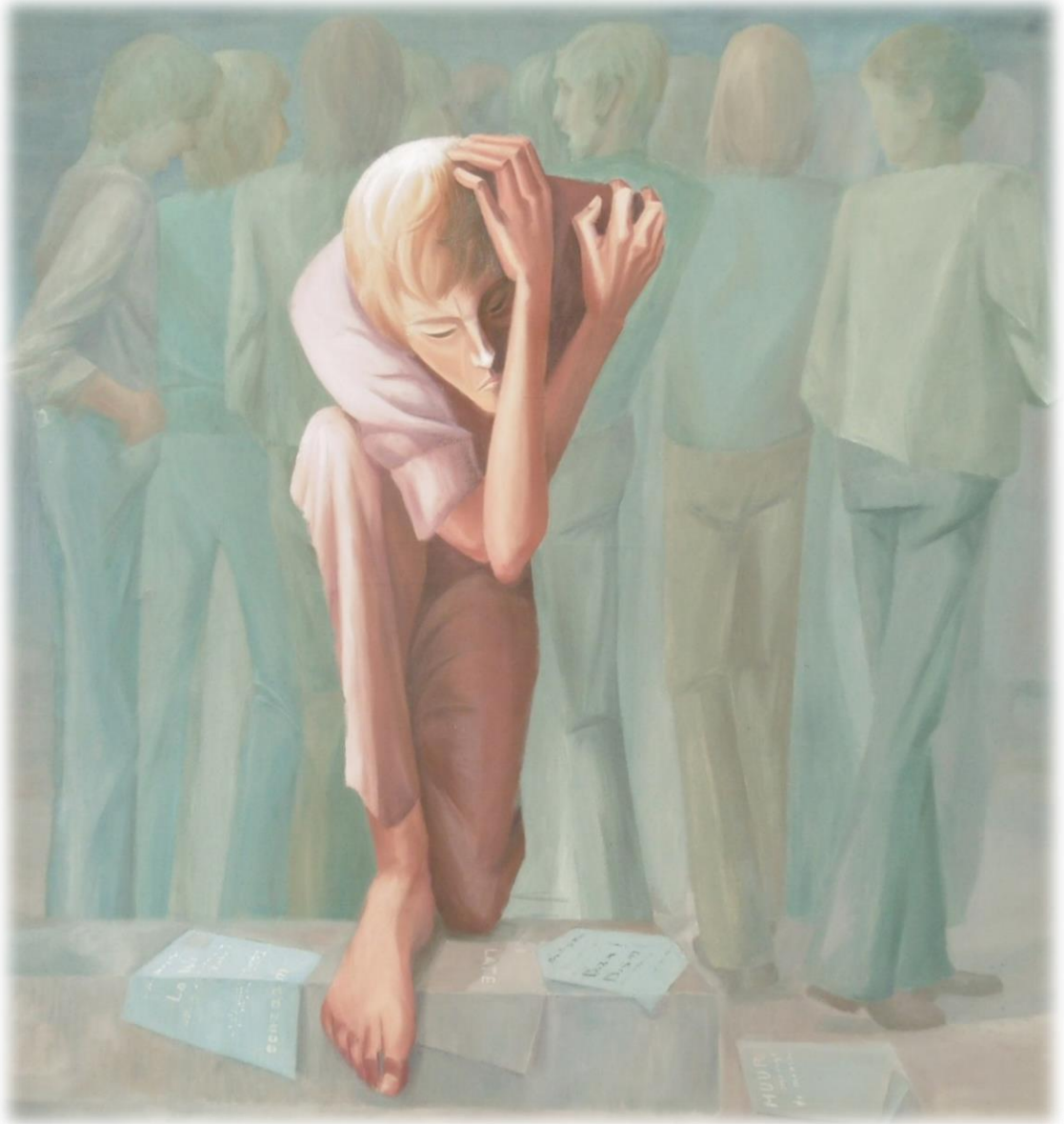


Identity constructions at the intersection of mental health, religion, ethnicity and gender in Belgium



Elise Rondelez



Identity constructions at the intersection of mental health, religion, ethnicity and gender in Belgium

A dissertation submitted to the Faculty of Political and Social sciences of
Ghent University in partial satisfaction of the requirements
for the degree Doctor in Sociology by

Elise Rondelez

Supervisor:

Prof. dr. Piet Bracke

Co-supervisors:

Prof. dr. Sarah Bracke

Prof. dr. Griet Roets

2018

Was I ever crazy? Maybe,... Or maybe life is. [...]

Crazy isn't being broken, or swallowing a dark secret

It's you or me. Amplified.

If you ever told a lie and enjoyed it,

if you ever wished you could be a child, forever.

They were not perfect, but they were my friends.

[...]

Some I've seen. Some never again.

But there isn't a day my heart doesn't find them.

(Girl Interrupted, 1999)

Table of contents

Introduction	1
Chapter 1 Theoretical perspectives	5
1. Migration and mental health: State of the art	5
1.1. Migrants and mental health: Increased risk.....	5
1.2. Explanations for the higher incidence of mental health problems amongst diasporic migrants	11
1.3. Other research evidence	14
2. Under-representation of diasporic migrants with mental health problems: The state of the art.....	17
2.1. Epidemiological data.....	17
2.2. Different prevalence among social groups	18
2.3. Institutional frameworks.....	23
2.4. Several explanations for the under-representation of diasporic migrants in mental healthcare	24
3. An intersectional approach.....	33
3.1. Disability and mental health.....	34
3.2. Ethnicity and race.....	38
3.3. Religion	39
3.4. Gender (and gender studies).....	41
3.5. Socio-economic status.....	45
3.6. Multiple intersections: An example	46
4. Research questions	47
5. Methodology	48
5.1. Research context	48
5.2. Research questions	64
5.3. Research process	65
5.4. Ethical considerations.....	69

Chapter 2 Racism, migration and mental health: Theoretical reflections from Belgium	95
1. Introduction	97
2. At the cross-roads of social relations of power.....	100
3. Mechanisms of ‘Othering’ and/in mental health	106
4. The absent ‘missing revolution’ of postcolonialism in sociology	111
5. Conclusion	113
Chapter 3 Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent.....	123
1. Introduction	125
2. The subject of mental health.....	127
3. Mental healthcare professionals in Ghent.....	130
4. Shedding light on emerging insights	132
4.1. Ontological	132
4.2. Epistemological	138
4.3. Ethical.....	141
4.4. Technical	143
5. Conclusion	145
Chapter 4 Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims	155
1. Introduction	157
2. Framing mental health: An exploration of the work of Erving Goffman	160
2.1. A biomedical frame	161
2.2. A resocialisation frame	161
3. Re-conceptualising ‘frames’ for contemporary mental healthcare services .	162
3.1. A totalitarian notion of power and an essentialist notion of the subject	163
3.2. Goffman revisited.....	164
4. Research methodology.....	167
4.1. Research context.....	167
4.2. Data-collection strategies	167

4.3. Strategies of data analysis	169
5. Research findings	170
5.1. A biomedical frame	170
5.2. A resocialisation frame.....	172
5.3. A frame of cultural difference	174
6. Conclusion.....	176
Chapter 5 “But that is a cultural given.”: Diasporic Muslims, mental healthcare professionals and the cultural-difference frame	185
1. Introduction	187
2. Research methodology	189
3. Culture: What’s in a name?	190
4. The cultural-difference frame.....	195
4.1. Pressure from the community and culture as values and norms.....	196
4.2. Spiritual healing and culture as way of life.....	199
4.3. Psychosomatisation and culture as schemes of interpretation.....	203
5. Conclusion.....	205
Chapter 6 How to make sense of cultural difference in mental healthcare: Analysing the biographies of diasporic Muslim women with mental health problems.....	217
1. Introduction	219
2. An intersectional theoretical perspective.....	221
3. Agency.....	224
4. Methodology	226
4.1. Research context	226
4.2. Strategies of data-collection	227
4.3. Strategies of data-analysis	229
5. Findings.....	229
5.1. The embodied and embedded nature of mental health problems	230
5.2. Family and community life	233
5.3. Education and employment	240

5.4. Religion	242
6. Conclusion	247
General conclusion and discussion	261
1. Introduction	261
2. Theory.....	262
2.1. Subjectification.....	262
2.2. Agency.....	265
2.3. Frames	267
2.4. Culture and racialisation	268
3. Methodology.....	270
4. Ethical considerations	275
5. Results	276
5.1. The content of the frames	281
6. Further research	287
7. Implications for policy, practice and research	289
7.1. Implications for policy and practice	289
7.2. Implications for culturally sensitive professionals	295
7.3. Implications for research	295
Appendices	305
1. Appendice A: Information mental healthcare professionals.....	305
2. Appendice B: Information diasporic Muslims.....	307
English summary	309
Nederlandstalige samenvatting: Identiteitsconstructies op het snijpunt van geestelijke gezondheid, religie, etniciteit en gender in België	321
1. Probleemstelling	321
2. Onderzoeksvragen en hypothesen	322
3. Opzet.....	323
4. Conclusie	324
4.1. Bevindingen.....	324

4.2. Discussie – implicaties voor beleid en praktijk.....327

Acknowledgements/Dankwoord

“[My accomplishments] are not despite such incidents...I want to bring these personal bodily experiences closer to my center-not to claim that they constitute all of who I am, but that they are a central part of my identity; ... they are essential to understanding what I have done

(Zola in Devlieger et al., 2003).”

30 jaar geleden dacht niemand dat ik zou staan waar ik nu sta. Mijn familie zou al blij zijn als ik liep en sprak en mij eventueel ook normaal ontwikkelde. Dankzij mijn ouders en de stimulansen die zij mij gaven, kwam ik echter steeds verder. Ik kon naar een ‘gewone’ school, volgde ASO en kon zelfs verder studeren. Ik koos voor ‘sociologie’, een richting die niemand mij zag doen. Ik legde mijn lat steeds hoger en bereikte vaak het beoogde resultaat. Na mijn afstuderen, bleef het kriebelen en vroeg ik me af of ik een doctoraat zou aankunnen. Opnieuw bleven mijn ouders in mij geloven en zegden dat ik het gewoon moest proberen. Ondanks, of dankzij, de vele tegenslagen op mijn weg was ik steeds een vechter. Mijn ouders zeggen dat ik dit volledig aan mezelf te danken heb, hoewel ik geloof dat ik het voor een groot deel ook van hen heb meegekregen. Doorheen mijn hele leven heb ik, mede dankzij hen, ook een groot belang leren hechten aan waarden als rechtvaardigheid en hulpvaardigheid. Ik ben dan ook met hun steun voor de volle 100% voor mijn onderwerp gegaan.

Na 4,5 jaar ligt hier eindelijk mijn doctoraat voor u. Ik heb er al die jaren hard aan gewerkt, maar een doctoraat schrijven doe je natuurlijk niet alleen. Daarom zijn er een aantal mensen die ik op het einde van dit project graag zou bedanken.

Eerst en vooral bedankt Sarah, Griet en Piet, mijn promotors, die mij de nodige begeleiding gaven om deze uitdaging te kunnen doorstaan. Bedankt Sarah om mij vanuit Amerika, Brussel of Nederland te ondersteunen op emotioneel vlak en doorheen de theoretische uitdagingen die deze ontdekkingsreis met zich mee bracht. Bedankt ook Sarah om tijdens de begeleiding van mijn masterproef het zaadje van zin in onderzoek te planten. Bedankt Griet om mij emotioneel en praktisch in de dagdagelijkse uitdagingen bij te staan. Zeker de laatste helft van mijn doctoraat heb ik

daar veel aan gehad. Griet, ook bedankt voor dat onmisbare cadeau dat je me bezorgde bij de start van dit project. Dankzij Zazou heb ik me tijdens dit doorgaans eenzame werk nooit echt alleen gevoeld. Bedankt Piet om dit project bij aanvang al te redden. Zonder jou, zou mijn doctoraat niet eens van start zijn kunnen gaan.

Bedankt aan de voorzitter, en de leden van de examencommissie om dit eindproduct te willen doorworstelen en jullie bedenkingen erover met mij te willen delen.

Daarnaast ook bedankt aan Caroline en Audrey, die beiden gezorgd hebben voor een empirische verdieping van dit project. Bedankt Audrey, ik weet dat de weg naar je masterproef niet de gemakkelijkste was, maar ik hoop dat onze samenwerking in de zoektocht naar participanten toch ook jou vooruit geholpen heeft. Bedankt Caroline, je hebt een noodzakelijke aanvulling toegevoegd aan het project, een deel van het onderzoek, waar ik zelf de tijd niet meer voor had. Ik ben je zeer dankbaar dat je dit interessante, maar noodzakelijke werk op jou hebt willen nemen.

Bedankt ook aan de vele participanten, professionals en moslima's, die tijd hebben vrijgemaakt om in gesprek te gaan met ons over dit (moeilijke) onderwerp. Ik hoop dat ik jullie woorden zo heb weergegeven en geïnterpreteerd dat jullie je erin herkennen en trots kunnen zijn op onze samenwerking.

Bedankt aan de vele collega's van zowel de Korte Meer als de Dunantlaan die het werk eveneens minder eenzaam maakten. Aan de Korte Meer wil ik in het bijzonder Vera, Ad en Lore bedanken, mijn bureaugenootjes van de eerste helft. Daarnaast ook bedankt aan Ad en Rozemarijn om zich kandidaat te stellen om mijn peter en meter te willen zijn en mij zo extra te ondersteunen. Ik heb veel gehad aan de gesprekken met jullie. Tot slot wil ik bij de sociologen in het bijzonder ook nog Sarah Van den Bogaert bedanken voor de leuke en gezellige babbels en steun tijdens congressen en Hedera-weekends. Zeker ook bedankt voor de medische bijstand als ik me weer eens verbrand. Veel succes nog met je eigen doctoraat. Aan de Dunantlaan, bij de sociaal werkers, wil ik graag in het bijzonder Indra, Robin en Yan, mijn bureaugenootjes daar bedanken. Jullie maakten de tweede helft van mijn doctoraat echt aangenamer. Hier vind ik het moeilijk om nog anderen in het bijzonder te bedanken, omdat jullie mij allemaal zo

nauw aan het hart liggen. Ook al was ik een socioloog, ik voelde me nooit een vreemde eend in de bijt. Bedankt allemaal voor de ondersteunende én ontspannende babbels.

Bedankt, Carine, Deborah, Virginie en Astrid om de administratieve taken op jullie te nemen, zodat ik me daar al niet mee bezig moest houden. Zeker op het einde van het project hebben jullie mijn zorgen echt verlicht. Bedankt Tina en Patrick. Bedankt Patrick, voor de technische ondersteuning gedurende het proces, voor het oplossen van printer en kopieer problemen.

Bedankt Sylvie, Sofie, Fanny, Elise, Lobke, Charlene en dr. Biot voor jullie steun op de achtergrond zodat ik in staat was om dit project op een zo normaal mogelijke manier te voltooien.

Dan wil ik ook nog mijn familie bedanken, die mij bijstond gedurende dit ganse proces. Bedankt tante Marijke dat ik jouw werk, dat mij zo bekend is, mocht gebruiken als cover voor mijn werk. Bedankt mama en papa voor jullie geloof in mij dat ik ook dit project tot een goed einde zou brengen, maar ook voor jullie begrip in het geval ik er eerder zou mee stoppen. Bedankt Camille, Lukas, Luckas en Fenne voor jullie steun en interesse tijdens de weg hiernaartoe. Lukas ook nog bedankt om mee de allerlaatste puntjes op de i te zetten. Ik weet zeker dat jouw doctoraat (even) fantastisch zal zijn.

Rozelien, kleine meid, bedankt om dat straaltje zonneschijn te zijn waar ik zo van hou. Het is onbeschrijfelijk, maar ik ben zo ontzettend blij dat ik jouw meter mag zijn en dat jij de soms donkere dagen van mijn doctoraatsproces verlichtte.

Tot slot, bedankt Jan om te zijn wie je bent. Jij kwam anderhalf jaar geleden eerder als een verrassing in mijn leven. Bedankt dat je als ervaringsdeskundige luisterde naar mijn gezaag en geklaag en mij bijstond met tips en tricks om mijn doctoraat tot een goed einde te brengen. Bedankt voor je begrip, als ik weer eens geen tijd voor jou had. Ik kijk al uit naar de volgende avonturen die op onze weg liggen. Ik zie je graag.

“Strictly speaking, the question is not how to get cured, but how to live.

(Conrad in Szasz, 1978)”.

Introduction

One third of the Belgian population will face mental health problems during their lifetimes. Not all of these individuals will find their way to mental healthcare services. The situation is likely to be even worse for Muslims of migrant background. Evidence suggests that they are more likely to encounter mental health challenges. According to various studies, Muslims (and other individuals) of migrant background are under-represented in established mental healthcare services. This presents a conundrum that needs further exploration.

This conundrum has been studied from a number of different perspectives. Some studies are of a quantitative and epidemiological character. Others focus on the prevalence of mental health problems in different segments of the national population, as well as on the unequal distribution of mental health problems. A third line of investigation regards this under-representation as being influenced by institutional dynamics and the implicit bias of mental healthcare institutions. Most of this research is qualitative in nature. Finally, other qualitative studies focus on the socio-culturally constructed character of mental health problems. The existing literature lacks an in-depth, dynamic understanding of what happens in the interactions between professionals and individuals with mental health problems.

In that vein, this research project aims to produce insight into the frames used by mental health professionals and by diasporic Muslims in their encounters within the context of medical healthcare. It is also intended to explore the possible implications of these frames for the current common understanding of the under-representation of diasporic Muslims with mental health problems in established mental healthcare services.

The first chapter consists of the introduction to this dissertation and a description of the problem it addresses. This is followed by a discussion of the state of the art, in which I describe my research and the terminology I use. I then present and discuss various research insights emerging in various theoretical terrains of knowledge. The

research project is therefore based on an intersectional theoretical approach. Based on this intersectional thinking, I provide a further theoretical and empirical exploration of processes of subjectification that are at stake in interactions between mental healthcare professionals and diasporic Muslims.

This doctoral research project is intended to contribute to existing scholarship by posing and pursuing two research questions. First, by

mapping, analysing and theorising existing frames of mental healthcare towards diasporic Muslims of Turkish and Moroccan background amongst a wide spectrum of mental healthcare providers and professionals

and second, by

conducting biographical research with Muslims of migration background who are seeking mental healthcare. We do this to examine how they experience discourses and services in the Western mental healthcare system, along with the discourses and practices that are used within the Muslim community, in addition to theorising the strategies they develop in the process of seeking mental healthcare.

Doing this I want to formulate answers on the following questions: *Where do diasporic communities from various countries who identify as Muslim and settle in Belgium go with their mental health concerns? Do they find their way to the existing mental health services? If not, where do they take their mental health concerns? If yes, how do their contacts with, and trajectories through, the established mental health services look like? And what does their underrepresentation within mental health services reveal about the social organization of mental healthcare?*

These questions were investigated through qualitative research. To answer some of the questions, I conducted 31 qualitative interpretative interviews with a wide range of professionals from a variety of organisations in the city of Ghent, Belgium. The participants were selected according to a snowball-sampling strategy. The second empirical part consists of an analysis of the other side of the story: the stories of

diasporic Muslim clients. For this study, we conducted biographical research with 12 diasporic Muslims who were settled in Belgium who were seeking mental healthcare. We used qualitative, semi-structured interviews to explore the personal meanings that both parties assign to their experiences of their contacts in the context of mental healthcare.

The second chapter presents a theoretical exploration of the sociological literature on subjectification and the various intersections pursued in this dissertation: mental disability, religion, ethnicity/migration and gender. These critical lenses, each of which refers to a specific subject position that I regard as particularly important to the issue of under-representation addressed in this research, highlight the urgency of extensive empirical study. I define processes of subjectification as discursive strategies within the sociological literature that rely on the demarcation between the normal and the abnormal, thereby framing the subject of mental health in particular ways. I refer to these discursive strategies as ‘mechanisms of othering’.

Chapters 3-5 are empirical, examining the perspectives and experiences of mental healthcare professionals. In Chapter 3, I explore and analyse our interviews from the theoretical perspective of Nikolas Rose and Edward Said’s insights on ‘Orientalism’. In Chapter 4, I analyse the data drawing on insights from the theories of Erving Goffman and post-structuralists, including Judith Butler. In the analysis, I devote particular interest in the ways in which professionals construct frames. In addition to the biomedical and recovery frames, which are addressed in Goffman’s work, I identify a new frame: the frame of cultural difference. In Chapter 5, I consider this frame in more detail, drawing on the theory of Stuart Hall on race and culture as floating signifiers. Finally, Chapter 6 focuses on the other side of the story, that of diasporic Muslim women. Relying on theoretical insights in the work of Saba Mahmood and Rosi Braidotti, we theorise and explore the agency of these women and the ways in which they conceptualise mental health problems.

The final chapter of this dissertation is intended as a reflection on the most important insights emerging from these studies, as well as on the strengths and

limitations that should be taken into consideration, the issues that have yet to be resolved and the challenges for policy and the practice of mental healthcare.

