, we can provide information that is extremely important for making decisions and facilitating change. In a society where specialisation and expertise are often connected to education, decision-making processes can be revolutionised by turning ‘ordinary people’ into the experts on their own lives and using everyday life as a source of data. Patients frequenting a clinic know best why they choose to go there. People living in a specific neighbourhood or working in a specific factory know best what improvements need to be made. The anthropological perspective – our theory and method – leads us there and prepares us to handle the data that we find.

Partially because of this perspective, anthropology has an inherent potential to be critical. There is a subversion of power or at least a democratisation of power in elevating certain kinds of everyday knowledge into expertise. Working in a global setting accentuates this as people from outside the world’s power nodes get to set, or at least influence the agenda.

**How to Work for Change**

Let me turn to my work with the Sahrawi cause as an example. Western Sahara is a country south of Morocco. It was once an area populated by nomadic people, then it became a Spanish colony, and since 1975 has been a country occupied by Morocco. In other words, it is Africa’s last colony. Half of the Sahrawi population lives in the Occupied Areas, which is roughly two thirds of the country including all cities, natural resources, and the entire coast. The other half of the population lives in refugee camps in a barren desert area in neighbouring Algeria. BjörkåFrihet was an early supporter of the Sahrawi struggle for independence and started sending material support (clothes and shoes) to the refugee camps as soon as they were established in 1976.

When I began working for BjörkåFrihet, one of my tasks was to determine how we could deepen and expand our work for the Sahrawi cause. I started by reading the few books published on the issue, doing skype interviews with researchers, and talking to activists and organisations in Sweden. Then I went to the refugee camps in Algeria. The occupied areas are heavily militarised and foreign visitors are routinely deported for meeting the Sahrawi activists, so visiting them was not an option. In the camps I met the officials and people working with the international NGOs having offices on site, and also engaged with the local organisations and asked them to bring together groups of people with whom I could talk. The talks were structured as workshops where I asked the participants to analyse the problems in their community, the causes and effects they could identify, and the possible solutions.
This might sound easy, but coming to an understanding of a problem as complex as the occupation of Western Sahara with ten people whom you have never met before requires skills. To conduct four or five such workshops and then combine the results into some sort of action plan requires simplifying complexity without losing the important details. Anthropologists are good at this.

In this specific instance, the workshops demonstrated that people saw the main cause of their problems as the occupation of Western Sahara. They were very clear that European governments were part of the problem because of their complicity in the occupation. One of the main solutions proposed (the only one not involving armed warfare, in fact) was to mobilise international solidarity, especially in Europe, to put pressure on European governments to stop supporting Morocco.

This might sound trivial. Why would we need workshops to come to this conclusion? Let me answer this by pointing to an EU-funded project that was designed at the same time in the exact same setting. This project saw the main problem as the radicalisation of youth in the camps and the cause of this problem was the lack of work and leisure activities for young people. The response was an education campaign to help entrepreneurs and provide micro loans. In other words: the occupation was never seen as part of the problem. Rather, a specific way of mobilising resistance against the occupation became the problem. Instead of focusing on supporting other ways to mobilise resistance, the EU-funded project looked for ways to make life in the refugee camps more bearable and give youth things to do. Based on my experience, I interpret this campaign as an expression of the security concerns of the EU, not as an analysis based in actual exchange with youth in the camps.

Returning to my own example, the analyses made together with the workshop participants were then used by BjörkåFrihet to formulate a theory of change. Theories of change are used widely within the development sector and are often part of bigger project descriptions and applications for funds. A theory of change refers to the way that an organisation conceptualises a specific problem and how it can be addressed. If an organisation has a clear picture of a problem and its causes and effects, it can be clear about the potential solution and how the organisation can contribute to it. A theory of change answers a whole range of questions, but crucial are the questions ‘what should we do?’ and ‘why should we do it?’ A theory of change in other words, links an intervention (or if you will, a project) to a bigger picture and shows how the intervention can contribute to resolving a specific higher-level problem. For example, if you work with an information campaign, the theory of change helps explain why that campaign is relevant.

In my example, the people we spoke to identified advocacy work with European and US civil society as a crucial solution to the main problem, namely the occupation of Western Sahara. The theory of change thus indicated the main problem and also proposed solutions. It specifically told us to focus on international advocacy work. For some organisations this would have been an indication that we, as a Swedish NGO, should work with advocacy and lobbying in Sweden and Europe. We chose instead to focus on supporting Sahrawi media activists both in the camps and in the occupied areas. This strategy had several advantages. The main advantage was that it left the power of advocacy work in the hands of the people engaged in the struggle for independence. A second advantage was that the activists could focus on the most relevant audiences at the appropriate time. At a certain
point in time, resources might be better employed to have an impact in the US or France rather than in Sweden.

To summarise, this case shows how the anthropological insistence on seeing the people ‘on the ground’ as the source of knowledge, shaped the way we made our analysis and the way we sought to implement it.

I cannot emphasise enough how seldom development works this way. Other initiatives in the Sahrawi refugee camps in Algeria are either humanitarian (providing basic necessities) or run-of-the-mill development projects focusing on making life in the camps more bearable (such as the EU-project mentioned above, activities for youth, micro-loans or education). Very few interventions actually target the problem that has forced these people to live as refugees in camps for more than 40 years.

We as anthropologists can offer new ideas and strategies precisely because of the kind of data that we search for, where that data leads us, and because of the radical potential that our perspective carries. When we work with groups, we offer a way to see and analyse power differentials, and to shift them, if ever so slightly. Of course, this is a skill that is not always appreciated. Despite talks about ‘citizen dialogue’, ‘diversity’, ‘gender’, and ‘democracy’, organisations that hire anthropologists often want to be able to check a box saying that they have taken people’s views into consideration. The will to let people’s views guide the decision-making process is missing.

Let me give an example from a project that I was asked to evaluate, which focused on establishing dialogue between youth and politicians in a municipality. One of the project’s stated objectives was that the “youth felt the politicians had listened to them”. The project had no objective such as ‘politicst decisions were informed by youth perspectives’ or “suggestions put forward by youth were included in the final plan”. If an anthropologist had been involved in the project design, s/he would have sought to include these objectives. An anthropologist would have made the project about democracy, not PR.

One thing that we as anthropologists bring to the table is a critical perspective and the desire to shift power to the hands of the people who are affected by a given intervention or decision. This is not easy work, and even when an employer asks us to do this, he might regret it later. Nevertheless, I believe facilitating these shifts is one of our most important contributions as anthropologists. Whether or not we want to market ourselves as subversive, we can and should be critically attentive to power.

Conclusion

I conclude by returning to the question of what we as anthropologists working in applied settings, can bring to the table that only few others can. We can collect and make sense of complex data that few others can, and we see valuable knowledge in the unexpected and mundane. We transform conversations, anecdotes, and long rambling answers into something that can be of use for making decisions. We offer a critical perspective, as we bring forth the knowledge of groups and people who are never invited into board rooms and decision-making processes.

As Swedish anthropology is “put to work”, anthropologists will need to define their specific contributions to solving problems and making change. We will need to let non-anthropologists know what we can contribute with. This essay is my contribution to that need. In a complex world where economic, social, and environmental sustainability as well
as power relations should inform all decisions, our skills are needed. To put those words in perspective, I write this essay in the midst of a global pandemic and a global uprising against deadly state violence and police militarisation in poor urban areas. It is crucial that we as anthropologists let the world know what we can do. The way I see it, our skills and capacities bring with them a duty to be of use for social betterment – and there is much work to be done.