Chapter 1¹

Theoretical perspectives

1. Migration and mental health: State of the art

1.1. Migrants and mental health: Increased risk

Studies have indicated that migrants have an increased risk for some mental health problems. For example, second-generation migrants run a higher risk for schizophrenia and psychosis (34%) than do native Europeans (14%) (Cantor-Graae & Selten, 2005; Fossion et al., 2002; 2004; Gramaglia et al., 2016; Hoffer, 2009; Livingston & Sembhi, 2003; Marwaha & Livingston, 2002). Men are at particularly high risk (40%), as compared to native Belgians (14%) (Fossion et al., 2002). More post-traumatic stress disorders (Buytaert et al., 2009) and bipolar affective disorders are more common amongst migrants (Swinnen & Selten, 2007), although studies on depression and anxiety disorders are less clear (Bhugra & Mastrogianni, 2004; Doornbos et al., 2013; Lay et al., 2007; Levecque et al., 2009; Lindert et al., 2008; van Beelen, 2013). As reported by Levecque, Lodewyckx and Vranken (2007) depression and generalised anxiety are more prevalent amongst Turkish and Moroccan migrants than they are amongst native Belgians or migrants from origins in the European Union. In addition, some researchers emphasise the fact that mental health problems are socially constructed and are thus not independent of the culture, society or situation in which they occur (Doornbos et al., 2013; Summerfield, 2008). For this reason, comparisons between groups should be approached with caution (Veling et al., 2007b). Migrants from low-income or middle-income countries or from areas in which the majority of the population is black have been reported to be at higher risk for schizophrenia (Selten

¹ British English

& Cantor-Graae, 2007). For example, Turkish immigrant groups are unlikely to be much different from Western migrants (Selten et al., 2001), and the risk for schizophrenia is likely to be lower amongst Turks than it is amongst Moroccans (Lindert et al., 2008; Veling et al., 2007b). In addition, problems related to the migration process are likely to result in more mental health problems. Examples include homesickness, lack of a social network, adaptation problems and other problems or negative experiences during or after the migration process (van Beelen, 2013). At the same time, studies have also indicated that some migrant groups are largely under-represented in established mental healthcare services (Abas, 1996; Bäärnhielm & Mösko, 2012; Boneham et al., 1997; Doornbos et al., 2013; Heinz & Kluge, 2012; Karasz, 2005; Lawrence et al., 2006; Marwaha & Livingston, 2002; Vardar et al., 2012; ZorgnetVlaanderen, 2011). This creates a problematic situation in which the individuals to whom we² refer as diasporic Muslims are more likely to need mental healthcare, but often do not succeed in accessing these services.

1.1.1. Terminology

In this dissertation, I use the terms ‘diasporic Muslims’ and ‘mental health problems’. The term ‘diasporic’ is used in order to emphasise the journeys and genealogies that Muslims of Moroccan or Turkish background have created in Belgium. It also makes it possible to consider the second or even third generations of these communities. In this project, I also focus on processes of subjectification, as I believe that diasporic Muslims are constructed as subjects throughout their processes in mental healthcare. The term ‘diasporic’ also allows me to address these issues. I use the term ‘mental health problems’ in order to emphasise the socio-cultural, historical and political character of these problems. Although the element of social construction applies to all

² The research team exists out of Elise Rondelez (PhD-student, who was responsible for most of the first study), Piet Bracke, Sarah Bracke and Griet Roets (professors), Caroline Vandekinderen (post-doc, who was responsible for the second study) and Audrey De Roeck (master student, who did also interviews for the first study).

of the important notions in this dissertation, our articles are primarily about mental health.

1.1.1.1. Diasporic Muslims

Diasporic Muslims are more likely to experience mental health problems than are the populations of either their host countries or of their countries of origin (see Bäärnhielm & Mösko, 2012; Buytaert et al., 2009; Chakraborty et al., 2010; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour, 2011; Lawrence et al., 2006; Marwaha & Livingston, 2002; Rechel et al., 2013). I use the concept of diaspora as an analytical frame for examining the economic, political and cultural paths that have historically been traced by particular genealogies of migrancy (the history and development of migrant flows). I also use the concept to examine relationships between various migrancies in the fields of social and power relations, identity and subjectivity. I argue that the migration process also shapes the subjectification process of our participants. In addition, I consider the regimes of power inscribing the formation of particular diasporas and that allow internal distinctions of diasporas, in addition to situating them in relation to each other.

As a concept, ‘diaspora’ can also be used to critique discourses involving fixed origins, as not all diasporas include an ideology of return. This critique concerning fixed origins is also my reason for preferring to use the term ‘diaspora’ and not ‘native’ and ‘non-native’, as the latter terms focus primarily on the countries in which individuals were born.³ The situation is further complicated by the fact that the term ‘non-native’ has evolved into a general term for everyone with foreign roots, as long as those roots are situated outside of the Western world. A similar process has occurred with the term ‘migrant’. This term is an over-used term, and it is currently used to refer to people who have not migrated themselves. It is for these reasons that I have opted

³ It is important to recall that no concept or definitions will ever be able to provide a complete description of reality. They always result in inclusion and exclusion, and their redefinition (e.g. through time) will always provide an incomplete or relatively static reality (Wolffers et al., 2013).

for the adjective ‘diasporic’, as it also allows me to refer to the migration histories or familial backgrounds of individuals who have not migrated themselves.

Diasporas can be formed by different journeys to various parts of the world, each with its own particularities and history. The various migrancies can be integrated into a single journey by the convergence of narratives that have been lived (or re-lived), produced (or re-produced), remembered and transformed, whether individually or collectively. The identity of the imagined diasporic community is not specified in advance (Brah, 1996; Rondelez et al., 2016). Every notion could be subject to be criticism or in need of additions. These deficiencies are often related to aspects that are associated with the terms, rather than with the actual concept (Hoffer, 2009).

In Belgium, the diasporic community was defined by events including the influx of immigrants during the 19th century. Belgian mining companies attracted Polish, Italian, Hungarian, Moroccan and Algerian labourers, as well as labourers from the Balkan region. A second wave of migration developed after the Second World War, when the Belgian government signed the first bilateral labour-migration agreements with Italy, Spain and Greece. Between 1958 and 1961, however, the influx from these countries decreased, and Belgium had to sign new bilateral labour-migration agreements with Morocco, Turkey, Tunisia and Algeria. In 1927, 14% of all miners in Belgium were Muslim (Kaya & Kentel, 2007), and there are currently approximately 728,000 Muslims in Belgium. Many of these individuals are labour migrants who came to Belgium in the 1960s. The group of diasporic Muslims also includes the families of labour migrants who came to Belgium through family reunification programs or marriage, along with their descendants (i.e. second-generation or third-generation migrants). What was originally regarded as a temporary home became a permanent settlement in a new (host) country. In other cases, migrants sought ways to live between the countries.

The state reform of 1980 was accompanied by important components of migration policy, and ‘integration’ became a communitarian issue. Flanders, the Northern part of the country, invested in building a network of integration centres, which would eventually be complemented with minority organisations (after 1998). Studies have

indicated that migrants identify more strongly with the local level than they do with the national level (Fadil et al., 2015). For this reason, I focus on the city of Ghent, in which Turkish and Moroccan Muslims are amongst the largest groups of diasporic migrants. The first generations came as labour migrants. Although later generations have become increasingly integrated, they continue to be under-represented in the mental healthcare system.

1.1.1.2. Mental health problems

In this dissertation, I have chosen to use the term ‘mental health problems’ instead of other terms (e.g. mental illness). This is because, in many medical or psychological studies, mental illness is regarded as something inherent in the person. I am not convinced that this is the case (Barnes & Mercer, 2003; Beresford, 2000). The subjectification process that influences diasporic Muslims depends on the context in which it takes place. I have therefore opted for a more social approach that allows me to refer to the social, cultural, historical and political character of mental health problems (Barnes & Mercer, 2003; Corker & Shakespeare, 2002; Devlieger et al., 2010; Gustavsson et al., 2005; Vandekinderen & Roets, 2016).

One important shift in the perception of mental health problems was that from a biomedical frame towards a social frame. The biomedical frame was once characterized by the patient playing a passive role and the doctor-psychiatrist being regarded as an expert. This frame disregards social circumstances and reduces diseases to mere biological processes (Goffman, 1961). The biomedical frame has since been altered, and it can currently be summarised by five propositions. The first is the doctrine of specificity, which states that every disease can be explained by a biological cause (Engel, 1977; Wade & Halligan, 2004). The second has to do with the belief that the body and mind should be treated separately from each other (Borrell-Carrió et al., 2004; Engel, 1977; 1980; Wade & Halligan, 2004). The third element of the contemporary biomedical frame is the mechanistic metaphor, which entails the belief that the body can be conceptualised as a machine (Borrell-Carrió et al., 2004; Engel,

1977). Fourth, the biomedical frame adopts a technological imperative, meaning that it focuses on technological interventions (Borrell-Carrió et al., 2004; Engel, 1977; 1980). The final biomedical subtheme is the implicated reductionism that neglects socio-psychological explanations (Borrell-Carrió et al., 2004; Engel, 1977; 1980; Wade & Halligan, 2004). Various scholars have criticised the biomedical frame as pertaining to the medicalisation of society, neglecting socio-economic influences on diseases and regarding patients as passive objects (Borrell-Carrió et al., 2004; Engel, 1977; 1980; Wade & Halligan, 2004).

In contrast, a social frame treats mental health problems as being socially and culturally constructed. (Mental) health problems are the result of the construction of an imperfect environment. The social frame regards social and ecological relations and systems as the origins of (mental) health problems, which is situated within the environment. From this perspective, the problem is not situated within the individual, as is the case in the biomedical frame. The social frame can be used to investigate patterns of interaction between individuals and the environment within a system, which can have both positive and negative consequences. Mental health problems arise when individuals lack capabilities within a typical range, as well as when the environment is not adapted to the entire range of human existence. The social frame also regards mental health problems as situational or contextual, in addition to being relative and constructionist, in reference to the arbitrariness of our dichotomies. According to this frame, control over the situation resides in the capacity of the environment (Devlieger et al., 2010; Traustadóttir & Kristiansen, 2004). As with the biomedical frame, however, the social frame has been the subject of criticism. It has been criticised for an excessive focus on social and structural barriers, while ignoring cultural and experiential dimensions. It has also been said to ignore the biological, individualist basis of disorders, even though it is not restricted to at the examination of structural barriers. It is purported to neglect the experiences of people with certain types of problems or based on sexuality, ethnicity and gender. Finally, some claim that it is just as reductionist as the biomedical frame is (Traustadóttir & Kristiansen, 2004).

This approach focusses primarily on the socio-cultural construction of mental health problems, as well as on the construction of the mental health conditions included in the DSM (Bäärnhielm & Mösko, 2012; Heinz & Kluge, 2012; Summerfield, 2008). The social frame also studies differences in explanatory models (Bäärnhielm & Mösko, 2012; Heinz & Kluge, 2012; Hoffer, 2009; Kluge et al., 2012; Vardar et al., 2012). A third focal area of the social frame concerns the influences of structural and interlocking power relations (e.g. gender, ethnicity/race and class) on the interpretation of mental health problems (Crammond & Carey, 2016; Hoffer, 2009; Kapilashrami et al., 2015). Finally, in this context, the social frame also focusses on the influence of alternative therapies in the home countries of migrants on the conceptualization of mental health problems (Hoffer, 2009). This corresponds to the critical disability studies approach as an interdisciplinary theory that nurtures different paradigmatic shifts in relation to the epistemological and ontological grounds of disability (Goodley et al., 2012). Instead of reaffirming a Cartesian vision of disability that treats disabled minds and bodies as essentialist, pre-social and biological essences, critical disability studies challenge the idea that “biology is destiny (Linton, 1998: 532)”. From this perspective, disabled minds and bodies are reframed and captured according to an anti-essentialist frame as dynamic, relational, non-dualistic and fundamentally social phenomena within society (Roets & Braidotti, 2012; Rondelez et al., 2016).

1.2. Explanations for the higher incidence of mental health problems amongst diasporic migrants

Several explanations have been offered for the higher incidence of mental health problems amongst diasporic migrants. Given the dearth of research on diasporic migrants, it is also necessary to consult the literature about migrants in general. According to one stream of thought, the frequency of mental health problems is higher in the countries of origin. This is assumed to be the result of genetic differences or differences in environmental factors (Buytaert et al., 2009; Selten et al., 2001; 2005). Other researchers assert that people with mental health problems are more likely to

migrate.⁴ Some elements in people with a predisposition for schizophrenia (e.g. inner agitation, suspicion and detachment) are assumed to facilitate the decision-making process to migrate (Buytaert et al., 2009; Selten et al., 2001).

Another explanation that has been offered for the higher incidence of mental health problems amongst diasporic migrant populations is that cultural differences are likely to generate errors in the diagnosis of mental health problems in migrants in general (Buytaert et al., 2009; Inhorn & Serour, 2011). For example, the belief in witchcraft is quite common in Moroccan culture, and the Moroccan-Berber culture could be regarded as highly distrustful. Based on these characterisations, persecutory delusions amongst first-generation and second-generation Moroccan migrants are likely to be interpreted as having a different type of clinical significance and to be attributed to the Moroccan idiom of distress (Veling et al., 2007b). In Western cultures, hallucinations are taken as a symptom of schizophrenia. This is not always the case in other cultures. Thought processes that seem delusional are not necessary pathological if viewed within the appropriate cultural context. First-generation migrants of non-Western cultures are likely to experience psychosis as a reaction to stress, while the most common reaction to stress in Europe is depression (Haasen et al., 2000). Hallucinations are also more likely to be evaluated positively in foreign cultures than is the case in European cultures. For this reason, they may be more likely to be noticed and communicated to others (Veling et al., 2007b). Some researchers also stated that first-generation migrants present more psychotic symptoms when they have to speak in non-native languages or through an interpreter (Haasen et al., 2000).

Finally, researchers have addressed other societal elements (e.g. socio-economic position, experiences of racism, acculturation processes and traumatic experiences) in order to explain the higher incidence of mental health problems amongst migrants of all generations (Bäärnhielm & Mösko, 2012; Buytaert et al., 2009; Inhorn & Serour, 2011). First-generation and second-generation Moroccans with psychosis tend to have lower incomes and are more likely to be unemployed than are native Belgians (Fossion

⁴ A 'healthy migrant hypothesis' exists as well. It will be explained later on.

et al., 2004; Selten & Cantor-Graae, 2007; Veling et al., 2007b). The experience of discrimination in several different domains of life could result in thoughts that are more paranoid. In turn, this might result in greater susceptibility to psychosis. This is particularly likely to be the case for individuals who have experienced discrimination throughout their lifetimes. This could be an explanation for the higher rates of mental health problems that have been observed amongst second-generation diasporic migrants, as compared to their first-generation counterparts (Janssen et al., 2003; Lindert et al., 2008; Oh et al., 2014; Veling et al., 2007b). Migrants are more likely than non-migrants to develop a negative self-image. Individuals form their identities according to role models within the societies of which they are a part. The role models of migrants likely to be considered in a negative light by the dominant group. This increases the likelihood that migrants will incorporate such negative evaluations into their own (correspondingly negative) self-images (van den Muijsenbergh et al., 2013). Social exclusion, lower SES and racism, resulting in a chronic sense of inferiority and dismay (i.e. 'social defeat') is likely to increase the risk for psychosis, depression and addiction amongst migrants of all generations (Oh et al., 2014; Selten et al., 2013; Selten & Cantor-Graae, 2007; Veling et al., 2007a). This notion makes it possible to explain the difference between first and second generations of migrants: it is easier to feel unwelcome because one was born in another country than it is to feel unwelcome in the country in which one was born (Selten & Cantor-Graae, 2007; Selten et al., 2013).⁵ It could also explain the difference between Moroccan men and women. In Belgium, more educational and career opportunities are available to Moroccan women than are available to Moroccan men, who perceive greater pressure to achieve social status (Selten & Cantor-Graae, 2007; Veling et al., 2007a).

Some studies have indicated that the greater prevalence of depression and generalised anxiety amongst migrants is due primarily to the lower socioeconomic position of first-generation migrants (Levecque et al., 2007). Social defeat can be mitigated by social support for all generations of migrants (Fossion et al., 2004;

⁵ According to other studies, however, the prevalence of mood disorders is higher in foreign-born immigrants (Levecque et al., 2009).

Janssen et al., 2003; Levecque et al., 2007; 2009; Oh et al., 2014; Selten & Cantor-Graae, 2007). This explains why the Turkish community, which tends to be known for its strong social and family networks, exhibits fewer schizophrenic symptoms (Selten et al., 2001; Selten & Cantor-Graae, 2007). This situation also has to do with the fact that they form a greater proportion of the local population (Selten & Cantor-Graae, 2007; Selten et al., 2013). It could be that the Moroccan population is characterised by greater individualisation, and the conflict in the Rif mountains might explain why the Moroccan community tends to be more divided (Levecque et al., 2007; Selten et al., 2001). The suicide risk amongst migrants of different generations is also lower in neighbourhoods with higher ethnic density (Neeleman & Wessely, 1999).

One additional societal element on which researchers have focused is the acculturation process. Acculturation can have a variety of influences on the image of the 'self', as well as on interpersonal relationships. These effects could be associated with the emergence of psychopathology. Any form of acculturation can be linked to different stressors. For example, assimilation and segregation are associated with the lowest levels of short-term stress, while integration is likely to involve more short-term stress and a greater reduction of long-term stress. For example, for Russian and Iranian migrants in Germany, the stress of acculturation has been reported to be associated with psychological tension, low self-esteem, fear of failure and a sense of social isolation. When such tensions exceed the individuals' resilience, this increases the risk for depression and anxiety disorders. Although several specific cultural protective factors could potentially counteract acculturation stress, they are not sufficient (Haasen et al., 2008). When migrants undergo a positive acculturation process, this reduces the risk that they will develop mental health problems.

1.3. Other research evidence

According to some studies, the incidence of mental health problems in the migrants' countries of origin is not higher than it is in their host countries (Rechel et al., 2013; Selten et al., 2001; 2005). These claims are contradicted by studies conducted by the WHO on the incidence of schizophrenia in developed and less-developed countries

(Buytaert et al., 2009; Selten et al., 2001). This notion concerning higher incidence is also contradicted by the fact that, although Surinamese people in the Netherlands are more likely to experience more mental health problems in the Netherlands, the prevalence of such problems amongst Surinamese people in Suriname is equivalent to that of Dutch people in the Netherlands (Selten et al., 2005). Although comparisons of the prevalence of common mental health problems (depression and anxiety disorders) have revealed substantial differences between countries, these differences could possibly be due to differences in the amount of attention that clinicians pay to mental health problems, as well as to differences in social stigma and the accessibility of mental healthcare (Bhugra & Mastrogianni, 2004). Nevertheless, few studies have addressed possible differences in the incidence of common mental health problems between diasporic migrants and the native population in the country of origin.

The hypothesis that the most vulnerable people tend to migrate seems contradictory to the ‘healthy migrant effect’ (Rechel et al., 2013), which posits that first-generation migrants are often healthier than the host population. This is because such health advantages are necessary for the act of migration, which is accompanied by many stressors. This ‘effect’ thus appears to stand in contradiction to the increased prevalence of mental health problems amongst migrants. It is important to note, however, that some mental health challenges might not become apparent until after migration has occurred (Buytaert et al., 2009; Rechel et al., 2013). The ‘healthy migrant’ hypothesis also fails to explain why second-generation migrants – who did not migrate themselves – tend to have more mental health problems than first-generation migrants do (Cantor-Graae & Selten, 2005). Although some studies attempt to explain this situation by observing that diasporic migrants adapt to the lifestyle of the receiving country (de Jong, 2013). In addition, this hypothesis offers no explanation for the higher incidence of mental health problems among Surinamese migrants in the Netherlands, as a third of the Surinamese population migrated after Suriname became independent (Selten et al., 2001).

Another explanation explored in some studies is that the higher incidence is rooted in cultural differences. This argument seems to be flawed as well, however, as

the relatives of people with mental health problems also regard some behaviours that mental healthcare professionals consider strange as being strange as well (Buytaert et al., 2009; Inhorn & Serour, 2011; Selten et al., 2001; Veling et al., 2007b). Differences in symptoms are unlikely to be due solely to cultural differences, as not all non-Western ethnic minorities differ from the majority population (in this case, native Dutch people). The incidence of religious delusions amongst native Dutch people has been reported to be even higher than it is amongst Moroccans of all generations in the Netherlands. Researchers have asserted that there is an interaction between culture and adverse social experiences (Veling et al., 2007b).

A third argument holds that, because diasporic migrants are assumed to exhibit more psychosomatic symptoms, they are likely to receive fewer diagnoses of mental health problems (Buytaert et al., 2009; Inhorn & Serour, 2011). In addition, the supposition that lower SES tends to result in greater risk for schizophrenia is rather unlikely. Even if this were to be the case, it would not explain why schizophrenia has been observed to be more prevalent in less affluent countries. Studies have indicated that lower SES should be treated as an inducing or accelerating factor for mental health problems. According to some researchers, cultural sensitivity or the desire to be 'politically correct' often leads people to speak in terms of 'culture' instead of referring to 'ethnic differences', as observations concerning ethnic differences tend to be associated with racism. This reifies social differences and neglects discrimination (Heinz & Kluge, 2012). "The question is not whether racism operates, but when, where and how (Andrews & Jewson in van den Muijsenbergh et al., 2013)". This approach has also limited the number of studies on racism and discrimination in healthcare (including mental healthcare).

Having discussed the over-representation of mental health problems amongst diasporic migrants, I now address the scientific exploration of the under-representation of this target group in the use of mental healthcare services.

2. Under-representation of diasporic migrants with mental health problems: The state of the art

Sociological research has provided evidence of the under-representation and absence of diasporic migrants with mental health problems in the established mental healthcare system (Abas, 1996; Bäärnhielm & Mösko, 2012; Boneham et al., 1997; Doornbos et al., 2013; Heinz & Kluge, 2012; Karasz, 2005; Lawrence et al., 2006; Marwaha & Livingston, 2002; Vardar et al., 2012; ZorgnetVlaanderen, 2011). It is interesting to note, however, that studies on such under-representation focus on different epistemological and methodological commitments, which consequently lead to different interpretations.

2.1. Epidemiological data

One interpretation relies largely on quantitative studies of problems associated with investigating mental health amongst diasporic migrants. This approach draws on epidemiological data to explain the under-representation of this target group. Evidence is provided by noting the lack of registration of the ethnic origins of clients in healthcare, mental health and social welfare services (Hilderink et al., 2009; Kluge et al., 2012; Lodewyckx et al., 2005; Rechel et al., 2013). Given several limitations, however, it is not always clear that the data on which these studies are based are correct. These limitations include conceptual and methodological problems (e.g. differences in the definition of who is to be considered a migrant). Other problems include political sensibilities and their misuse in the context of racism and discrimination, the heterogeneity and small size of diasporic migrant communities – which requires over-sampling – and the difficulties associated with reaching some populations (Hilderink et al., 2009; Rechel et al., 2013).⁶ Most epidemiological studies are descriptive, and they often neglect structural elements, despite their importance. Some authors have nevertheless acknowledged the importance of recognising the

⁶ These problems have also been reported in qualitative studies, and I have encountered them in this study as well.

possibility that structural elements do not necessarily have different effects of different groups or that structure might affect everyone within a given group to the same extent. Moreover, epidemiological data might arguably focus more on similarities across social groups and differences within social groups. This is in contrast to the present approach, which often does the opposite (Crammond & Carey, 2016; Livingston & Sembhi, 2003).

2.2. Different prevalence among social groups

A second interpretation refers to both quantitative and qualitative studies that focus on the prevalence of mental health problems in different segments of the national population, as well as on the unequal distribution of mental health problems (Siller et al., 2015; Vardar et al., 2012). Such research proceeds from the assumption that precarity and poverty, which are unequally distributed, produce certain kinds of stress related to depression (Aichberger et al., 2012; Inhorn & Serour, 2011; Kleinman, 2012; Doornbos et al., 2013). The higher incidence of mental health problems among people living in poverty is reminiscent of the time in which asylums were also used as poorhouses (Grinker, 2007). Health inequalities are often interpreted as “systematic differences in the health of people occupying unequal positions in society (Graham, 2009 in Kapilashrami et al., 2015: 289)”. In many European studies, such differences have been conceptualised as socio-economic differences, thereby ignoring any biological, behavioural or cultural elements (Aichberger, 2012; Crammond & Carey, 2016; Inhorn & Serour, 2011; Kapilashrami et al., 2015; Rechel et al., 2013). For example, health differences between migrants and non-migrants often disappear when controlling for socio-economic status. Poor socio-economic status can nevertheless be a result of migrant status, as evidenced in processes of social exclusion (Aichberger et al., 2012; Chakraborty, 2010; Rechel et al., 2013).

The theory of cultural health capital takes exception with the aforementioned reasoning. Cultural health capital has been defined as “the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more

optimal health care relationships (Shim, 2010: 1)”. It is a particular form of cultural capital that emerges and is exchanged in the interaction between mental (or other) healthcare professionals and people with mental (or other) health problems (Chang et al., 2016).

Based on Bourdieu’s theory, cultural health capital offers a way to study clinical interactions and, in particular, dynamics of unequal treatment, by linking macro-level elements (which structure the distribution of capital) to micro-level interactions, in which different forms of capital are mobilised and exchanged (Abel & Frohlich, 2012; Shim, 2010). This approach can be used strategically and deliberately, in addition to being deeply embodied and habitual (Chang et al., 2016). The theory of cultural health capital refers to the social stratification that is present in clinical interactions. Stratifying elements (e.g. race, class and other signifiers of social status) are replicated in or refracted by specific forms and effects of cultural health capital (Chang et al., 2016; Shim, 2010).

Elements of cultural health capital is used both by people with mental health problems as well as by mental healthcare professionals to promote positive health interactions. For example, if used by both mental healthcare professionals and people with mental health problems, cultural health capital could potentially reduce stigma. The field of mental healthcare is characterised by certain norms and rules that reflect social patterns of stratification, and this influences the process of subjectification. Some of these norms can exacerbate stigma. For example, professionals have relatively more authority, and their hierarchies are institutionally embedded. Institutional medical authority trickles down to informal interactional authority, however, and professionals have certain expectations of what constitutes a ‘good patient’. Such expectations are used to formulate the norms, attitudes and behaviour that are valued in the examination room. In addition, many healthcare settings do not provide enough time or resources for professionals and/or people with mental health problems to disentangle and address the complexities involved in interactions between people of different ethnic origins (Chang et al., 2016).

In some cases, however, individuals are not able to use their cultural health capital in typical professional-patient interactions, as they rarely experience healthcare in this type of healthcare setting. The field of healthcare for such groups is of a different character, and it requires additional types of health-relevant cultural capital that are not included in the original conception of cultural health capital (Madden, 2015). Mental healthcare professionals could also discourage individuals with mental health problems from using their cultural health capital. In clinical encounters, this is more likely to occur with disadvantaged minority groups. This could be because professionals tend to assert control over the situation and distance themselves from persons with mental health problems, in order to maintain the ideas of self-identity and power (Sudhinaraset et al., 2016).

Scholars have only recently begun to address migration as a social determinant of mental (or other) health (Bäärnhielm & Mösko, 2012; Buytaert et al., 2009; Rechel et al., 2013), in addition to devoting attention to culture and gender. Nevertheless, studies often conceptualise culture in terms of religion, ethnicity and race. Researchers have demonstrated that depression and anxiety affect women more than men, especially when there is a lack of culturally sensitive care. The intersection of poverty, gender and ethnicity is associated with high vulnerability to depression and anxiety (Doornbos et al., 2013). Another limitation that has been identified is that the socio-economic position of people with mental health problems is often constituted by individual-level elements, thus making it impossible to consider the role of social structures (Crammond & Carey, 2016; Kapilashrami et al., 2015; Rechel et al., 2013). American researchers have paid more attention to ethnicity/race: the life expectancy of African Americans is five years lower than that of White Americans (Kapilashrami et al., 2015). Explanations for this pattern often refer to correlations with socio-economic differences, with race often used as a proxy for socio-economic status. According to some researchers, however, this reasoning is overly simplistic. For example, it neglects the influence of personal and institutional racial discrimination, both of which have been linked to poorer health outcomes (Chakraborty et al., 2010; Kapilashrami et al., 2015). Another aspect that research has identified is that low-income ethnic minorities

often remain untreated or do not receive the right treatment for their mental health problems. This might be due to their experiences of somatization and their desire for self-care (Doornbos et al., 2013). Another possible explanation is that culture often influences what is considered symptomatic of mental health problems. People in poverty might thus be more likely to consider such ‘symptoms’ as symptoms of poverty. For example, instead of seeking treatment, they might seek ways of making more money (Grinker, 2007).

The focus on gender has increased in recent decades. Studies have indicated that the socially unequal positions of women and men are reflected in gender health inequalities. Their differences in access to certain resources and privileges generate differences in their health and well-being. For example, differences in income have a more pronounced impact on the health of women than they do on the health of men. Women are more likely to be employed in lower paid, less secure and informal work characterised by precarious conditions, minimal regulation and minimal social protection (Kapilashrami et al., 2015). People who are unemployed, who have less education and who are in poverty are more likely to seek help from primary healthcare services, while other groups are more likely to seek help from specialised care (Kovess-Masfety et al., 2014). Their greater use of primary healthcare and their limited use of specialised care are also linked to their lower socio-economic positions – although this observation is not consistent throughout Europe (Buffel et al., 2014; Van de Velde et al., 2010). This depends upon the type and severity of mental health problems.

Outpatient services and general mental health services are characterised by greater gender difference than is the case for specialised services. This is related to gender-specific psychological profiles. Impulsive and addictive disorders, which are associated with less use of mental healthcare, are more prevalent amongst men, as are high levels of social and self-stigmatization. Anxiety and depressive disorders, which are more prevalent amongst women, are associated with more help-seeking behaviour, as well as with greater acceptance of help-seeking behaviour, compliance with treatment regimens and willingness to adopt the sick role (Kovess-Masfety et al.,

2014). Having children can be a supportive element for seeking mental healthcare, although it can also have a burden effect. Given that housekeeping and the childcare continue to be primarily female responsibilities, this burden effect is expected to be greater amongst women. This could also explain why women's mental health suffers more from marital and family strains – although this effect also differs across European countries (Bambra et al., 2008; Buffel et al., 2014; Lewis, 2006; Rosenfield, 1992; Van de Velde et al., 2010). For example, many researchers have demonstrated that depression is linked to or a consequence of power (or the lack thereof). In addition, the roles of women tend to be related to a lack of choice and the role overload of competing social roles and undervaluation (Backhans et al., 2007; Van de Velde et al., 2013). Although studies have also indicated that employed women have more decision-making power than housewives do: the more hours a woman works for pay and the more income this work generates, the more decision-making power the woman will have (Blumberg & Coleman, 1989; Rosenfield, 1992).

For a long time, however, scholars have paid little attention to women's mental (or general) health, apparently reflecting a male bias in health research (Kapilashrami et al., 2015). Around 30 years ago, this changed, with the focus shifting to the mental health of women (Backhans et al., 2007; Connell, 2005; Van de Velde et al., 2010). In addition, the effect of the social changes that have taken place in the past two or three decades with regard to male depression and the risk and vulnerability factors of men have yet to be studied sufficiently (Connell, 2005; Van de Velde et al., 2010). More recently, the interconnections between masculinity, gender and the relative neglect of men's health has once again been recognised. The heterosexual male identity also has a decisive effect on risk-taking and negative health-seeking behaviour amongst men. For example, in many societies, men are more prone to excessive drinking than women are. The influence of disabilities or other factors on health inequalities remains largely uncharted (Kapilashrami et al., 2015).

2.3. Institutional frameworks

A third interpretation focusses on under-representation as being influenced by institutional dynamics and the implicit bias of mental healthcare institutions (Heinz & Kluge, 2012; Kluge et al., 2012; Rechel et al., 2013; Vardar et al., 2012). This type of research is most often qualitative. The access of ethnic and religious minorities might be hampered by the white middle-class frameworks that are prevalent in established mental healthcare services (Inhorn & Serour, 2011; Rechel et al., 2013). They therefore do not consider particular cultural and religious sensitivities. The subjectification process thus constructs a person with mental health problems who does not fit the situation of diasporic migrants. One solution suggested by some scholars involves the availability of accessible interpreting services and the training of health workers to use them (Inhorn & Serour, 2011; Rechel et al., 2013). Another proposed solution is to work with the members of ethnic minorities in order to overcome mistrust and ensure cultural sensitivity (Boneham et al., 1997). One solution to the problem of under-representation that fits within this stream of research involves improving the health literacy of diasporic migrants. This could be done through health-promotion programmes that take into account the different frameworks through which individuals view mental health problems (Hilderink, 2009; Inhorn & Serour, 2011; Rechel et al., 2013). Another solution involves the development of cultural competence amongst healthcare workers (Hilderink, 2009; Inhorn & Serour, 2011; Rechel et al., 2013). According to some researchers, however, the notion of cultural competence is subject to several problems. First, it apparently assumes that culture can be reduced to a technical skill for which individuals can be trained. As a result, culture is often treated as synonymous with ethnicity, nationality or language, especially in medicine (Vardar et al., 2012). This interpretation stands in opposition to many studies that distinguish between ‘modern’ and ‘traditional’ medicine, and that place diasporic migrants on the side of traditional health beliefs (Vardar et al., 2012). Such studies have also been criticised for turning cultural competence into a series of ‘do’s and don’ts’ for how to treat patients of particular ethnicities (Kleinman & Benson, 2006). In addition to

considering the culture of the client, it is important to address the culture of the mental healthcare professional (i.e. biomedicine). The biomedical culture is regarded as an important channel for the transmission of stigma, the incorporation and maintenance of institutional racial bias and the construction of health differences across minorities. Finally, culture is not always the most important factor, and it can sometimes even hamper the understanding of health differences (Kleinman & Benson, 2006).

2.4. Several explanations for the under-representation of diasporic migrants in mental healthcare

Drawing primarily on the aforementioned qualitative stream of literature, researchers have formulated several explanations for the under-representation of diasporic migrants in mental healthcare. Explanations that have been proposed include (1) the belief that migrants are likely to consider the intervention ineffective (Boneham et al., 1997; Lawrence et al., 2006; Marwaha & Livingston, 2002; Schnittker, 2003), because they conceptualise the problem in social and moral terms and are more inclined to seek other sources of help (Lawrence et al., 2006; Marwaha & Livingston, 2002); (2) the expectation that community stigma will make them more inclined to regard their problems as being of a spiritual nature (Boneham et al., 1997; Karasz, 2005; Lawrence et al., 2006) or (3) to be more likely to somatise (Buytaert et al., 2009; Marwaha & Livingston, 2002); and (4) the assumption that the mental healthcare system poses obstacles for diasporic migrants (Bäärnhielm & Mösko, 2012; Boneham et al., 1997; Marwaha & Livingston, 2002; Schnittker, 2003). With regard to the actual institutions, they are likely to fear that treating this group would require additional work, in addition to being ethnocentric, with a tendency to apply middle-class frames in therapeutic settings (Vardar et al., 2012).

2.4.1. Differing conceptualisations

According to some researchers, sources of the ineffectiveness of the solutions proposed by mental healthcare professionals include differences in the conceptualisations of mental healthcare professionals and those of diasporic migrants

(Bäärnhielm & Mösko, 2012; Lindert et al., 2008; Memon et al., 2016; Vardar et al., 2012). Diasporic migrants, and especially diasporic Muslims, are likely to conceptualise mental health problems in terms of stressors related to their family or friends. Such social interpretations are in contrast to the more individualistic notion of Western societies (Karasz, 2005). It has been argued that diasporic Muslims also have little confidence in psychotherapy or the efficacy and side-effects of psychiatric medication, in addition to having more pessimistic opinions concerning mental health problems and a more negative vision with regard to their own ability to influence illness (Abas, 1996; Lawrence et al., 2006; Lindert et al., 2008; Schnittker, 2003; Vardar et al., 2012). Studies have indicated that some migrants are more likely to interpret symptoms of depression as spiritual problems (Marwaha & Livingston, 2002). Migrants, especially those who were born and raised in their home countries, have also been reported to have trouble recognising symptoms of mental illness as such (Memon et al., 2016). This could also explain their tendency to seek other solutions (Livingston & Sembhi, 2003), such as their family or alternative therapy possibilities in their home countries (e.g. traditional healers, religious leaders) (Buytaert et al., 2009; Memon et al., 2016; Vardar et al., 2012). This approach could lead them to delay reporting symptoms, resulting in their presentation as a crisis or emergency (Memon et al., 2016). It is assumed that diasporic Muslims often live in closed communities, in which families are expected to look after sick members. Seeking external help is regarded as a shortcoming or threat to their honour (Buytaert et al., 2009; Fossion et al., 2002). Individuals living in extended family structures are likely to have more supportive family members and allies in case of conflict. They might also be at less risk for 'network burnout' (Fossion et al., 2004; Memon et al., 2016), which occurs when the network becomes tired of always providing help to an individual with mental health problems. Studies have also demonstrated that the presumption that diasporic Muslims live in extended family networks that can help them is a stereotype (Abas, 1996; Boneham et al., 1997). Family involvement can also lead to more conflicts and hostility, which may have negative effects on mental health problems (Fossion et al., 2004).

2.4.2. Stigma

One common belief holds that there is stigma on mental health problems in the Muslim community. This belief stems from the notion that mental health problems result in lower status – as is also the case in other communities. The nature of the stigma is that it restrains diasporic Muslims from seeking help, thereby reducing the risk that someone might become aware of their problems (Boneham et al., 1997; Fossion et al., 2002; 2004; Memon et al., 2016). The consideration of community stigma can also lead to a greater preference for private coping strategies (e.g. prayer and religious practices). This could explain why traditional healers and religious leaders could be regarded as better sources of help than Western psychiatric care (Lawrence et al., 2006). Scholars are nevertheless uncertain with regard to whether traditional frameworks are less stigmatising than the psychiatric framing of mental problems (Karasz, 2005). ‘Invisible’ illnesses can often be regarded as two illnesses: the actual known symptoms, combined with the stigma and exclusion attributed to them. The paradox associated with ‘invisible’ illnesses is that, although they are less noticeable, they can result in more burden, stigma and shame, and they are more likely to be associated with moral judgements. This can thus be regarded as a second illness (Grinker, 2007).

2.4.3. Somatisation?

The somatisation hypothesis is not always correct. Studies have demonstrated that somatic symptoms are associated with mental health problems in both Western and traditional societies. Moreover, Western and ethnic minority groups both tend to deny emotional distress (Karasz, 2005). Other researchers have referred to the colonial inability to pay attention to the various emotions of diasporic migrants and the difficulties associated with looking beyond initial somatic experiences (Abas, 1996). Whether researchers refer to ‘somatisation’ or ‘psychosomatisation’ depends upon the perspective from which they are speaking. Diasporic migrants are convinced that their complaints are somatic, while health practitioners assume that they are more likely to

report somatic complaints. At the same time, however, health practitioners and researchers are also convinced that these complaints are actually psychosomatic.

2.4.4. Obstacles in mental healthcare

Scholars have identified several obstacles that the mental healthcare system poses for diasporic migrants.

2.4.4.1. *Language barriers*

The first obstacle has to do with differences in language (Bäärnhielm & Mösko, 2012; Buytaert et al., 2009; Gramaglia et al., 2016; Lindert et al., 2008; Vardar et al., 2012), which is an important aspect in and of mental (and other) healthcare. It can be regarded as an essential element in the diagnostic and therapeutic process (Ang, 2007; Memon et al., 2016; van der Kwaak & Wolffers, 2013). At the same time, language is also important for national cohesion and the construction of an identity (van den Muijsenbergh et al., 2013). Studies have indicated that diasporic migrants often do not have the opportunity to speak to their healthcare providers in the languages that are most comfortable to them (Diaz-Perez et al., 2004; Memon et al., 2016). Language barriers are also associated with additional time needed for clinical visits, less frequent clinical visits, less understanding of what the physician says, more laboratory tests, more emergency visits, fewer contacts with specialists, less follow-up and more negative views on mental health care (Lindert et al., 2008; Memon et al., 2016; van der Kwaak & Wolffers, 2013). Older, poorer and women migrants tend to have more difficulty learning the new language (Lindert et al., 2008). Professionals have a tendency to regard people who do not speak the language of the host country very well as morally deficient, stupid or less reactive. Professionals with such views are likely to be less motivated to devote additional effort to understand these people, and people with mental health problems are less capable of breaching prevailing stereotypes (van den Muijsenbergh et al., 2013).

In some cases, this problem is resolved by involving relatives or other professionals who speak the patient's native language, although this is not an ideal solution. An alternative involves working with professional interpreters who are also familiar with the language and culture of the mental healthcare professional (van der Kwaak & Wolffers, 2013).

2.4.4.2. Culture

Differences in culture could also constitute an important obstacle (Buytaert et al., 2009; Vardar et al., 2012). Cultural factors play an important role in diagnosis, treatment and care (Kleinman & Benson, 2006). Healthcare professionals are often unfamiliar with the cultures of diasporic migrants (Ang, 2007; Buytaert et al., 2009; Lindert et al., 2008). They may also be unaware of their own cultural frames of reference and regard the culture of diasporic migrants with mental health problems as being responsible for the problems (Ang, 2007). They might not recognise that the International Classification of Diseases (ICD), the Diagnostic and Statistical Manual of Mental Disorders (DSM) and other systems for classifying mental health problems are actually based on Western cultural interpretations (Summerfield, 2008). They play an important role in the subjectification process that constructs the 'ideal' person with mental health problems. As a result, diasporic migrants might not feel understood by professionals (Ang, 2007; Memon et al., 2016) and they might tend to perceive the healthcare system more negatively (Abas, 1996; Diaz-Perez et al., 2004; Fossion et al., 2002; Lawrence et al., 2006; Marwaha & Livingston, 2002; Vardar et al., 2012). They are likely to have a preference for more culture-specific voluntary and other services (Abas, 1996; Boneham et al., 1997).

The use of intercultural mediators is often suggested as a way to overcome obstacles relating to culture in mental health care. The knowledge of healthcare professionals could be improved through diversity management and the incorporation of more ethnically and culturally diverse staff members (Ang, 2007; Bäärnhielm & Mösko, 2012; Boneham et al., 1997; Lindert et al., 2008; Memon et al., 2016), as well

as by increased collaboration with the communities concerned (Ang, 2007). As indicated by many studies, however, it is important not to treat cultural competence merely as a technical skill or as a list of ‘do’s and don’ts’ for treating patients of a particular cultural group. Various authors have argued that culture should not be used synonymously with ethnicity, nationality or language, although this is often the case. In addition, culture might also not always be the most central aspect in a case. It would be better to avoid treating culture as an individual, processual aspect that cannot be stereotyped or falsely ascribed with characteristics due to the clients’ assumed affiliation with a particular group (Bäärnhielm & Mösko, 2012; Kleinman & Benson, 2006; Memon et al., 2016).

Cultural sensitivity often denotes a certain knowledge of the experiences of various groups and of the concepts of oppression and privilege. It denotes certain skills for working with different clients in a culturally appropriate, affirmative and empowering way. It also denotes a certain awareness of one’s own biases and cultural dynamics that might affect the therapeutic alliance. While the discourse of cultural sensitivity initially focused on racial and ethnic minorities, it is not limited to those minorities. Although the cultural studies literature has suggested a critical perspective on multiculturalism, this discourse is largely absent from ‘mainstream’ psychology, which tends to regard the function of the imperative of multicultural inclusion as producing a diverse context while maintaining the status quo. In this vein, critiques of the lack of human cultural diversity are countered by an institutional claim of commitment to diversity. From this perspective, multiculturalism can even be viewed as facilitating structural and institutional violence, as the deployment of diversity can perpetuate inequalities and explain away racial disparities. For these reasons, some cultural studies scholars are convinced that multiculturalism has the potential for redistribution, justice and equity – but this does not mean that it is redistributive, just or equitable (Grzanka & Miles, 2016).

2.4.4.3. Lack of information about mental healthcare

A third obstacle that has been identified involves a possible lack of information about mental healthcare and its institutions amongst diasporic migrants (Boneham et al., 1997; Buytaert et al., 2009; Lindert et al., 2008; Marwaha & Livingston, 2002; Vardar et al., 2012). Diasporic migrants often seem unfamiliar with the mental healthcare systems of their host countries with regard to seeking health-related information and navigating needed services (Carrillo et al., 2011; Lindert et al., 2008). They often do not hear about the services or are unfamiliar with the concepts used (Boneham et al., 1997; Carrillo et al., 2011; Memon et al., 2016). The problems that diasporic migrants experience in adapting to a new health culture are associated with a lack of information about available healthcare services, as well as with their experiences with the healthcare system. Educational resources and other preventive approaches – especially in the form of written material – reach only a part of all diasporic migrants (Lindert et al., 2008). For this reason, even if they want help, they are not always able to find it (Diaz-Perez et al., 2004; Memon et al., 2016). One solution that has been proposed for solving this problem is to improve knowledge about the Belgian mental healthcare system amongst various diasporic migrant groups (Buytaert et al., 2009; Diaz-Perez et al., 2004). In this context, translated brochures appear less useful than employing empathic staff to convey information about services available within a migrant's neighbourhood (Boneham et al., 1997). For example, some studies have reported that diasporic migrants believe that it would be better for general practitioners to know more about community organisations, so that they could discuss the full range of treatment options available (Memon et al., 2016).

2.4.4.4. Discrimination

A fourth obstacle that has been identified is a perception amongst diasporic migrants that the system is characterised by racial discrimination (Diaz-Perez et al., 2004; Livingston & Sembhi, 2003; Marwaha & Livingston, 2002; Schnittker, 2003; Vardar et al., 2012). People who experience discrimination are likely to avoid preventive

services, postpone medical tests and treatment, make less use of health services in general and to report poorer communication with their physicians and lower satisfaction with the care that they receive (Stepanikova & Oates, 2017). Migrants with mental health problems are sometimes strongly aware of the ‘Whiteness’ of the subjectification process of mental health institutions, which are likely to reinforce a White, Eurocentric model of mental healthcare that does not pay attention to ethnicity (Memon et al., 2016). This explains why some studies have found that diasporic migrants tend to prefer mental healthcare professionals of the same ethnicity (Hutchinson & Gilvarry, 1998; Memon et al., 2016). For example, according to some studies, some African Americans (Schnittker, 2003) and half of all Mexican immigrants (Diaz-Perez et al., 2004) have experienced disrespectful or discriminatory attitudes on the part of their physicians, or they believe that they would receive a higher standard of care if they were of a different race (Diaz-Perez et al., 2004; Memon et al., 2016; Schnittker, 2003). Trust is an important element in the relationship between clients and mental healthcare professionals. Mistrust can be regarded as an important barrier to minorities receiving mental healthcare. Beliefs about mental healthcare professionals are therefore of crucial importance (Schnittker, 2003). A lack of trust could also explain why diasporic migrants tend to approach their family and friends first with regard to their mental health problems, before seeking other sources of assistance (Memon et al., 2016).

2.4.4.5. Lower income

A final obstacle concerns the fact that diasporic migrants often do not have sufficient financial resources to access a mental healthcare service (Buytaert et al., 2009; Lindert et al., 2008; Vardar et al., 2012). Studies have demonstrated that diasporic migrants often have a lower rate of salaried employment. This is associated with a higher incidence of mental health problems, although there are major intra-ethnic differences (Fossion et al., 2002; 2004; Kleinman, 1988; Lay et al., 2006; Lindert et al., 2008; Marwaha & Livingston, 2002). A substantial body of evidence indicates that the state

of the economy influences the rate of hospital admissions for mental illness and attempted suicide. The amount of time spent in psychiatric hospitals increases during economic depressions, due to economic stress and unemployment. People of lower SES are more likely than others to report that they are in poor health. These groups are also the least likely to access mental healthcare services (Kleinman, 1988). This is particularly problematic, as psychotherapy is not covered under the compulsory health insurance in Belgium (Memon et al., 2016). Higher income might also be associated with less perceived discrimination, and lower education might be linked with more perceptions of discrimination. Although the association between education and discrimination is more common amongst Whites than it is amongst ethnic minorities, where this relation could be reversed. With regard to income, it has also been observed that lower income is linked to more perceived racial discrimination, and this risk is likely to increase for people who must forego care due to the cost (Stepanikova & Oates, 2017). People in the lower social classes are less likely to speak with specialised healthcare professionals than is the case for those in the middle or upper classes (Buffel et al., 2014; Kovess-Masfety et al., 2014; Lindert et al., 2008).

Studies have also revealed gender-based differences with regard to lower income. Women with mental (or other) disabilities are less likely to hold paid employment than are men with disabilities, and they tend to earn less than men with disabilities do. Although unionization decreases the difference between people with and without disabilities, it does not have much of an effect on the difference between women and men with disabilities. In developing countries, many women with mental disabilities have no income, and they are therefore likely to be totally dependent on others. The literacy rate amongst this group tends to be lower, and girls with disabilities are less likely to attend school than boys with disabilities are (Frohman & Meekosha, 2012).

Having discussed several elements of research concerning migrants and mental health in general, I now consider them as resources with which to clarify the observed conundrum of diasporic migrants and mental healthcare from the viewpoint of subjectification. My analysis of the problem proceeds from the intersectional approach, which is discussed below.

3. An intersectional approach

The approaches described in the previous sections generate a variety of valuable insights into question concerning the under-representation of diasporic migrants in established mental healthcare services. They nevertheless only scratch the surface of a dimension that is of particular interest, both theoretically and empirically: with regard to the interactions of diasporic Muslims with mental healthcare professionals (Buytaert et al., 2009; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour, 2011). I explore this dimension from the perspective of processes of subjectification that occur within, as well as in terms of the frames that shape these interactions. Despite the existing body of knowledge concerning the mental health of migrants and their under-representation in established mental healthcare services, there is a lack of dynamic knowledge with which to grasp this phenomenon (Boneham et al., 1997; Hilderink et al., 2009; Inhorn & Serour, 2011; Lindert et al., 2008). In particular, there is no theoretical perspective with which to organise the available knowledge. A more intersectional approach is needed.

The intersectional focus on mental health problems is underdeveloped. Many studies continue to focus solely on socio-economic position, with less attention to gender, ethnicity/race, religion, disability or various combinations to explain differences in mental health (Crammond & Carey, 2016; Kapilashrami et al., 2015). For example, it is important to realise that migrant status is not the only factor leading to under-representation in mental healthcare. It can also be due to differences existing within and between diasporic migrant groups resulting from such factors as gender, age and socio-economic status (Hoffer, 2009). Scholars have recently been paying increased attention to the intersections of disability with other identity categories, as well as to the marginalization or resistance associated with feminism, critical race and class analysis. In terms of theory, the field of disability studies has addressed several interesting intersections (Goodley et al., 2012). The consideration of multiple categories at the same time enhances the investigation of social dynamics and the exercise of power across institutions instead of across social categories. It recognizes

that social categories are mutually constitutive and that the experiences of a given social category can differ across other categories. When facing multiple social obstacles, individuals from an intersected category are likely to experience more problems than are indicated by disparities along single axes (Grzanka & Miles, 2016; Jackson et al., 2016). There is also the risk of essentialising, instead of considering such a category as made, negotiated, and achieved (Lawler, 2014). For example, gender can be seen as a complex system that creates, maintains and reproduces specific differences through core social institutions, and subsequently organising social relations based on such differences. Such systems construct the manner in which power is embedded within the social hierarchy. These power relations form the most important causes of gender inequality and determine who will fall ill, whose health needs will be acknowledged and with which consequences. Although several attempts to use an intersectional approach have been made within the field of health research, it has not necessarily resulted in any substantive reconfiguration of the analytical level. It is therefore necessary to attempt to overcome gender binaries by developing a more nuanced understanding of power at the intersections of multiple structural positions and their consequences for health. This approach allows the analysis to be grounded in such socio-political factors as colonial history, migration, developmental violence and the construction of socio-cultural identities (Kapilashrami et al., 2015; Van de Velde et al., 2013).

A more intersectional approach might also enhance the recognition that the concepts used in Western Europe and the United States to describe illnesses and health are based on Western frames of reference (Hilderink et al., 2009).

3.1. Disability and mental health

There are 650 million people with disabilities in the world, accounting for 10% of the world's population. Although one fifth of these people have experienced their disabilities since birth on, most acquire their disabilities after the age of 16 years, as they approach their working lives. Most of these people (80%) live in developing countries (Frohmader & Meekosha, 2012).

The definition of ‘disability’ and ‘illness’ is a matter of debate and social construction, as it is a contingent category that contains so many different human conditions and varieties of impairment.⁷ This is the result of the wide variety of ways in which society has defined ‘normal’ and ‘identity’ (Chesler, 2005; Grech, 2012; Linton, 1998). The very notion of ‘disability’ is a Western concept, which must be linked to a particular, historical, European context. This notion has only recently broken through to the world beyond the West. For example, in the global South, disability issues are still associated with colonial and neo-colonial elements. The category ‘disabled’ cannot be considered homogenous, and different individuals with disabilities assign different meanings to disability (and non-disability) (Grech, 2012). The prevailing theoretical model within the field of disability studies – the social model – is also a dominant Western, construct (Grech, 2012; Roets & Braidotti, 2012). It was developed during the 1960s and 1970s by activists who had disabilities themselves. The model locates disability within the social organisation of society, with the most important solution being the elimination of barriers to participation (Frohman & Meekosha, 2012). The dominance of this model might have been due to the fact that there was almost no attention to disability within development contexts, along with the assumption that Western disability theories are universally applicable. This perspective fits nicely with the continuing Western imperialism in the production and dissemination of knowledge. Any observation that does not fit within this Western model and thinking is likely to be neglected. There was little interest in the living conditions, experiences and barriers faced by non-Western people with disabilities and their families (Grech, 2012).

Inquiries within the field of critical disability studies thus concern the meanings that society assigns to certain human variations with which society creates “the normal

⁷ The constructed difference between ‘impairment’ and ‘disability’ is also a result of the social model. In this model ‘impairment’ is presented as the lack of or a problem with a limb, organ or bodily mechanism. In contrast, ‘disability’ is regarded as the result of the historical, socio-economic, political and cultural exclusions of individuals with impairments. In this conceptualisation, impairment is individualised and of a relatively biological and negative character, often with references to pathology, social death or limitations (Roets & Braidotti, 2012).

versus the pathological, the insider versus the outsider, or the competent citizen versus the ward of the state (Linton, 1998: 2)”. ‘People with disabilities’ emerge only within certain ‘systems of power-knowledge’. Outside of those systems, they are no longer pathological or of outsider status (Nunkoosing & Haydon-Laurelut, 2012). This is logical, given that the meaning of disability depends upon its hybrid context and connections to socio-political and economical-cultural locations. Contexts vary, however, and they are as dynamic as the interpretation of ‘personhood’ is. When such dynamics change, the meaning of impairment changes as well, along with individual, familial and social contexts. Thereby producing a complex and heterogeneous concept of ‘disability’ (Grech, 2012). With the rise of disability studies, scholars have increasingly commented on the fact that disability has primarily been regarded as a medical category, instead of a designation with social and political significance. These scholars were motivated by the desire to facilitate the entry of people with disabilities into everyday civic life after a history of being screened from public view. The field of disability studies also directs particular attention to the oppression of people with disabilities by those without disabilities (Linton, 1998). In other words, the rise of ‘therapeutism’ –the belief that people with mental health problems can be cured by paid healers –also gives rise to the critique that it makes people with disabilities increasingly passive (Chesler, 2005). In addition, scholars of disability studies continue to be more conscious of the necessity of studying ‘the norm’ as well (Grech, 2012; Linton, 1998).

It is by considering certain differences as pathological that society can regulate itself. The idea of deviance is the necessary condition for a society for regulate social life and maintain the social order. This regulation is often known as social control. Normative expectations constitute a form of social control that often goes unnoticed. Social control is a way in which society deals with individuals who are considered problematic. What is identified as problematic, however, is defined by what people are expected to do, and not by what they actually do (Kristiansen, 2004). “Deviance [...] is created and exists in ‘the eye of the beholder’, an ‘eye’ which is collective, often devastatingly unconscious, and complex to unveil (Wolfensberger in Kristiansen,

2004: 368)”. Critical disability theory has questioned the often pathological, biomedical, individual approaches to impairment and disability (Barnes & Mercer, 2003; Beresford, 2000). Instead of focusing on a Cartesian interpretation of disability that considers disability as a biological, pre-social and essentialist essence, or on the still dominant socially constructivist vision that regards the body as inert matter constructed by socio-cultural and symbolic influences, critical disability studies do not assume that “biology is destiny (Linton, 1998: 143)”. As a result, disabled bodies and minds are regarded as non-dualistic, dynamic, relational and social phenomena in society (Roets & Braidotti, 2012).

Some disability scholars highlight the complex, contested nature of the relationship between critical disability studies and mental health problems (Beresford, 2000; Kristiansen, 2004; Vandekinderen & Roets, 2016). Critical disability studies have come to focus on theorising the difference between disability and impairment and embracing a social approach to mental health (Vandekinderen & Roets, 2016). Mental health problems are also socially created categories with a labelling function related to political, material and socio-economic conditions, structures and institutional agencies (Chesler, 2005; Kristiansen, 2004; Linton, 1998).

As evident from the discussion presented above, the disability position of an individual can be very complex. As only one of the positions that a person may have, it is important consider a variety of dynamic and interacting aspects:

“the type of impairment; quantities and quality of health care (and associated costs); the presence of other health conditions (e.g. HIV/AIDS) and/or impairments; prices and price hikes (e.g. of food and medication); family (if any) composition and number of dependents (compared to those engaged in remunerated activities); rurality and geographic isolation; types of livelihood; ages; class (or caste); role in the household economy (e.g. household head/main income earner); presence of extended family and communities; ill-health and disability among other family members (that could absorb resources or affect financial inflows); status and citizenship (e.g. refugees); conflict (past or

present); organizational or other formal support; religious and other beliefs; and so on (Grech, 2012: 58)."

In light of the shifts and changes in these various elements, the meaning of 'disability' should also be regarded as shifting and dynamic, in addition to being renegotiated and referring to a variety of non-comprehensive models and discourses (Grech, 2012).

3.2. Ethnicity and race

In addition to the lack of attention to gender in disability research, ethnic and racial minority perspectives are largely absent from disability research. The importance of this gap is demonstrated by the following study conducted amongst Pakistani families with children with disabilities. In many of these families, the parents do not understand the inherent difficulty of traditional and cultural gender expectations and roles for their oldest daughters, who are expected to help in the care for their younger siblings with disabilities. In addition, healthcare and social workers often assume that, in such cultures, it is 'normal' for female siblings to contribute more to care duties. Such assumptions tend to reinforce the prevailing gender roles (Sørheim, 2004).

In the past, sociological studies of mental health (and mental healthcare) paid little attention to ethnicity or culture (Abdullah, 2007; Doornbos et al., 2013; Inhorn & Serour, 2011; Missinne & Bracke, 2012). This was demonstrated in the critique of how epidemiologic estimations are often based on Western clinical notions, and it can be illustrated with the seemingly contradicting results of the WHO Studies of Schizophrenia. One critique on this study is that, from a cultural point of view, the most interesting patients were omitted, and only those respondents who were willing to accept the 'schizophrenia prototype' were included, resulting in a restricted and constructed sample (Burns, 2009; Kleinman, 1987). A second critique states that the WHO studies do not place sufficient emphasis on cultural differences in symptomatology or help-seeking behaviour (Kleinman, 1987). Most epidemiological studies continue to regard mental health problems as biomedical and universal (Patel, 2001). According to cross-cultural measurements of depression, however, the central importance that is assigned to mood changes within the clinical picture of

schizophrenia refers to a Western cultural configuration. This is less applicable in ‘other’, non-Western, contexts. This often results in lower rates of depression when the measurements are based solely on ‘Western biomedical classifications’, like the DSM (Patel, 2001). For example, one recent Dutch study indicates that depressive and anxiety disorders are more prevalent amongst Turkish and Moroccan people than they are amongst Dutch people. This cannot be explained by a higher tendency amongst Turks and Moroccans to emphasise symptoms. These groups also exhibit similar depressive symptom profiles (Niewenhuisen et al., 2015).

The dropout rate of diasporic migrants from mental healthcare is also significantly higher than that of natives. This could be due to problems in the construction of a strong and lasting therapeutic relationship, possibly caused by differences in cultural background and different conceptions of the doctor-patient relationship (Gramaglia et al., 2016). According to Chu and colleagues (2016), most ethnic minority clients have a preference for ethnically matched mental healthcare professionals. This preference is even more pronounced when the professional belongs to the same cultural group. They are believed to be more credible, trustworthy, less biased and more competent with members of their own ethnic groups. An ethnic and language match is assumed to be associated with lower treatment dropout and longer therapy attendance. There is less evidence of a possible positive influence of ethnic and language matching and improvements in clinical outcomes. Therapy in the client’s native language seems to be more effective, however, as does group therapy with participants of the same race (Chu et al., 2016).

3.3. Religion

Religion and faith form a third gap within the field of disability studies. This situation reflects a broader secularism, which assume that religion evaporates when people develop economically and ‘primitive superstition’ and ‘backward’ religious worldviews are replaced by rationality. This view also bears an influence on the scientific study of disability, resulting in a supposedly universal, disembodied and decontextualised knowledge (Grech, 2012).

Although God is removed from the rational firmament, many societies and cultures continue to attach considerable importance to religion and faith within the context of individuals' socio-economic, political and embodied realities. They continue to constitute critical discourses that influence worldviews and social roles, particularly with regard to disabilities. The situation is unlikely to change in the near future, as people are likely to remain in uncertain ontological struggles concerning finitude and fragility. Disabilities reinforce this situation. In contrast, religious narratives could shift the focus away from the temporary character of life and conceptualise death as liberating. Religions can also function as sources of resistance and resilience for people with disabilities, in addition to influencing the opinions and actions of others (Grech, 2012).

Some diasporic migrant groups (e.g. Asians, African-Caribbeans and West Africans) do make more references to religion and the supernatural in the explanations and treatments of mental illnesses. In contrast, Western individuals with mental health problems are more likely to attribute their symptoms to biological causes. Supernatural explanatory models are likely to lead individuals to seek help from traditional faith healers, instead of from mental health services. This could increase the duration of untreated psychosis, while leading to worse prognoses and relapse rates. Other factors that influence the tendency to seek help from faith healers could include family and community influences and elements at the level of services (e.g. a lack of spiritual and cultural awareness on the part of mental healthcare professionals). Ethnic minority groups nevertheless use faith-based and mental health services concurrently (Singh et al., 2015).

Religious narratives can also construct negative influences on people with disabilities and their environments. For example, disabilities could be conceptualised as the result of current or past sins. More powerful groups in society could refer to religion to legitimate suffering, to construct a status quo and to fight religious resistance (Grech, 2012).

3.4. Gender (and gender studies)

The historical lack of respect for women is the result of patriarchy, in which supposedly superior men control supposedly inferior women. Moral injustice and social disrespect refer to situations in which people feel that they are not receiving the recognition they deserve (Frohmader & Meekosha, 2012).

Although the dominant social model in disability studies contributed to the political and personal power of people with disabilities, it has been criticised by some feminists. They believe that the model is not capable of understanding the situation of women with disabilities. This conclusion is based on the supposed neglect of the disabled body (Frohmader & Meekosha, 2012). They criticise the social distinction between impairment (biological) and disability (social), as it ignores the importance of impairment. According to their argument, this is an aspect of dualistic thinking that emerges from essentialism and modernism. As argued by postmodern feminists, these two elements are culturally and discursively constructed (Traustadóttir & Kristiansen, 2004). Feminist disability studies emerged under the influence of women scholars with disabilities (Frohmader & Meekosha, 2012; Traustadóttir & Kristiansen, 2004), who focused on differences, representation, identity, subjectivity, sexuality and the body (Frohmader & Meekosha, 2012). ‘Gender’ is an important element that influences and shapes the services and support for people with disabilities. It is for this reason that feminist disability researchers focus on the importance of ideas to disability studies. This is especially the case for feminist researchers with disabilities, who have called upon feminists without disabilities to include disability in their work. This is because the two traditions – feminist and disability research – share a focus on power relations, social exclusion, oppression and marginalisation (Traustadóttir & Kristiansen, 2004). For example, studies have indicated that, when women have more power at the macro level, they could be able to create opportunities that can benefit their health (Van de Velde et al., 2013).

Another critique has to do with the place of personal experiences of impairment. The British social model considers them as private and personal. According to feminist

critics, this is due to traditional patriarchal thinking, which separates the private from the social and the personal from the public. The following critique considers the fact that the idea of ‘restrictions’ is focused on activity in the material world and neglects psycho-emotional aspects (Traustadóttir & Kristiansen, 2004). Feminist disability researchers present social relations of disability as endangering the individual’s emotional well-being and a focus on the contextual and historical dimensions of women with disabilities’ experiences. For example, the situation of women who live in cities is different from women who live in contexts that are more rural. This even goes for the notion of ‘disability’ itself. In indigenous and traditional societies, the notion is often not used. However, most women with disabilities share the fact that they do not have much power or influence, and that their situation is often not recognized or respected (Frohmader & Meekosha, 2012).

At the outset of feminist research, feminist scholars drew a distinction between ‘sex’ (biological) and ‘gender’ (social/cultural). This distinction has since been subjected to so much criticism that it is no longer accepted or unified. It is increasingly accepted that their meanings and significance is varied, in addition to being historically and culturally specific. Both concepts are also regarded as constructed and mediated through culture and discourse (Butler, 1988; West & Fenstermaker, 1995; West & Zimmerman, 1987). The category ‘women’ is regarded as a broad, internally differentiated category, which thus allows for attention to class, ethnicity, religion, sexual orientation and age, but very limited attention to disability (Traustadóttir & Kristiansen, 2004). Groups of men and women are thus not homogenous. For example, the degree of gender inequality differs between social groups within a society depending upon other power structures (e.g. class, age, ethnicity and family composition). Each of these power structures determines access to resources that can damage or promote mental health (Backhans et al., 2007; Kawachi et al., 1999; Van de Velde et al., 2013).

Although different groups of women are subjected to different degrees of patriarchal power, women are also capable of exercising class, race, national or patriarchal power over men who are situated lower in the patriarchal hierarchy than

their own male kin (Kawachi et al., 1999). According to the ‘doing-gender’ hypothesis, which focuses on the manner in which gender is constructed through daily behaviour and gendered expectations in interactions, people manage social interactions by referring to normative expectations. These expectations differ between societies, as well as between groups within societies. In counter-normative situations, women tend to perform more stereotypically female tasks, while men perform more stereotypically male tasks (Backhans et al., 2007; Van de Velde et al., 2013; West & Zimmerman, 1987).

The limited body of research that has considered the intersection of feminist and disability studies has been devoted primarily to the experiences and lives of women with disabilities. Scholars have paid less attention to the experiences of men with disabilities (Traustadóttir & Kristiansen, 2004). According to the doing-gender hypothesis, the gender-typical behaviour that is common in counter-normative situations can result in harm to the health of people of both genders. For example, in more gender-equal societies, unhealthy compensatory masculine behaviour is likely to be more prevalent amongst higher-class women, as well as amongst lower-class men (Backhans et al., 2007; Rosenfield, 1992; Van de Velde et al., 2013). The unfinished equality often translates into greater burdens on women and the elimination of prior privileges for men (Backhans et al., 2007; Rosenfield, 1992). Another example involves the use of gender socialisation to explain gender-based differences in suicidality. According to this reasoning, women and men are assumed to adapt the self-destructive behaviours most congruent with their culturally determined gender scripts. For example, men are more likely to abuse alcohol, and women are more likely to commit suicide, given nonfatal suicide behaviour is more stigmatising for men than it is for women. Currently, however, this gender difference is apparently becoming less pronounced (Boyd et al., 2015). Various authors have also reported that people with disabilities are often referred to as non-gendered, uniform and one-dimensional (Reinikainen, 2004; Ytterhus, 2004). This is assumed to be the result of the ideas that are at play within the general society (Reinikainen, 2004).

A second area of interest in the body of research at the intersection of feminist and disability studies has to do with relationships between gender and caring in relation to disability. One important critique in this respect notes that the focus of such studies is often on the female caregiver's burden, thereby treating people with disabilities as dependent, even though they are also capable of being caregivers (Traustadóttir & Kristiansen, 2004).

Other intersecting studies have indicated that most women with disabilities do not experience the same level of socio-economic, cultural or political equality as is customary for men with disabilities. One condition for achieving equality in this respect concerns the development of social recognition and respect for women with disabilities, as the absence of such respect could be harmful for their understandings of 'themselves'. The mortality rate amongst girls with disabilities is higher than that amongst boys with disabilities, due to a greater tendency of girls to be neglected and to lack medical care or access to food and related resources. Women with disabilities are more likely to be confronted with a lack of basic necessities than men with disabilities are. At the same time, women are at greater risk for developing disabilities, due to lack of health care resources, poor working conditions, gender-based violence and traditional practices that are harmful (Frohmader & Meekosha, 2012).

Although the factors of gender and disability together comprise a set of social relations and relationships with bodies, their nature is not exclusively physical. Bodies can be both objects and agents of the social practices that shape our conceptualisation of disability and gender. The combined contributions of the two identities 'female' and 'disability' to the unequal status of women can be regarded as placing women at a 'double handicap'. This notion can nevertheless be problematic when used to describe the multi-dimensional experiences of women with disabilities. Society as a whole can refer to these identities as well, for purposes of containment or violence. At the same time, society does not always recognise the particular needs of women with disabilities (Frohmader & Meekosha, 2012).

3.5. Socio-economic status

People with lower socio-economic status (SES) have been reported more likely to be admitted to psychiatric facilities involuntarily, where they face longer periods of care in wards with more severe case-mixes. They receive fewer antidepressants and less psychotherapy, and they exhibit fewer improvements in functioning and symptoms. Patients with lower SES tend to report more severe symptoms and to prefer medication, while people with higher levels of education tend to prefer psychotherapeutic treatment (Lorant et al., 2003; Vandeurzen, 2014). In addition, belonging to an ethnic minority group increases the likelihood of compulsory admission. Scholars have reported that compulsory admission is more likely in the absence of a less restrictive alternative or when the patient refuses care. Diasporic migrants and people without paid employment are more likely to face such a lack of alternatives. In the case of diasporic migrants, this is not necessarily because of a supposed dangerousness, but because they are assumed to be more demanding patients, for which alternatives are lacking. They are also assumed likely to refuse care (Lay et al., 2006; Lorant et al., 2007). People who are non-White or of lower SES tend to be approached more negatively by mental healthcare professionals. Such people are often attributed with negative personalities, competencies, behaviour, intelligence, education, attitudes, risky behaviour and therapy loyalty. Professionals are likely to adapt their behaviour and decisions based on their own image of individuals with mental health problems (van den Muijsenbergh et al., 2013).

Most Turkish and Moroccan diasporic migrants can be regarded as being of lower SES (Lay et al., 2006; Lorant et al., 2007; Nieuwenhuijsen et al., 2015). Ethnic minorities more often experience unfavourable working conditions (e.g. with fewer opportunities for recovery). Evidence concerning perceived working stress is less clear. Both of these factors (lack of recovery opportunities and perceived working stress) result in poorer mental health (Nieuwenhuijsen et al., 2015). Finally, people with disabilities are over-represented in lower-paying occupations and, conversely,

under-represented in higher-paying occupations. Those who are employed tend to be younger, better educated or male (Lehtomäki, 2004).

As clearly indicated in the patterns mentioned here, the relationship between lower SES and poor mental health is reciprocal. People with poor health are more likely to have lower income, and people with lower income are more likely to have poor health. Certain risk factors (e.g. unhealthy lifestyles or living conditions) are more prevalent amongst people of lower SES, and diasporic migrants are over-represented within this category (van Beelen, 2013).

3.6. Multiple intersections: An example

3.6.1. Gender, disability and ethnicity

The number of women with disabilities worldwide is currently estimated at 325 million. Many of these women live in rural areas in developing countries. This is only an estimation, as few studies have addressed the intersection between gender and disability. In addition, data collection is often hindered by challenges relating to quantification (e.g. more women living in poverty, culturally determined gender roles, various types of exploitation) (Frohmader & Meekosha, 2012).

Some studies have addressed the intersection between gender, disability and ethnicity. For example, some researchers have observed that men of ethnic or racial minority groups are less willing to talk about their problems, particularly with mental healthcare professionals. This might be related to feelings of pride and strength (Memon et al., 2016). Other studies report an increase in mental health problems amongst women of ethnic or racial minorities. This might be due to the greater exposure of women to psychosocial stressors, while men are likely to experience more stress-protective factors. According to a study conducted in Switzerland, female diasporic migrants are less likely than their male counterparts are to be admitted (or re-admitted) to psychiatric hospitals. The same study indicates that the proportion of female diasporic migrant inpatients is significantly lower than the proportion of females in the general population of diasporic migrants. The admission rates of male

diasporic migrant inpatients were far higher. This was especially the case for diasporic migrants from Turkey, from ‘other’ countries and from Eastern Europe. Compared to native Swiss people of the same gender, diasporic migrants from Southern, Northern and Western Europe had lower admission rates (Lay et al., 2007).

This doctoral research project proceeds from the expectation that an intersectional approach will lead to new insights into problems relating to the under-representation of diasporic migrants in established mental healthcare services. It focuses on processes of subjectification (Rondelez et al., 2016) stemming from this intersectional approach.

4. Research questions

This dissertation aims to contribute to the knowledge about the problem presented above by posing and solving two research questions by

1. mapping, analysing and theorising existing frames of mental healthcare towards diasporic Muslims of Turkish and Moroccan background amongst a wide spectrum of mental healthcare providers and professionals and
2. conducting biographical research with diasporic Muslims who are seeking mental healthcare. We do this to examine how these migrants experience the discourses and services that are prevalent in Western mental healthcare, as well as the discourses and practices that are applied within the Muslim community, as well as to theorise the strategies that these migrants develop when seeking mental healthcare.

In the following section, I discuss the methodology used to answer those research questions: ‘*Where do diasporic communities from various countries who identify as Muslim and settle in Belgium go with their mental health concerns?*’, ‘*Do they find their way to the existing mental health services?*’, ‘*If not, where do they take their mental health concerns?*’, ‘*If yes, how do their contacts with, and trajectories through, the established mental health services look like?*’, ‘*And what does their*

underrepresentation within mental health services reveal about the social organization of mental healthcare?'. First, I provide a more detailed discussion of the research context of diasporic Muslims in Belgium and mental healthcare in Belgium. I then discuss the aim of this research, followed by the research process and several ethical considerations.

5. Methodology

5.1. Research context

5.1.1. Diasporic Muslims in Belgium

At the end of the 19th century, Belgian mining cooperations started to look for labour migrants in various countries, including Spain, Greece, Morocco and Algeria. The economic crisis of the 1930s brought this influx to a halt. On 31 March 1936, the Belgian government initiated a mechanism of labour permissions that restricted the migration process. Following the Second World War, Belgium signed bilateral labour migration agreements with Italy, Spain and Greece. The migration process slowed between 1958 and 1961 (Kaya & Kentel, 2007). Policies aimed at attracting foreign inhabitants were also motivated by fears of demographic shortage and the perceived ageing of the population. With regard to the first concern, it was hoped that the migrants would make of Belgium their permanent home country. This was also a reason for encouraging family reunification programmes (Fadil et al., 2015; Kaya & Kentel, 2007). The influx of labour migrants ended in 1974, when the Belgian borders were closed to foreign manual labourers in response to the oil crisis and the successive economic crisis. This development reflects an important shift in Belgian migration policy: from a focus on temporary labour migration to a focus on encouraging foreign minorities to settle in Belgium. Another important political event occurred 10 years later, when access to Belgium was restricted even further by the discontinuation of family reunification policies and the enactment of policies restricting access to social welfare for migrants and accelerating the process of Belgian naturalisation (Fadil et al., 2015; Kaya & Kentel, 2007).

In 1927, Muslims accounted for 14% of all people working in the mining sector. The number of Muslims in Belgium currently amounts to approximately 728,000. Islam has thus become an important religious tradition in Belgium. This relatively new social phenomenon within the originally Catholic country has led to some controversies. Topics of extensive discussion have included butchering without stunning, the referendum in Turkey and Belgian fighters going to IS territory to defend the Islamic state. Belgium is not the only country in which Islam has become a subject of considerable debate – this is the case throughout Western Europe. The discussion has been influenced by post-1989 civilisation narratives, combined with other global events such as 9/11, the terrorist attacks in London, Berlin, Paris and Brussels, as well as the general war on terror. As a result, the frame that presents Islam as a security threat has become linked to the problematisation of the demographic presence and growth of Muslims in Europe (Fadil et al., 2015).

The most important influx of Muslims in Belgium consists of labour migrants, who came to Belgium after the signing of the bilateral labour migration agreements in 1964 (with Morocco and Turkey) and 1967 (with Tunisia and Algeria). These labour migrants came to work in low-skilled jobs in the coal-mining, steel and car industries. This explains why most of the Muslims currently living in Belgium are second-generation or even third-generation descendants of these labour migrants.

In 1974, Belgium officially recognised Islam as a religious confession (Fadil et al., 2015; Kaya & Kentel, 2007). Beginning in the late 1980s, however, the Belgian vision on Muslim communities increasingly became expressed in terms of radicalisation, given the influence of international events on the Belgian situation. The events included the oil crisis, which was initiated by Saudi Arabia, and the developments in Libya. The headscarf debate began to emerge in Belgium in 1989. In this debate, the headscarf was portrayed as a rejection of Western values and a call for Muslims to return to more traditional Islamic values (Fadil et al., 2015). In response to the fall of the USSR and the rise of discourses around conflicting societies, European societies developed a discourse based on security. Within this context, migration was regarded as a threat to European communities. Accordingly, it became stigmatised and

associated with the major problems that they were facing (Kaya & Kentel, 2007). In Belgium, the situation concerning Islam was further influenced by a major state reform that was enacted in 1980. In this development, important parts of migration policy and ‘integration’ became a communitarian issue. In Flanders, the Northern part of the country, the government invested in networks of integration centres and, in 1998, minority organisations were added (Fadil et al., 2015).

The contemporary situation of Turkish and Moroccan minorities in Belgium reflects their weak socio-economic integration and structurally precarious condition. The poverty level amongst these groups is almost four times higher than the national poverty level (Fadil et al., 2015). They experience greater difficulty accessing the job market (Fadil et al., 2015; Kaya & Kentel, 2007; Martens et al., 2005), and Moroccan and Turkish employees are under-represented in the higher job categories and over-represented in non-qualified or lower qualified jobs (Martens et al., 2005). These minorities also tend to have weaker academic careers, to be more likely to drop out of school and to be over-represented in technical and vocational orientations. Other problems faced by Turks and Moroccans in Belgium have to do with discrimination or unequal treatment on the job market (Fadil et al., 2015).

More recently, the focus of the discourse on diasporic migrants has shifted slightly towards problematising their religious and cultural background. Minority cultures in general, and particularly Islamic culture, have become problematised and conceptualised in terms of hampering the integration of ethnic-religious minorities in Western Europe. According to some studies, however, there is no clear relationship between Islamic religiosity and socio-cultural integration (Fleischmann & Phalet, 2012). These studies indicate that the recognition and societal openness are more important in determining the impact of Islamic religiosity on the socio-economic integration of Muslims. In contrast, other authors have reported that the level of identification amongst migrants is higher at the local level than it is at the national level (Clycq, 2011), although racism and discrimination can hamper those identification processes. Another issue has to do with the distrust that diasporic

Muslims feel towards local authorities, as they tend to prefer first-generation men as interlocutors, and governments have enacted a ban on headscarves for city personnel.

In many cases, attention to religious aspects remain limited to the public aspects of the Islamic religion, largely ignoring religious experiences. This is due to the fact that Belgium is ruled by the principle of neutrality: a constitutionally ingrained principle of pro-active recognition and state support of religious denominations. The state thus recognises and financially supports confessional traditions, but it does not intervene in their internal organization. Places of worship, their development and recognition play an important role in the institutionalisation of Islam. In Belgium, mosques and imams did not receive any money from the government until 2007, even though Islam had been officially recognised since 1974. The length of this delay was due in part to the absence of a body that could administer the public funding. Another element of institutionalisation concerns the official representation of the Muslim community. Although the possibility of establishing a representative body of Muslims had been discussed since the 1970s, the Executive of Muslims of Belgium would not be established until 1999. Its establishment nevertheless did not mark the end of the representative crisis, as its operation and decision-making processes continue to be subjected to internal and external challenges. There are several reasons. First, the institutional construction is based on the structure of the Catholic Church and, as such, it is not suited to the composition of the Muslim community, which is more heterogeneous. Second, political authorities often intervene in the Muslim representative body, due to its political sensitivity.

Another issue relating to the public role of Islam concerns the civic and political participation of Muslims. Processes of political mobilisation are increasingly containing references to the Islamic identity. There is the rise of Muslim elites, who are forming a new political entity that is capable of passing political claims on to local or national authorities. Muslims of the younger generations who were born in Belgium are particularly likely to translate Islam into a civic identity, and this influences how they relate to society.

For these reasons, this study focus on the city of Ghent, in which Turkish and Moroccan Muslims comprise the largest groups of migrants. The first generations came as labour migrants, and later generations have become even better integrated, although they continue to be under-represented in mental healthcare services.

5.1.2. Mental healthcare in Belgium

Between one fourth (Gerken & Merkur, 2010; Vandeurzen, 2010) and one third (Vandeurzen, 2014) of all Belgians are confronted with mental health problems, half of which are classified as serious (e.g. depressive feelings, somatic complaints, anxiety disorders or sleeping problems). The Belgium mental healthcare system could be described according to three characteristics. First, it is based on the principle of therapeutic freedom, and clients or patients are free to choose their own physicians or counsellors. Compulsory health insurance covers most of the costs of the system. Second, the healthcare system is fragmented, as is the whole of Belgian society, with its three language communities and three regions. Third, such fragmentation complicates the decision-making process. The federated entities are responsible for the organisation and financing of community care, with the federal authority bearing responsibility for in-patient services (e.g. hospitals) (Gerken & Merkur, 2010; Nicaise et al., 2014; Vandeurzen, 2010).

In the following sections, we discuss the history of the Belgian mental healthcare system and the frames that accompany it. It is important to note that ideas are not always restricted to specific timeframes: they transcend them. For example, the process of deinstitutionalisation extends beyond the rehabilitation era, and it is still in progress during the recovery era.

5.1.2.1. Segregation

The modern history of psychiatry in Belgium began with the rise of asylums between 1880 and 1950. Many thousands of individuals were incarcerated, many of whom were women. The asylums were regulated by religious congregations and the Department

of Justice. Their primary function focused on security, protecting people outside the institution from the inmates, and protecting the inmates from the cruel and dangerous outside world. For this reason, they were often situated in desolate places. The inmates could thus walk around freely, without posing any danger for society. The segregation of people with mental health problems thus consisted of physical relocation and the separation of the sexes. Such practices were also intended to relieve and support the families. The inmate population comprised individuals with a variety of mental health problems or learning disabilities. The asylums originally aimed to treat the inmates so that they could eventually return to society. This optimistic perspective ultimately proved overly ambitious. Around the turn of the century, the focus shifted again towards the dangers of the inmates, with institutionalisation regarded as a way of controlling them. Inmates were seen as a threat to the social order and the health of the nation. Other means of controlling inmates include occupational therapy and discipline. Inmates were assigned minor tasks in order to teach them to be on time, deal with assignments and obey the staff. Although this was considered good preparation for life outside the institution, it could also have been seen as a punishment with which to drive out their sinful nature. Women did jobs that prepared them to be good housewives, working in the laundry and kitchen, and engaging in handicrafts. In contrast, men made furniture and shoes, or worked in the fields (Barnes et al., 1999; Chesler, 2005; Engwall, 2004; Kristiansen, 2004; Linton, 1998; Roets et al., in press; Stockman, 2000; Vandeurzen, 2010; Van Weeghel & Zeelen, 1990).

The segregation of people with mental health problems can be interpreted as an example of Durkheim's notion that defining what is pathological helps to maintain the rules and standards of a society. It can also be interpreted according to the framework developed by Giddens, in which deviance is constructed to regulate social life and support the social order. Known as social control, this process is often so embedded within society that it remains unnoticed and is not perceived as controlling. Social control can therefore be conceptualised as "the organised ways that society deals with people who are deemed problematic, threatening or undesirable in some way

(Kristiansen, 2004: 367)”. The rise of scientific medicine generated new forms of social surveillance and discipline for use on people with mental health problems.

“An increasing range of techniques was introduced to identify, classify, and regulate sick and disabled people. This heralded the ‘therapeutic state’ with its novel and polarized conceptions of normal and abnormal, sane and insane, healthy and sick (Barnes et al., 1999: 19).”

Other ideas that were related to the dominance of asylums included panopticism and symmetry. Panopticism refers to the manner in which asylums were constructed to allow overall surveillance. In the buildings, it was possible to see all the way down corridors in all directions from above. This design was intended to allow staff members to control the behaviour of inmates, in addition to registering, categorising and differentiating them (Kristiansen, 2004). Symmetry refers to the notion that the minds of the inmates were imbalanced and that routines and symmetry could be used to restore stability, order and balance (Kristiansen, 2004; Roets et al., in press).

The discourse concerning institutions and inmates refers to the notion of ‘morality’, which ranges from regarding inmates as personally immoral to interpreting the structural and social causes of madness as being immoral (Kristiansen, 2004; Roets et al., in press). The discourse also contains references to ‘hygiene’ and ‘impurity’. This had to do with the tendency to associate inmates with danger and fear. The era of asylums reflected Victorian values on gender. In particular, women with mental health problems were seen as having minds that were chaotic or unstable. They were also presented as hypersexual beings. This highlighted the need for symmetry and order, which also became evident in the design and decoration of the rooms and gardens. The institutions were home-like, and they were operated according to family-based norms, with the goal of preparing the women for lives as homemakers (Chesler, 2005; Kristiansen, 2004). In this case, marriage could offer a way out of the status of deviancy. Another goal of the asylums was to change the sexual behaviour of women inmates. Improper language and indecent appearance were corrected, and their clothing and hairstyles were asexual. In this way, femininity was regulated. Other

efforts to exclude female inmates from sexuality and fertility included prohibitions against marriage and involuntary sterilisation (Chesler, 2005; Engwall, 2004).

Marriage and family were considered the norm in general society. It was the woman's task to take care of the family. Both physical and mental health problems gave cause for excluding women from the right to fulfil these duties, partly for fear that they might transmit bad hereditary traits. This notion is consistent with the ideology of the eugenic movement, and sterilization was regarded as a way to sidestep the prohibition against marriage. Sterilization also was introduced to exclude the inmates from normal family life. It nevertheless made it easier to allow women with mental health problems to live in society, as it eliminate the danger that they would transmit their damaged genes. On the other hand, some feared that sterilization would stimulate more promiscuous behaviour. The eugenic inspiration for such sterilisation policies was also motivated by considerations of a more social nature. Women with mental health problems were considered incapable of taking care of children (their own, or others), a task that was regarded as a particularly female responsibility (Engwall, 2004; Kleinman, 1988; Roets et al., in press).

Two people played a particularly important role in the development of psychiatric care in Belgium: Peter Joseph Triest, who founded the Brothers of Charity (in Dutch, *Broeders van Liefde*) in 1807, and Dr Joseph Guislain, who is regarded as the first psychiatrist in Belgium and who founded the first psychiatric hospital in Belgium (Stockman, 2000; Vandeurzen, 2010). Triest and Guislain represent the shift from confinement to treatment and segregation, with an element of activation within the institutions. Such activation is no longer as prominent in residential institutions, although the focus remains on treatment, with an increasing emphasis on psychotropic medication. The element of segregation remained important until the Second World War.

5.1.2.2. Rehabilitation

After the Second World War, attention began to shift towards community-based care, humanisation and rehabilitation. The insight gradually emerged that stabilised long-term ‘patients’ actually did not belong in hospitals, but were in need of specialised care within the community. The focus shifted towards the possibility that individuals with mental health problems could once again become full citizens (Bachrach, 1995b; Stein, 1995; Stockman, 2000; Vandeurzen, 2010). This was nevertheless on the condition that these people would adjust to society. This view entailed a process of normalisation, which emerged from critiques of the institutions, which symbolised human rights violations, unacceptable living conditions and enormous economic costs. Community care was expected to be much less expensive than institutional care. This shift should be considered within the context of a changing vision on citizenship. There was a desire to extend welfare provisions and citizenship rights to the entire population, including groups that had initially been excluded, such as people with disabilities (Bachrach, 1995a; Roets et al., in press; Stein, 1995; Traustadóttir & Kristiansen, 2004).

Deinstitutionalization was considered a therapeutic alternative to the inhumane asylums. A belief even emerged that individuals with mental health problems would recover if they were allowed to leave those pathogenic conditions. There was a tendency to deny the severity and chronicity of mental health problems – positive thinking was preferred (Bachrach, 1995a). Deinstitutionalisation consists of two processes: a decrease in the number of hospital beds, the extension of community care services to take over the functions of psychiatric hospitals. Although the first process developed early on, the second occurred later, and it currently remains a minor evolution. The vision accompanying these developments in the past 40 years is known as rehabilitation. The rehabilitation process can be regarded as one in which individuals with fewer possibilities must accept their limitations and are provided with assistance so that they can live their lives as normally as possible using the capacities that they do possess. Rehabilitation settings must present clear norms and values to

people with mental health problems, along with opportunities to practice different accepted roles. Appropriate behaviour must be rewarded. It is nevertheless unclear whether it truly is desirable for people with mental health problems act like ‘normal’ people do (Bachrach, 1995a; Bennett, 1995; Pieters & Peuskens, 1995; Stein, 1995; Stockman, 2000). Although the frame of community-based services arose in the 1950s, the policy goal of deinstitutionalisation would not be articulated until the 1960s and 1970s (Roets et al., in press). Belgium has lagged behind other countries with regard to deinstitutionalisation.

The rehabilitation paradigm retained a focus on occupational therapy. In many cases, rehabilitation was introduced through paid industrial work in the hospitals. In addition to teaching instrumental skills to people with mental health problems, such facilities taught them what they could expect from mainstream society. The work originated outside of the hospital, and the persons with mental health problems were paid for doing it. As rehabilitation shifted from hospitals to community care, the character of the work that needed to be done shifted towards home-making tasks (e.g. shopping, cooking). In addition, there was still a need to develop sheltered workplaces for individuals with mental health problems who would never be able to become integrated (or re-integrated) into a ‘normal’ work situation (Bennett, 1995; Van Weeghel & Zeele, 1990).

The counterculture of the 1960s, with its protests against political, sexual and racial injustices, was accompanied by the notable rise of anti-psychiatry. The earliest seeds of this movement can be identified in Goffman’s *Asylums*, in which the author describes psychiatric institutions as total institutions, in which the circumstances are as pathogenic as the individuals who are completely adapting to the system. From this perspective, personal reality is regarded as independent of hegemonic definitions of normality that, in this case, are likely to be imposed by psychiatric, economic and cultural interests. The rise of anti-psychiatry resulted in the closing of many asylums. The ideas of anti-psychiatry can be summarised as the rejection of the medical model, the rejection of the asylum-based psychiatry (with its compulsory admissions, high doses of drugs and convulsive and psychosurgical procedures), the rejection of the

social control function of psychiatry and a positive appreciation of madness. The intentions of the anti-psychiatry movement were not developed further, however, as they did not provide for alternatives. It nevertheless influenced developments in the 1970s (Grinker, 2007; Rissmiller & Rissmiller, 2006; Stockman, 2000).

The 1970s witnessed the rise of psychotropic medication, which eliminated the necessity of incarceration. When people with mental health problems appear to present fewer symptoms, they appear less sick. This supports the ideology of deinstitutionalisation (Bachrach, 1995a; Bhugra & Mastrogianni, 2004; Grinker, 2007; Stockman, 2000; Vandeuren, 2010), which was accompanied by the rise of psychotherapy, which in turn led to experimental forms of treatment. In the 1970s the anti-psychiatric movement supported these forms of treatment (Bhugra & Mastrogianni, 2004; Grinker, 2007; Stockman, 2000; Vandeuren, 2010). Experimental forms of care resulted in a diversification of care and responsibility for patients. This constituted an attack on the dominance of institutional psychiatry, although its dominance is still in place. Following the publication of the DSM-III, which resulted in a shift of power from psychoanalytic clinicians to empiricists searching for validity, the DSM became the Bible of psychiatry. Although professionals are seldom 'slaves' to the DSM, and although some continue to question its diagnostic criteria, its focus on problems and the modifications that are needed, and yet others challenge its reliability, almost nobody challenges its right to exist or to guide psychiatry (Grinker, 2007).

Not all of the effects of deinstitutionalisation were positive. It eventually became necessary to acknowledge that the transition from centralised, easily accessible services to decentralised, fragmented community care did not proceed smoothly for all people with mental health problems, and especially not for those with less initiative or motivation and those with more serious mental health problems. In many cases, these groups were excluded from community care organisations. At first, deinstitutionalisation focused only on issues relating to residence. In other words, the primary question was whether people with mental health problems would live inside or outside the asylum. Other needs (e.g. psychiatric or medical care and opportunities

for rehabilitation) were somewhat neglected. Nevertheless, many people with mental health problems are now living much happier lives than they had when they were living in asylums (Bachrach, 1995a; Kleinman, 1988).

This socio-political shift was combined with challenges to the dominant biomedical frame. The 'disability problem' is no longer situated with the individual, but in the environmental and social context (Pieters & Peuskens, 1995; Traustadóttir & Kristiansen, 2004). The deinstitutionalisation process and the focus on community-based services was not successful in achieving the full integration of people with mental health problems in the community. Some were as isolated in the community as they had previously been in the institutions (Traustadóttir & Kristiansen, 2004).

It is possible that there will always be a small minority of people with mental health problems (e.g. those who are unable to cope with the stress of everyday life) who will continue to need extended residential care in mental healthcare institutions. Unlike in the era of large asylums, however, extended institutionalisation is no longer inevitably accompanied by further restrictions. It is currently possible to run hospital wards in a non-institutional manner. The first step to this end is to avoid treating individuals with mental health problems as one homogeneous group, in addition to avoiding strict routines. The second step involves the elimination of depersonalising treatments and attitudes. The third consists of diminishing the distance between staff members and people with mental health problems (Bennett, 1995).

In Belgium, one important development occurred in 1963, when responsibility for supervising psychiatric institutions was transferred from the Department of Justice to the Department of Public Health. As a consequence of this shift, mental health problems are no longer regarded as legal facts, and that there is room for the appropriate treatment of individuals with mental health problems. The focus shifted towards medical control and social rehabilitation. In the same year, two important laws were approved. The first arranged a financial intervention for hospitalisation in residential psychiatric hospitals. The second law focused on accreditation standards for hospitals (Stockman, 2000; Vandeurzen, 2010).

The legally mandated construction of ambulant centres for mental healthcare (in Dutch, *Centra voor Geestelijke Gezondheidszorg*) with multidisciplinary teams in 1975 intensified the focus on the psychosocial elements of mental health problems, as well as for ambulant forms of care that makes it possible to care for people with mental health problems in the community. Around the same time, recognition increased for psychiatric wards in general hospitals and the benefits of partial treatment during the day or night.

Belgium has had difficulty following the WHO guidelines with regard to mental health. These rules call for integrating mental healthcare into the general healthcare sector, reducing the number of large psychiatric hospitals, instead focusing on community mental health services. Belgium currently emphasises large psychiatric hospitals. The number of psychiatric beds in Belgium (1.7 per 1000 inhabitants) is greater than the European average (0.93 beds per 1000 inhabitants) (Lorant et al., 2003).

The first reconversion movement took place in 1990, although the focus remained on care in the community and extramural services, along with the scaling down of institutional care (Stockman, 2000; Vandeurzen, 2010; 2014). The two components of deinstitutionalisation – the decrease in the number of hospital beds and the construction of a network that can take over various functions of the psychiatric hospital and stimulate the social integration of individuals with mental health problems – occurred in response to developments that had already taken place in society. Resulting initiatives included psychiatric nursing homes, shelters and in-home care (Gerkens & Merkur, 2010; Pieters & Peuskens, 1995). The organisation of residential care was improved by the construction of dialogue platforms (in Dutch, *overlegplatforms*), which are responsible for the dialogue between all types of mental healthcare services concerning the regional coordination of the supply of medical and psychosocial services for people with mental health problems (Gerkens & Merkur, 2010; Stockman, 2000; Vandeurzen, 2010; 2014). Psychiatric hospitals are also launching pilot projects involving case management.

A second reconversion movement occurred in 1999. A new reform called for establishing cooperations between the intramural and extramural sectors. This reform focused on improving psychiatric hospitals and increasing the availability of intensive and specialised care, accompanied by further cutbacks in the number of hospital beds by shifting them to beds in psychiatric nursing homes or places in sheltered accommodations. This development focused more on specific target groups (e.g. based on age or specific problems) and their needs, as well as on the construction of networks of care. This was accompanied by a focus on innovative work-driven activation programs situated in psychiatric home care (Gerkens & Merkur, 2010; Stockman, 2000; Vandeurzen, 2010; 2014). Justification for this development is provided in Articles 11 and 107 of the Royal Decree for the Coordination of the Law on Hospitals and other Care Facilities (Vandeurzen, 2010). Recent years have seen the introduction of care circuits consisting of care programmes, services and networks of services. It is hoped that these networks will create a more integrated approach to patients and clients through various care arrangements (Gerkens & Merkur, 2010; Vandeurzen, 2014).

5.1.2.3. Recovery

The next phase in the history of mental health care was characterised by ‘recovery’. One important development in this regard involved the extension of the process of deinstitutionalisation. The Belgian system for the delivery of mental healthcare is currently operating according to Article 107 (of the Hospitals Act of 2008), which states that psychiatric hospitals are allowed to reallocate funds for long-term beds to networks of community-based services (Nicaise et al., 2014). This article is also part of a shift from supply-driven residential care to demand-driven community-based care. Whether ‘clients’ also want more community-based care, however, is not entirely clear (Nicaise, 2014; Rohde, 1997). Established to support the process of deinstitutionalisation, the policy surrounding Article 107 appears more focused on balanced cooperation between psychiatric (and other) hospitals and community-based care. Although hospitals may play a relatively minor role in the delivery of care, they

remain the major participants in the management of healthcare networks, thereby influencing the constituent partners (Nicaise et al., 2014). For this reason, hospitals are starting to work with case management projects, which are aimed at (1) strengthening the quality of patient care by focusing on health restoration and continuity of care; (2) decreasing costs by focusing on empowering people with mental health problems and their surroundings, in addition to enhancing their self-care capabilities and minimising unnecessary and lengthy stays in hospitals (Lee et al., 1998; Vandeurzen, 2010); (3) improve the satisfaction and professional development of everyone involved by focusing on multi-disciplinary collaborative practices and coordinated care. Case management could potentially meet the cultural needs of a particular context (Lee et al., 1998). There is nevertheless a risk that the major influence of hospitals will lead to demand-driven case management projects that are influenced by an ideology of managed care (Rohde, 1997).

Recovery also entails the necessity of having the environment adapt itself to the individual with mental health problems. Under rehabilitation, the desired adaptation was still assumed to be the unidirectional adaptation of individuals to their environments. Recovery has been defined as

“the process whereby one combines direct assistance to the patient with guidance and manipulation of the environment, aimed at the best use of the present capacities, so that he can function at an optimal level in a social framework, as normal as possible (Pieters and Peuskens, 1995: 14 [our translation])”.

Recovery can be regarded as a never-ending process, the result of which depends upon the person with mental health problems, the immediate social context and society as a whole. The recovery framework also focuses explicitly on the positive possibilities of individuals with mental health problems (Pieters & Peuskens, 1995), which can be developed through learning processes (Bachrach, 1995b). Another area of focus has to do with the expansion of choices concerning such areas as housing, employment and the social contexts in which individuals prefer to stay (Pieters & Peuskens, 1995).

As with the rehabilitation framework, one important element of the recovery framework is its focus on the individual. It are the individuals with mental health problems that can develop their capacities. This framework stands in opposition to the impersonal treatment of individuals with mental health problems in asylums and attaches importance to the environment. The adaptation between the person and the environment is bidirectional. Recovery proceeds from the strengths of the individual with mental health problems. In addition to its psychopathology, the ego always has a healthy part, which strives to give hope to the person with mental health problems, who is often confronted with diminished self-respect. One important way to restore the individual's self-respect is by focusing on work (whether paid or unpaid), as well as on other social and recreational engagements. Through such efforts, people with mental health problems actively participate in their own recovery process. This stands in contrast to the institutional tendency to do things for the individual with mental health problems. The recovery process is a continuous form of support for the individuals involved, who face functional limitations, changing social environments, the lifelong character of their vulnerabilities and possible problems with generalising the skills they have learned to new situations (Bachrach, 1995b).

Drawbacks of the recovery model include the fact that some recovery programmes 'close the gates' for most people with mental health problems. The largest 'problem' with this, however, is that the programmes often neglect the closing of the gates, thereby resulting in people with mental health problems who do not fit in any programme and who have no alternative for treatment. Another more negative element of the recovery model maintains its strong focus on work, while minimising other important elements. This leads efforts to be dominated by the benefits of employment, and this is problematic for those people who will never be able to work (Bachrach, 1995b).

As mentioned above, the process of deinstitutionalisation in Belgium has led to the creation of ambulant centres for mental healthcare. Those centres offer medical-psychiatric and psychotherapeutic assistance to anyone with a severe psychic problem, from children to the elderly. The ambulant centres for mental healthcare are usually

divided in various teams, each composed of psychiatrists, psychologists and social workers. The teams are responsible only for ambulant consultations, and not for hospitalisations. In Flanders (the Dutch speaking part of Belgium) and Brussels, there are currently 20 of these centres. Two are located in the city of Ghent: Eclips and the more regional Deinze-Eeklo-Ghent. Eclips is divided into nine centres that are targeted to specific groups, including young people, substance addicts and forensic care (Zorgen Gezondheid, 2017).

5.2. Research questions

The aim of this research project is to generate additional insight into the accessibility (or inaccessibility) of mental healthcare services for diasporic Muslims who are struggling with mental health problems in Flanders (the Dutch speaking part of Belgium). The existing body of scholarship suggests that, although these individuals are particularly at risk for mental health problems, their access to established mental healthcare services remains relatively limited. Moreover, there is a lack of knowledge that can be applied to address this phenomenon. The research reported in this dissertation is aimed at generating an in-depth understanding of this situation.

This study draws upon qualitative and interpretative research that was conducted in two synergetic and inter-related clusters of empirical research activities. Proceeding from a relatively novel intersectional approach, we examine the relationships between diasporic Muslims and mental healthcare professionals by:

1. mapping, analyzing, and theorizing existing frames of mental health care towards diasporic Muslims of Turkish and Moroccan background amongst a wide spectrum of mental healthcare providers and professionals, and
2. conducting biographical research with diasporic Muslims who are seeking mental health care. We do this to examine how these migrants experience the discourses and services that are prevalent in Western healthcare, as well as the discourses and practices that are applied within

the Muslim community, as well as to theorise the strategies these migrants develop in seeking mental healthcare.

In the following paragraphs, I discuss the research process that we developed in order to formulate an answer to these questions: *'Where do diasporic communities from various countries who identify as Muslim and settle in Belgium go with their mental health concerns?'*, *'Do they find their way to the existing mental health services?'*, *'If not, where do they take their mental health concerns?'*, *'If yes, how do their contacts with, and trajectories through, the established mental health services look like?'*, *'And what does their underrepresentation within mental health services reveal about the social organization of mental healthcare?'*. The discussion includes an overview of the chapters of this dissertation.

5.3. Research process

The first study (Chapter 2) consists of an extensive critical literature review of sociological research on the topic. I have tried to draw theoretical conclusions concerning this literature. Looking to social theory is very useful, as it challenges us to question the underlying assumptions, discourses and ideologies of the exclusion of some individuals and the focus on the social roles of others, which are taken-for-granted (Goodley et al., 2012). Proceeding from the Foucaultian view that mental health institutions shape the subjects that pass through them, I focus on the role of subjectivity in the under-representation of diasporic migrants in established mental healthcare services. In this first stage of this research project, I sharpened the critical perspectives that are needed for an intersectional approach of the problem: disability, religion, ethnicity, migration and gender. The article "Racism, migration and mental health: Theoretical reflections from Belgium" identifies a general tendency amongst the various critical lenses. Each of these lenses is based on mechanisms of 'othering'. The modern formation of the Western subject is based on an opposition to the mentally ill, religious, non-white, female 'other'. Although this perspective has been criticised in post-colonial research, I have identified the lack of a 'missing revolution' of post-colonial theory in sociological theory. I also observed that the literature devotes little

attention to the agency of diasporic Muslims with mental health problems. At the end of this chapter, I examine the ways in which such attention could make it possible to unpack the initial conundrum in which diasporic Muslims have poorer mental health, but are under-represented in established mental healthcare services.

In addition to its theoretical component, this study drew upon qualitative research to map the existing frames of mental healthcare amongst a wide spectrum of mental healthcare providers in the city of Ghent, Belgium. We also conducted biographical research with diasporic Muslims who were seeking mental healthcare services.

The second study (Chapters 3, 4 and 5) focuses on the role of mental healthcare professionals. I conducted 31 qualitative interpretative interviews with a wide range of professionals from various organisations. The participants, who were selected through snowball sampling, consist of social-cultural workers, psychologists, psychiatrists and general practitioners in organisations, including umbrella organisations in the mental health sector, city services, community mental health centres, mental health services, psychologists, and welfare organisations. My primary focus was on ambulant professionals, as the process of deinstitutionalisation gave them a more important role. Mental healthcare professionals are important, as the presence of a supporting role and relationship of trust play an important role in the healing process for individuals with mental health problems. The duration of the interviews ranged from 45 minutes to 2 hours. I conducted those interviews, together with Master's student Audrey De Roeck, who participated in this doctoral research project in the context of her Master's thesis.

With the snowball selection, I constructed a cartography of social meaning constructions concerning diasporic Muslims with mental health problems. The advantage of mapping meanings is that it involves multiple entry points and is capable of expressing multiple dimensions, in addition to examining the various ways in which cultures construct subject positions. Given that subjects are embodied and embedded in sense-making processes, which result in different versions of socially created realities, leading to the emergence of different standpoints. Creating such meanings requires real-life individuals with discursive subjectivities and mapping diverse subjectivities of research subjects. Mapping and constructing cartographies of

disability can thus help disability researchers to question and challenge essentialist constructions of impairment (Roets & Braidotti, 2012).

First, in “Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent” (Chapter 3), I focus on the first interviews conducted, analysing them according to a framework distilled from the work of Nikolas Rose. This framework’s specific focus on processes of subjectivity drew my attention to the ways in which ‘a proper subject of mental healthcare’ is or is not created. I identified four different aspects of subjectivity in Rose’s work: ontological, epistemological, ethical and technical. I have expanded this perspective to address a cultural difference logic, based on the work of Edward Said. This resulted in a blind spot in the analysis.

Second (Chapter 4), I shifted our analytical attention to the frames used by mental healthcare professionals, as conceptualised by Goffman and Butler. Although some studies have examined the under-representation of diasporic Muslims in mental healthcare, many lack an in-depth and dynamic understanding, in theoretical as well as empirical terms, of what takes place in the interactions between mental healthcare professionals and diasporic Muslims. In “Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims” I attempt to disentangle the various frames that mental healthcare professionals use when they approach diasporic Muslims. A focus on frames is interesting, as the world as we receive it is always framed. Such frames function as a guide or rule for recognizing the phenomena in question. For example, we can identify disability in ourselves and in others when the frames of disability guide us to such recognitions. In most cases, however, we are not aware of the actual frames (Titchkosky & Michalko, 2012). Based on the empirical research, I identified three frames: the biomedical frame, the resocialisation frame and the cultural difference frame. The first two frames were also present in the work of Goffman. Over time, however, the resocialisation frame has been transformed into a recovery frame, and it is important to remember that the context within which Goffman wrote his work has changed as well. The final frame is

thus a new frame, which I refer to as the ‘cultural difference frame’. This frame did not appear in Goffman’s writings.

Third, in ““But that is a cultural given.” Diasporic Muslims, mental healthcare professionals, and the cultural difference frame” (Chapter 5), I examine this final frame in even more detail. Although the interviewed professionals differ in their conceptualisations of culture, almost all of them construct a difference between ‘us’ and ‘them’. This frame can be disentangled into three tropes: pressure of the community, spiritual healing and psychosomatisation.

Our third study, “How to make sense of cultural difference in mental healthcare: Analysing the biographies of diasporic Muslim women with mental health problems” (Chapter 6) consists of an analysis of the other side of the story – the stories of the diasporic Muslim clients themselves – provides an answer to the second research question. In this study, we conducted biographical research with diasporic Muslims settled in Belgium with mental health problems. Stories are an important source in the quest for knowledge about the relationship between physicians and patients, particularly with regard to the patient’s convictions, emotions, norms and values. People who recognise themselves in such stories can take their identities from these stories, which can help to give sense to their lives. The stories of others can build a base for self-reflection and understanding (Van Baarsen, 2013). It is important to realise that, although stories can be individualised, this process is influenced by shared narratives of illness. These narratives determine the content of what can be told, how the story should be constructed and how others will perceive the story. Different narrative types are told repeatedly and in alternation. The narrative at the beginning can be different from the narrative(s) at the end of a story or situation (Frank, 2013). From our interviews, we found that seeking help from mental healthcare professionals is only one of several strategies. Other strategies have to do with such aspects as the positioning of individuals within their families and communities, their education and/or work trajectories and religion. Covering those strategies is the observation from a hybridization of culture.

It is important to realise that the process of writing stories down entails isolating them from the narrative flux of storytelling in real life. When stories are told, it is important to avoid immediately moving on to the next story, but to live through it, reflect upon who the individual becomes through the story and how it is being modified by the teller. It is also important to consider how the story is used in the various moments in which it is told, given that, over time, repetition at those moments leads people to hear it differently. Stories also provide continuity between those moments (Frank, 2013). The interviews and initial analysis for this part of the research were conducted by Caroline Vandekinderen.

Finally, we discuss several ethical considerations with which we were confronted during our research.

5.4. Ethical considerations

The foundation of this explorative, qualitative research is the belief that the lived experiences of individuals with mental health problems and their mental healthcare professionals can provide rarely recognised but valuable sources of knowledge. In many cases, a process of ‘othering’ remains, especially in the case of diasporic Muslims with mental health problems. Attention to research ethics can help to avoid reproducing the colonising discourse of the ‘other’, given that many qualitative studies have also engaged in ‘othering’. This is also the case in the field of disability studies, and some authors have maintained and perpetuated the alienation, objectification and exclusion of persons with disabilities.

5.4.1. Procedural research ethics

Procedural research ethics can be defined as the ethics of the Institutional Review Board committees. These rules have become the controlling mechanisms with which the government ensures that sciences and knowledge are always value-neutral. They provide researchers with professional codes concerning informed consent, confidentiality, the right to privacy, deception and protecting human subjects from harm (Ellis, 2007).

Several requirements have been identified especially for ethical research in the field of mental health studies. They have to do with moral principles for preventing harm, focusing on respectful attitudes and behaviour towards the research participants (DuBois, 2008). They are all founded in the belief that individuals with mental health problems are vulnerable and that mental healthcare professionals, with their higher social status, are stronger (DuBois, 2008; Hoeyer et al., 2005; Oeye et al., 2007). Most often, such guidelines are based on the ethical guidelines of the medical field with regard to informed and voluntary consent and the estimation of risks and benefits. The adoption of these guidelines can have an important influence on the formulation of research designs, which must often be modified to suit positivist standards in order to be approved. Possible examples include the need to cooperate with the staff, to determine whether patients are capable of providing informed consent, to acknowledge the possible increase in the potential to do harm and to state that the benefits to participants (in our case, individuals with mental health problems) are uncertain. One possible harmful consequence for mental healthcare professionals is that the participants might perceive the entire study as a form of surveillance, as it concerns their attitudes and behaviour towards diasporic Muslims with mental health problems. Although informed consent is usually obtained through a written form, this is not always possible with vulnerable groups. In the past, the informed consent procedure focused on the full disclosure of the research. The focus has recently shifted towards the participants' ability to understand the research and their decision-making capacity. Because some of the diasporic Muslims with mental health problems who participated in our study did not understand Dutch, it was necessary to provide a translation. This was difficult in some cases, however, as many women participants did not trust having an acquaintance as interpreter. In many cases, these precautions are not taken when seeking informed consent from mental healthcare professionals (Dubois, 2008; Oeye et al., 2007). This demonstrates how mental healthcare is influenced by the biomedical frame of care, based on positivist notions of illness, health and research.

The influence of the biomedical frame became clear in my research, as the mental healthcare professionals did not request the informed consent procedure when they

were interviewed. Some even considered it odd to sign the form, even though they demand the procedure with regard to their clients and patients. This illustrates that they do indeed regard individuals with mental health problems as vulnerable. On the other hand, denying competent participants the opportunity to enrol in a study in which they wish to participate could reflect a form of paternalism, possibly violating the autonomy of the clients. Informed consent is also intended to protect the interests of participants, however, and when people are unable to exercise informed self-determination, others have a duty to protect them (DuBois, 2008). The institutional Review Board also asked for a preliminary screening of the diasporic Muslim women for a number of pathologies, “because we would otherwise not know how vulnerable they are”. We addressed this objection by asking the professionals. This is consistent with the recommendation to use the mental healthcare professionals to evaluate the ability of individuals with mental health problems. Another observation I made is that the non-medical professionals accepted the permission of the Institutional Review Board Committee of the faculty of Psychology and Educational Sciences, while the medical professionals requested permission from the University Hospital. This could be interpreted as a less biomedical orientation on the part of the first group, as compared to the second group.

5.4.2. Situational research ethics

Situational research ethics are intended to help researchers cope with subtle, unpredictable, ethical aspects in the field (Ellis, 2007).

It is important to consider that the social setting in which the research was conducted also had an influence on the findings. Research participants who are interviewed in a medical clinic are more likely to refer to physical complaints, as they believe that this is what the researcher wishes to hear. Those who are interviewed in other settings (e.g. in the home) are more likely to refer to other elements. It is also necessary to consider the effect of differences in ethnicity or background between the interviewer and the participant (Kleinman, 1988). In this case, the differences

concerned the fact that the interviewers were not of Turkish or Moroccan descent, and they were not medically trained.

For the last part of this doctoral research project, we interviewed diasporic Muslims with mental health problems themselves. Obtaining the perspectives of those actually experiencing the problems can be difficult, as their voices are easily ignored. They are often faltering in tone, and they tend to send mixed messages concerning human vulnerability, which people often prefer to forget. Although it is difficult to listen to such stories, it is also a basic human activity: in listening for the ‘other’, we listen for ‘ourselves’ (Frank, 2013). This is an important consideration, given that many participants had not often received the opportunity to talk about the topic of diasporic Muslims in mental healthcare. For this reason, some participants seemed unable to stop talking about their experiences and their stories. Although this was very enriching for the research, it was exhausting for the interviewers.

5.4.3. Relational research ethics

Relational research ethics concern how researchers should cope with changing relationships with their research participants (Ellis, 2007). Although Institutional Review Board committees provide useful guidelines in this regard, most are based on the perspective that research is performed on strangers with whom the researcher has no prior relationship or will have no future relationship. Moreover, there are no clear rules or universal principles for addressing this situation.

Relational research ethics can also be linked to an ethics of care and feminist ethics, given the focus on mutual respect, dignity and connections between the researcher and the researched and between researchers and the communities in which they work (Ellis, 2007). It is thus also the foundation for the researcher’s obligation to interact with participants in a humane, non-exploitative manner, always remaining conscious of one’s role as a researcher.

One important question from the feminist agenda that this study is intended to address is, ‘Who can do research with whom?’ Feminists who conduct research with ‘others’ often wonder about the possibility and ethics of studying groups of ‘others’ to

whom they do not belong. This is especially the case with regard to marginalized groups (Traustadóttir & Kristiansen, 2004).

In the process of interviewing them, we developed relationships with the research participants. As a research method, interviewing is often used to investigate the social world, and it can take a variety of forms (Davies, 2008). Our interviews were semi-structured, meaning that they were not exactly the same as natural conversations, but also not completely structured by asking only predetermined questions. We used an interview schedule composed of a number of written questions, thereby allowing flexibility in the wording or order of questions and offering the possibility of adding new topics (Davies, 2008). As is the case in most studies on individuals with mental health problems, we selected our participants through professional access. We are aware that this comprises only a part of the population of individuals with mental health problems (DuBois, 2008).

Ellis (2007) writes about the reluctance of researchers to share their work with participants, out of fear that it will hurt them or that they would not understand it. This consideration was also at play in our research. For example, when one mental healthcare professional asked after the interview if she could read some of the things that I had written based on her story, I originally did not see this as a problem. When analysing the data, however, I realised that she might have interpreted the results as an overly negative representation of the viewpoints of mental healthcare professionals. I debated about sending her several articles. I eventually decided to send her the complete, finalised manuscript of my dissertation and invite her to my defence, in the hope that she would understand the story as a whole.

Two of the parties involved in this study – mental healthcare professionals and social scientists – often have relatively negative and stereotypical images of each other. Within the field of medical anthropology, a process of reverse ethnocentrism and romantic relativism can result in the depiction of biomedical practitioners as maleficent and homogeneous. Under an anti-psychiatric influence, such researchers are likely to consider biomedical mental healthcare professionals as all-powerful jailers of individuals with mental health problems and to view medicalisation as evil. Such

stereotypical representations are not helpful, and it is good that these stereotypes are diminishing. Social scientists often make long-term commitments to healthcare and relate to medical institutions without diminishing their own autonomy. Social scientists should also regard psychiatry as a good topic for cultural reconsideration and for linking social science to other conceptual concerns. For example, this evolution was particularly helpful in moving the focus of anthropology beyond traditional small-scale, non-Western societies. Mental healthcare and care systems have also become a central issue for other social sciences (e.g. sociology). They provide context that allow for the development of both theory and research methodologies (Kleinman, 1988).

Every party involved also plays an important role in the construction of ‘self-stories’, as the ‘self’ is formed in what is told. We tell stories to ‘others’, as well as to ‘ourselves’, always taking into account that there is a ‘self’ that is able to tell something to another actor, which has its own ‘self’ and which functions as an audience. The process of telling also entails a reaffirmation of relationships with ‘others’ and of the ‘self’ (Frank, 2013).

5.4.4. Socio-political research ethics

In addition to procedural and relational research ethics, it is also important for researchers to consider the social, political and historical processes in which their research takes place. This refers to the fact that all knowledge and research participants are social constructs in relation to power (Davies, 2008; Hoffer, 2009; Traustadóttir & Kristiansen, 2004). In this research, I regard identity not in the modern Western way as unique and individual, but as a social and collective process. For this reason, to the examination of what are considered ‘troubled identities’ can provide considerable insight into what is considered ‘normal’ (Lawler, 2014).

Any frame of medical thought and action can be regarded as a socio-cultural construction: ideas and treatments developed by people, which differ and change according to place and time (Hoffer, 2009). Considering such mental health problems and treatments as frames does not negate the existence of the behaviours of people who are regarded as having mental health problems or as being psychiatrists. Although

these behaviours do exist, for those who do not accept psychiatric explanations, they are merely claims of people with mental health problems and their professionals. The non-believers do not believe that it are medical problems or treatments. Psychotherapeutic treatments can also be considered not to be medical, but moral, or as not literal, but metaphorical (Szasz, 1978). Research can thus never be neutral. Researchers themselves are also situated biographically and socially, and this can make situations quite complex when they are addressing procedural and relational ethics, research in general and the research participants that they construct (Davies, 2008). Each individual has a particular perspective on the world. It is influenced by the various standpoints of the social categories that individuals adopt. Examples include race, gender, sexuality, social class and disability. Our worldviews are also influenced by our interests, concerns, anxieties and aspirations. This results in a wide variety of perspectives and realities. Although we have different perspectives on the world, we also believe that we are experiencing the world in the same way that other people do. This is because we assume that they perceive the world in the same way that we do, and we assume that we would perceive the world as they do if we were to be in their position (Titchkosky & Michalko, 2012). Knowledge is co-constructed by researchers and participants, each having their own backgrounds (Davies, 2008). It is therefore important to consider the ways in which knowledge, sociology or the study of mental health is created by our participation in it. We must also consider the structure of our relationships, how we are accountable for them and the actions that perpetuate them, in addition to considering (and reconsidering) our observations and readings (Mallet & Runswick-Cole, 2012). Each narrative that an individual uses is a reflection of that individual's cultural and personal preferences. If these preferences are strong, they can form new barriers to listening to the stories of those to whom the individual is listening. Relevant to our research, institutional and individual influences can lead people with mental health problems in the direction of certain narratives, while other narratives that they might have are not heard. The barriers that are constructed in such communication can also be insightful, however, as reflecting on

them and on the process of listening to ‘others’ and telling our own stories helps to construct the individuals we are (Frank, 2013).

To clarify this point, in my research, I follow the feminist recommendation of ‘writing oneself in our research’. Because researchers always participate in the worlds they are studying, reflexivity is needed (Traustadóttir & Kristiansen, 2004). Contemporary academics often seem to believe that identities have become more fluid. Outside of the ivory tower, however, identities continue to be relatively fixed and unproblematic. Although roles could be regarded as changeable, the identities that people seem to link with particular characteristics (e.g. ‘men’ or ‘women’) are not (Lawler, 2014). All of this can be summarised with the following quotation from Zola:

“I want at the very least to bring these personal bodily experiences closer to my center – not to claim that they constitute all of who I am, but that they are a central part of my identity; not that they explain all that I have accomplished but that they are essential to understanding what I have done (Zola in Overboe, 2012: 116)”.

Given that research is a political process, the ethical aspects are also political and in need of some degree of reflexivity. It is necessary to identify the assumptions about the world that are being taken for granted. Critical self-reflection is also necessary in order to clarify the research process and to document and examine the complexity and contentious, contradictory nature of research. The influence of certain characteristics of researchers and their sociocultural contexts should be considered (Davies, 2008).

Finally, such reflexivity helps to uncover the interpretative, paradigmatic frames that we use as guidelines for our action. The combination of the epistemological, ontological and methodological principles that researchers use can be regarded as their paradigmatic frames. Especially in interpretative research, it is important to be aware of the epistemological and ontological guidelines for conducting research. For this reason, research ethics are associated with the ontological question and the knowledge systems on which it is based. In the context of our research, we seek our

epistemological and ontological guidelines in the work of poststructuralist critical disability studies and feminist researchers.

The quality of qualitative research is difficult to control. It is undoubtedly related to the purposes of the study and those who consult its results. It is nevertheless possible to assist the consumers of research by having the quality of studies assessed by researchers who report sufficient details about the data collection and processes of analysis (Patton, 1999). In this case, it is important to note that we applied investigator triangulation, as the interviews of the mental healthcare professionals were conducted by two different researchers, and the interviews of the people with mental health problems were conducted by yet another researcher. I also applied theoretical triangulation, as I analysed the data from the mental healthcare professionals according to the theories of Rose (1998; 1999), Goffman (1956; 1961; 1974) (and Butler (1993; 1997; 2009)) and Hall (1992; 1996). The data from the individuals with mental health problems were analysed according to yet another theory. Qualitative data should be varied, detailed and contextualised, and they should reflect the participants' experiences, actions and perceptions. In this case, I accomplished this by providing information about the various research settings and my reasons for choosing them. This provides readers with insight into the initial motivation and approach of the researchers.

For practical reasons, all of the settings and participants were located in Ghent. This is not necessarily problematic. From a sociological point of view, I focus on the cultural categories and structural arrangements that guide the lives of my participants, and these aspects are not limited to geographical boundaries (Prior, 1993). Finally, the information concerning the process of gaining access, role negotiations, reflexivity and ethics increases the credibility of this study, as it focuses on the important role of the researcher in qualitative research. Given that qualitative researchers can be regarded as the instruments of the research, it is important to include information about them as well. It is important to know which experience, training and perspective are involved, in addition to details about the personal connections that the researcher has to the people or topics being studied. Another reason that it is important to know about the

background characteristics of researchers is that they could affect how they are received by their participants (Patton, 1999).

Some theorists believe that subordination results in a privileged view on oppression and, more specifically, a subjective experience of oppression. From an intersectional perspective on subordination, however, such subjectivities of oppression are diversified. This complicates the representation of the perspective of the oppressed, which differs from that of the critically engaged researcher (Bhambra, 2007).

Our status as researchers with no medical or psychological training positioned us as outsiders with regard to the participants (Gair, 2012). In qualitative studies, researchers are regularly insiders (i.e. members of the social groups they are studying). This has several benefits, including familiarity with the setting and the culture being studied. Furthermore, being an insider renders issues of gaining access only minor concerns. It also makes it more difficult to understand routine procedures, however, as it is easy to overlook them. As outsiders, we were able to observe and question the ways in which various actors shape routine processes that could be easily overlooked by people who are familiar with mental healthcare. As a person with Autism and depression, however, I am an insider in the field, thus requiring a careful balance between the insider and outsider positions.

The 'common wound effect' is used to describe situations in which mental healthcare professionals who have experienced health conditions themselves feel more empathy toward patients, and especially towards those with the same health condition. This could also lead them to engage in more self-disclosure with their patients (Gair, 2012). My own disabilities could have resulted in a common wound effect in our research as well. Because of my intimate familiarity with the system, I had some experience before the research was started. Given the interpretative nature of the study, which is founded in an empathic understanding of the daily lived experiences of our participants (as revealed through in-depth interviews), this was considered an asset (Gair, 2012). I did not mention this in advance to the mental healthcare professionals, as I did not wish to influence their answers to the interview questions. Towards the end of the interview, however, I mentioned my own experiences, often accompanied

by more informal answers or stories, as the mental healthcare professionals regarded me as a kind of professional in the system.

References

- Abas, M. (1996). *Depression and Anxiety Among Older Caribbean People in the UK: Screening, Unmet Need and the Provision of Appropriate Services*. *International Journal of Geriatric Psychiatry*, 11: 377-382.
- Abdullah, S. (2007). *Islam and counseling: Models of practice in Muslim communal life*. *Journal of Pastoral Counseling*, 42: 42–55.
- Abel, T. & Frohlich, K. (2012). *Capitals and capabilities: Linking structure and agency to reduce health inequalities*. *Social Science & Medicine*, 74: 236-244.
- Aichberger, M.C., Bromand, Z., Heredia Montesinos, A., Temur-Erman, S., Mundt, A., Heinz, A., Rapp, M.A. and Schouler-Ocak, M. (2012). *Socio-economic Status and Emotional Distress of Female Turkish Immigrants and Native German Women Living in Berlin*. *European Psychiatry*, 27: 10-16.
- Ang, W. (2007). *Werken met allochtonen: culturele sensitiviteit in de klinische praktijk*. *Tijdschrift voor Geneeskunde*, 63(12): 556-560.
- Bäärnhielm, S. & Mösko, M. (2012). *Cross-cultural Training in Mental Health Care – Challenges and Experiences from Sweden and Germany*. *European Psychiatry*, 27: 70-75.
- Bachrach, L. (1995a). Aspecten van deinstitutionalisering. In: G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapspsychiatrie*. Leuven: Garant.
- Bachrach, L. (1995b). Psychosociale rehabilitatie en psychiatrische begeleiding in de zorg voor chronische patiënten. In: G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapspsychiatrie*. Leuven: Garant.
- Backhans, M.C., Lundberg, M. & Månsdotter, A. (2007). *Does increased gender equality lead to a convergence of health outcomes for men and women? A study of Swedish municipalities*. *Social Science & Medicine*, 64: 1892-1903.

- Bambra, C., Pope, D., Swami, V., Stanistreet, D., Roskam, A., Kunst, A. & Scott-Samuel, A. (2008). *Gender, health inequalities and welfare state regimes: a cross-national study of 13 European countries*. *Journal of Epidemiology and Community Health*, 63: 38-44.
- Barnes, C. & Mercer, G. (2003). *Disability*. London: Polity.
- Barnes, C., Mercer, G. & Shakespeare, T. (1999). *Exploring Disability. A Sociological Introduction*. Cambridge: Polity Press.
- Bennett, D. (1995). Veertig jaar psychiatrische rehabilitatie: een overzicht. In: G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapspsychiatrie*. Leuven: Garant.
- Beresford, P. (2000). *What have madness and psychiatric system survivors got to do with disability and disability studies?* *Disability & Society*, 15: 167-172.
- Bhambra, G.K. (2007). *Rethinking Modernity: Postcolonialism and the Sociological Imagination*. Basingstoke: Palgrave Macmillan.
- Bhugra, D. & Mastrogianni, A. (2004). *Globalisation and mental disorders. Overview with relation to depression*. *British Journal of Psychiatry*, 184: 10-20.
- Blumberg, R.L. & Coleman, M.T. (1989). *A Theoretical Look at the Gender Balance of Power in the American Couple*. *Journal of Family Issues*, 10(2): 225-250.
- Boneham, M.A., Williams, K.E., Copeland, J.R.M., McKibbin, P., Wilson, K., Scott, A. & Saunders, P.A. (1997). *Elderly people from ethnic minorities in Liverpool: mental illness, unmet need and barriers to service use*. *Health and Social Care in the Community*, 5(3): 173-180.
- Borrell-Carrió, F., Suchman, A.L. & Epstein, R.M. (2004). *The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry*. *Annals of Family Medicine*, 2(6): 576-582.
- Boyd, A., Van de Velde, S., Vilagut, G., de Graaf, R., O'Neill, S., Florescu, S., Alonso, J. Kovess-Masfety, V. & the EU-WMH investigators (2015). *Gender differences in mental disorders and suicidality in Europe: Results from a large cross-sectional population-based study*. *Journal of Affective Disorders*, 173: 245-254.
- Brah, A. (1996). *Cartographies of diaspora. Contesting identities*. London: Routledge.

- Buffel, V., Van de Velde, S. & Bracke, P. (2014). *Professional care seeking for mental health problems among women and men in Europe: the role of socioeconomic, family-related and mental health status factors in explaining gender differences*. *Social Psychiatry and Psychiatric Epidemiology*, 49: 1641-1653.
- Burns, J. (2009). *Dispelling a myth: Developing world poverty, inequality, violence and social fragmentation are not good for outcome in schizophrenia*. *African Journal of Psychiatry*, 12: 200–205.
- Butler, J. (1988). *Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory*. *Theatre Journal*, 40(4): 519-531.
- Butler, J. (1993). *Bodies that Matter: On the Discursive Limits of Sex*. London: Routledge.
- Butler, J. (1997). *Excitable Speech: A Politics of the Performative*. London: Routledge.
- Butler, J. (2009). *Frames of War. When is Life Grievable?* Brooklyn: Verso.
- Buytaert, E., Vandendrinck, E. & Lemmens, G. M. D. (2009). *Psychiatrische stoornissen bij migranten: feiten en hypothesen*. *Tijdschrift voor Geneeskunde*, 65: 1-8.
- Cantor-Graae, E. & Selten, J-P. (2005). *Schizophrenia and Migration: A Meta-Analysis and Review*. *American Journal of Psychiatry*, 162(1): 12-24.
- Carrillo, J.E., Carrillo, V.A., Perez, H.R., Salas-Lopez, D., Natale-Pereira, A. & Byron, A.T. (2011). *Defining and Targeting Health Care Access Barriers*. *Journal of Health Care for the Poor and Underserved*, 22(2): 562-575.
- Chakraborty, A. T., McKenzie, K. J., Hajat, S. & Stansfeld, S. A. (2010). *Racism, Mental Illness and Social Support in the UK*. *Social Psychiatry and Psychiatric Epidemiology*, 45: 1115-24.
- Chang, J. Dubbin, L. & Shim, J. (2016). *Negotiating substance use stigma: the role of cultural health capital in provider-patient interactions*. *Sociology of Health & Illness*, 38(1): 90-108.
- Chesler, P. (2005). *Women and Madness*. New York: Palgrave MacMillan.

- Chu, J., Leino, A., Pflum, S. & Sue, S. (2016). *A Model for the Theoretical Basis of Cultural Competency to Guide Psychotherapy*. *Professional Psychology: Research and Practice*, 47(1): 18-29.
- Clycq, N. (2011). *Muslims in Antwerp*. Open Society Foundation [At Home in Europe Project]. London: Open Society Foundation.
- Connell, R.W. (2005). *Masculinities (second edition)*. Cambridge: Polity Press.
- Corker, M. & Shakespeare, T. (2002). *Disability/postmodernity: Embodying disability theory*. New York: Bloomsbury Academic Press.
- Crammond, B.R. & Carey, G. (2016). *What do we mean by 'structure' when we talk about structural influences on the social determinants of health inequalities?* *Social Theory & Health*, doi: 10.1057/s41285-016-0020-3.
- Davies, C.A. (2008). *Reflexive Ethnography. A guide to researching selves and others*. New York: Routledge.
- Devlieger, P., Rusch, F. & Pfeiffer, D. (2010). Rethinking disability as same and different! towards a cultural model of disability. In: P. Devlieger, F. Rusch & D. Pfeiffer (eds.) *Rethinking Disability. The Emergency of New Definitions, Concepts and Communities*, 3rd ed. Antwerpen: Garant.
- De Jong, J. (2013). Migratie en geestelijke gezondheidszorg. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 231-250). Bussum: Countinho.
- Diaz-Perez, M., Farley, T. & Martin Cabanis, C. (2004). *A Program to Improve Access to Health Care Among Mexican Immigrants in Rural Colorado*. *The Journal of Rural Health*, 20(3): 258-264.
- Doornbos, M. M., Zandee, G. L., Degroot, J. & Warpinski, M. (2013). *Desired Mental Health Resources for Urban, Ethnically Diverse, Impoverished Women Struggling with Anxiety and Depression*. *Qualitative health research*, 23: 78-92.
- DuBois, J.M. (2008). *Ethics in Mental Health Research. Principles, Guidance, and Cases*. Oxford: Oxford University Press.
- Ellis, C. (2007). *Telling Secrets, Revealing Lives. Relational Ethics in Research With Intimate Others*. *Qualitative Inquiry*, 13(1): 3-29.

- Engel, G.L. (1977). *The Need for a New Medical Model: A Challenge for Biomedicine*. *Science*, 196(4286): 129-136.
- Engel, G.L. (1980). *The Clinical Application of the Biopsychosocial Model*. *The American Journal of Psychiatry*, 137(5): 535-544.
- Engwall, K. (2004). Implications of being diagnosed as a “feeble-minded woman”. In: Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Fadil, N., Asri, F.E. & Bracke, S. (2015). Islam in Belgium. Mapping an emerging interdisciplinary field of study. In: J. Cesari (Ed.), *The Oxford Handbook for European Islam* (pp. 222-261). Oxford: Oxford University Press.
- Fleischmann, F. & Phalet, K. (2012). *Integration and religiosity among the Turkish second generation in Europe: a comparative analysis across four capital cities*. *Ethnic and Racial Studies*, 35(2): 320-341.
- Fossion, P., Ledoux, Y., Valente, F., Servais, L., Staner, L., Pelc, I. & Minner, P. (2002). *Psychiatric disorders and social characteristics among second-generation Moroccan migrants in Belgium: An age- and gender-controlled study conducted in a psychiatric emergency department*. *European Psychiatry*, 17: 443-450.
- Fossion, P., Servais, L., Rejas, M.-C., Ledoux, Y., Pelc, I. & Minner, P. (2004). *Psychosis, migration and social environment: an age-and-gender controlled study*. *European Psychiatry*, 19: 338-343.
- Frank, A.W. (2013). *The Wounded Storyteller: Body, Illness & Ethics*. (2nd edition). The University of Chicago Press: Chicago.
- Frohman, C. & Meekosha, H. (2012). Recognition, Respect and Rights: Women with Disabilities in a Globalised World. In: D. Goodley, B. Hughes, & L. Davis (Eds.), *Disability and Social Theory. New Developments and Directions*. (pp. 287-307). Basingstoke: Palgrave Macmillan.
- Gair, S. (2012). *Feeling Their Stories: Contemplating Empathy, Insider/Outsider Positionings, and Enriching Qualitative Research*. *Qualitative Health Research*, 22(1): 134-143.

- Gerkens, S. & Merkyr, S.M. (2010). *Belgium: health system review*. Health systems in transition, 12 (5): 1-266.
- Goffman, E. (1956). *The Presentation of Self in everyday life*. Edinburgh: University of Edinburgh Social Science Research Centre.
- Goffman, E. (1961). *Asylums. Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.
- Goffman, E. (1974). *Frames of analysis. An essay on the organization of experience*. Boston: Northeastern University Press.
- Goodley, D., Hughes, B., & Davis, L. (2012). Introducing Disability and Social Theory. In Goodley, D., Hughes, B. & Davis, L. (eds.) *Disability and Social Theory. New Developments and Directions* (pp. 1-14). Basingstoke: Palgrave Macmillan.
- Gramaglia, C., Gambaro, E., Rossi, A., Toso, A., Feggi, A., Cattaneo, C. I., Castignoli, G., Mainini, P., Tarricone, I., Torre, E. & Zeppego, P. (2016). *Immigrants' Pathways to Outpatient Mental Health: Are there Differences with the Native Population?* Journal of Immigrant and Minority Health, 18: 878-885.
- Grech, S. (2012). Disability and the majority world: A neocolonial approach. In D. Goodley, B. Hughes & L. Davis (Eds.) *Disability and Social Theory. New Developments and Directions* (pp. 52-69). Basingstoke: Palgrave Macmillan.
- Grinker, R.R. (2007). *Unstrange Minds: Remapping the World of Autism*. New York: Basic Books.
- Grzanka, P.R. & Miles, J.R. (2016). *The Problem with the Phrase "Intersecting Identities": LGBT Affirmative Therapy, Intersectionality, and Neoliberalism*. Sexuality Research and Social Policy, 13: 371-389.
- Gustavsson, A., Sandvin, J., Traustadóttir, R. & Tossebro, J. (2005). *Resistance, Reflection and Change. Nordic Disability Research*. Lund: Studentlitteratur.
- Haasen, C., Yagdiran, O., Mass, R. & Krausz, M. (2000). *Potential for misdiagnosis among Turkish migrants with psychotic disorders: a clinical controlled study in Germany*. Acta Psychiatr Scand, 101: 125-129.

- Haasen, C., Demiralay, C. & Reimer, J. (2008). *Acculturation and mental distress among Russian and Iranian migrants in Germany*. *European Psychiatry*, 23: 10-13.
- Hall, S. (1992). Cultural Studies and its Theoretical Legacies. In: L. Grossberg, G. Nelson & P. Treichler. *Cultural Studies*. London: Routledge.
- Hall, S. (1996). *Race, the Floating Signifier. Featuring Stuart Hall*. Media Education Foundation, 61 min.
- Heinz, A. & Kluge, U. (2012). *Editorial. Mental Health in Different Groups of Migrants and Ethnic Minority Within Europe and Beyond: Regional and Cross-national Challenges and Approaches in Research, Practice and Training*. *European Psychiatry*, 27: 1-3.
- Hilderink, I., Van 't Land, H. & Smits, C. (2009). *Drop-out onder allochtone GGZ-cliënten. Zicht op de onderliggende factoren en aanbevelingen om drop-out te verminderen*. Utrecht: Trimbos-instituut.
- Hoeyer, K., Dahlager, L. & Lynøe, N. (2005). *Conflicting notions of research ethics. The mutually challenging traditions of social scientists and medical researchers*. *Social Science & Medicine*, 61: 1741-1749.
- Hoffer, C. (2009). *Psychische ziekten en problemen onder allochtonen Nederlanders: beleving en hulpzoekgedrag*. Assen: Van Gorcum.
- Hutchinson, G. & Gilvarry, C. (1998). *Ethnicity and dissatisfaction with mental health services*. *British Journal of Psychiatry*, 172: 95-96.
- Inhorn, M. C. & Serour, G. I. (2011). *Islam, Medicine, and Arab-Muslim Refugee Health in America After 9/11*. *The Lancet*, 378: 935-943.
- Jackson, J.W., Williams, D.R. & VanderWeele, T.J. (2016). *Disparities at the intersection of marginalized groups*. *Social Psychiatry and Psychiatric Epidemiology*, 51: 1349-1359.
- Janssen, I., Hanssen, M., Bak, R., Bijl, R.V., De Graaf, R., Vollebergh, W., McKenzie, K. & Van Os, J. (2003). *Discrimination and delusional ideation*. *British Journal of Psychiatry*, 182: 71-76.

- Kapilashrami, A., Hill, S. & Meer, N. (2015). *What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach*. *Social Theory & Health*, 13(3/4): 288-307.
- Karasz, A. (2005). *Cultural differences in conceptual models of depression*. *Social Science & Medicine*, 60: 1625-1635.
- Kawachi, I., Kennedy, B.P., Gupta, V. & Prothrow-Stith, D. (1999). *Women's status and the health of women and men: a view from the States*. *Social Science & Medicine*, 48: 21-32.
- Kaya, A. & Kentel, F. (2007). *Belgische Turken. Een brug of een breuk tussen Turkije en de Europese Unie?* Brussels: Koning Boudewijn Stichting.
- Kleinman, A. (1987). *Anthropology and psychiatry. The role of culture in cross-cultural research on illness*. *The British Journal of Psychiatry*, 151: 447-454.
- Kleinman, A. (1988). *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: The Free Press.
- Kleinman, A. (2012). *Epilogue*. *European Psychiatry*, 27: 81-82.
- Kleinman, A. & Benson, P. (2006). *Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It*. *PLoS Medicine*, 3(10): 1673-1676.
- Kluge, U., Bogic, M., Deville, W., Greacen, T., Dauvrin, M., Dias, S., Gaddini, A., Koitzsch Jensen, N., Ioannidi-Kapoulou, E., Mertaniemi, R., Pucipinos, I., Riera, R., Sandhu, S., Saravry, A., Soares, J.J.F, Stankunas, M., Straßmayr, C., Weibel, M., Heinz, A. & Priebe, S. (2012). *Health Services and the Treatment of Immigrants: Data on Service Use, Interpreting Services and Immigrant Staff Members in Services Across Europe*. *European Psychiatry*, 27: 56-62.
- Kovess-Masfety, V., Boyd, A., Van de Velde, S., de Graaf, R., Vilagut, G., Haro, J.M., Florescu, S., O'Neill, S., Weinberg, L. Alonso, J & the Eu-WMH investigators (2014). *Are there gender differences in service use for mental disorders from the EU-world Mental Health survey*. *Journal of Epidemiology and Community Health*, 68: 649-656.

- Kristiansen, K. (2004). Madness, badness, and sadness revisited: Ontology control in 'mental health land'. In: Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Lawler, S. (2014). *Identity: Sociological Perspectives* (2nd edition). Cambridge: Polity.
- Lawrence, V., Banerjee, S., Bhugra, D., Sangha, K., Turner, S. & Murray, J. (2006). *Coping with depression in later life: a qualitative study of help-seeking in three ethnic groups*. *Psychological Medicine*, 36: 1375-1383.
- Lay, B., Laubner, C., Nordt, C. & Rössler, W. (2006). *Patterns of inpatient care for immigrants in Switzerland: A case control study*. *Social Psychiatry and Psychiatric Epidemiology*, 41: 199-207.
- Lay, B., Nordt, C. & Rössler, W. (2007). *Mental hospital admission rates of immigrants in Switzerland*. *Social Psychiatry and Psychiatric Epidemiology*, 42: 229-236.
- Lee, D.T.F., Mackenzie, A.E., Dudley-Brown, S & Chin, T.M. (1998). *Case management: a review of the definitions and practices*. *Journal of Advanced Nursing*, 27: 933-939.
- Lehtomäki, E. (2004). Education and employment: Gender differences among people deaf or hard-of-hearing from childhood. In: K. Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Levecque, K., Lodewyckx, I. & Vranken, J. (2007). *Depression and generalized anxiety in the general population in Belgium: A comparison between native and immigrant groups*. *Journal of Affective Disorders*, 97: 229-269.
- Levecque, K., Lodewyckx, I. & Bracke, P. (2009). *Psychological distress, depression and generalised anxiety in Turkish and Moroccan immigrants in Belgium: a general population study*. *Social Psychiatry and Psychiatric Epidemiology*, 44(3): 188-197.
- Lewis, J. (2006). *Men, women, work, care and policies*. *Journal of European Social Policy*, 16(4): 387-392.

- Lindert, J., Schouler-Ocak, M., Heinz, A. & Priebe, S. (2008). *Mental health, health care utilisation of migrants in Europe*. *European Psychiatry*, 23:14-20.
- Linton, S. (1998). *Claiming Disability: Knowledge and Identity*. New York: New York University Press.
- Livingston, G. & Sembhi, S. (2003). *Mental health of the ageing immigrant population*. *Advances in Psychiatric Treatment*, 9: 31-37.
- Lodewyckx, I., Janssens, A., Ysabee, P. & Timmerman, C. (2005). *Allochtone en autochtone jongeren met psychische problemen en gedragsproblemen: Verschillende trajecten naar de hulpverlening?*, Drukkerij Peten.
- Lorant, V., Kamfl, D., Seghers, A., Deliège, D., Closon, M.C. & Ansseau, M. (2003). *Socio-economic differences in psychiatric in-patient care*. *Acta Psychiatr Scand*, 107: 170-177.
- Lorant, V., Depuydt, C., Gillain, B., Guillet, A. & Dubois, V. (2007). *Involuntary commitment in psychiatric care: what drives the decision?* *Soc Psychiatry Psychiatr Epidemiol*, 42: 360-365.
- Madden, E.F. (2015). *Cultural Health Capital on the margins: Cultural resources for navigating healthcare in communities with limited access*. *Social Science & Medicine*, 133: 145-152.
- Mallet, R. & Runswick-Cole, K. (2012). *Commodifying Autism: They Culture Context of 'Disability' in the Academy*. In D., Goodley, B., Hughes, & L., Davis (eds.) *Disability and Social Theory. New Developments and Directions* (pp. 33-51). Basingstoke: Palgrave Macmillan.
- Martens, A., Ouali, N., Van de maele, M., Vertommen, S., Dryon, P. & Verhoeven, H. (2005). *Etnische discriminatie op de arbeidsmarkt in het Brussels Hoofdstedelijk Gewest. Onderzoek in het kader van het Sociaal Pact voor de werkgelegenheid van de Brusselaars*. Brussels: BGDA.
- Marwaha, S. & Livingston, G. (2002). *Stigma, racism or choice. Why do depressed ethnic elders avoid psychiatrists?* *Journal of Affective Disorders*, 72: 257-265.
- Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T. & de Visser, R. (2016). *Perceived barriers to accessing mental health services among*

- black and minority ethnic (BME) communities: a qualitative study in Southeast England.* *BMJ Open* 6: doi 10.1136/bmjopen-2016-012337.
- Missinne, S. & Bracke, P. (2012). *Depressive symptoms among immigrants and ethnic minorities: A population based study in 23 European Countries.* *Social Psychiatry and Psychiatric Epidemiology*, 47: 97–109.
- Neeleman, J. & Wessely, S. (1999). *Ethnic minority suicide: a small area geographical study in south London.* *Psychological Medicine*, 29: 429-436.
- Nicaise, P., Dubois, V. & Lorant, V. (2014). *Mental health care delivery system reform in Belgium: The challenge of achieving deinstitutionalization whilst addressing fragmentation of care at the same time.* *Health Policy*, 115: 120-127.
- Niewenhuijsen, K., Schene, A.H., Stronks, K., Snijder, M.B., Frings-Dresen, M.H.W. & Sluiter, J.K. (2015). *Do unfavourable working conditions explain mental health inequalities between ethnic groups?; cross-sectional data of the HELIUS study.* *BMC Public Health* 805: DOI 10.1186/s12889-015-2107-5.
- Nunkoosing, K. & Haydon-Laurelut, M. (2012). *Intellectual Disability Trouble: Foucault and Goffman on ‘Challenging Behaviour’* In D., Goodley, B., Hughes & L. Davis (eds.) *Disability and Social Theory. New Developments and Directions.* (pp. 195-211) Basingstoke: Palgrave Macmillan.
- Oeyen, C. Bjelland, A.K. & Skorpen, A. (2007). *Doing participant observation in a psychiatric hospital – Research ethics resumed.* *Social Science & Medicine*, 65: 2296-2306.
- Oh, H., Yang, L.H., Anglin, D.M. & DeVlyder, J.E. (2014). *Perceived discrimination and psychotic experiences across multiple ethnic groups in the United States.* *Schizophrenia Research*, 157: 259-265.
- Overboe, J. (2012). *Theory impairment and impersonal singularities: Deleuze, Guattari and Agamben.* In D., Goodley, B., Hughes, & L., Davis, (eds.) *Disability and Social Theory. New Developments and Directions* (pp. 112-126). Basingstoke: Palgrave Macmillan.
- Patel, V. (2001). *Cultural factors and international epidemiology.* *British Medical Bulletin*, 55: 33–45.

- Patton, M.Q. (1999). *Enhancing the Quality and Credibility of Qualitative Analysis*. Health Services Research, 34(5) 1189-1208.
- Pieters, G. & Peuskens, J. (1995). Inleiding: Gemeenschapspsychiatrie en rehabilitatie. In G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt*. Leuven: Garant.
- Prior, L. (1993). *The social organization of mental illness*. Los Angeles: Sage.
- Rechel, B., Mladovsky, P., Ingleby, D., MacKenbach, J.P. & McKee, M. (2013). *Health in Europe 5: Migration and Health in an Increasingly Diverse Europe*. The Lancet, 381: 1235-1245.
- Reinikainen, M.-R. (2004). Gendered subject positions for the disabled woman and man. In: Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Rissmiller, D.J. & Rissmiller, J.H. (2006). *Evolution of the Antipsychiatry Movement Into Mental Health Consumerism*. Psychiatric Services, 57: 863-866.
- Roets, G. & Braidotti, R (2012). Nomadology and Subjectivity: Deleuze, Guattari and Critical Disability Studies. In: Goodley, D., Hughes, B. & Davis, L. (eds.) *Disability and Social Theory. New Developments and Directions*. (pp. 161-178). Basingstoke: Palgrave Macmillan.
- Roets, G., Dean, H. & Bouverne-De Bie, M. (in press). Disability rights and disability studies in social work: uncovering different interpretations of rights and needs of people with learning disabilities in social work practice. In: F. Kessl, W. Lorenz, & H.-U. Otto (eds.), *European Social Work: a compendium*. Barbara Budrich Publisher.
- Rohde, D. (1997). *Evolution of Community Mental Health Case Management: Considerations for Clinical Practice*. Archives of Psychiatric Nursing, XI(6): 332-339.
- Rondelez, E., Bracke, S., Roets, G. & Bracke, P. (2016). *Racism, Migration and Mental Health. Theoretical Reflections from Belgium*. Subjectivity: doi:10.1057/s41286-016-0003-9.

- Rose, N. (1998). *Inventing Ourselves. Psychology, Power, and Personhood*. Cambridge: Cambridge University Press.
- Rose, N. (1999). *Governing the Soul. The Shaping of the Private Self*. London: Free Association Books.
- Rosenfield, S. (1992). *The Costs of Sharing Wives' Employment and Husbands Mental Health*. *Journal of Health and Social Behavior*, 33(3): 213-225.
- Schnittker, J. (2003). *Misgivings of Medicine? African Americans' Skepticism of Psychiatric Medication*. *Journal of Health and Social Behavior*, 44 (4): 506-524.
- Selten, J-P., Veen, N., Feller, W., Blom, J.D., Schols, D., Camoenie, W., Oolders, J., Van Der Velden, M., Wijbrand Hoek, H., Vladár Rivero, V.M., Van Der Graaf & Kahn, R. (2001). *Incidence of psychotic disorders in immigrant groups to The Netherlands*. *British Journal of Psychiatry*, 178: 367-372.
- Selten, J-P., Zeyl, C., Dwarkasing, R., Lumsden, V., Kahn, R.S. & van Harten, P.N. (2005). *First-contact incidence of schizophrenia in Surinam*. *British Journal of Psychiatry*, 186: 74-75.
- Selten, J-P. & Cantor-Graae, E. (2007). *Hypothesis: social defeat is a risk factor for schizophrenia?* *British Journal of Psychiatry*, 191(51): 9-12.
- Selten, J-P., van der Ven, E., Rutten, B.P.F. & Cantor-Graae, E. (2013). *The social defeat hypothesis of schizophrenia: An update*. *Schizophrenia Bulletin*, 39(6): 1180-1186.
- Shim, J.K. (2010). *Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment*. *Journal of Health and Social Behavior*, 51(1): 1-15.
- Siller, H., Renner, W. & Juen, B. (2015). *Turkish Migrant Women with Recurrent Depression: Results from Community-based Self-help Groups*. *Behavioral Medicine*, DOI: 10.1080/08964289.2015.1111858.
- Singh, S.P., Brown, L., Winsper, C., Gajwani, R., Islam, Z., Jasani, R., Parsons, H., Rabbie-Khan, F. & Birchwood, M. (2015). *Ethnicity and pathways to care during first episode psychosis: the role of cultural illness attributions*. *BMC Psychiatry*, 15: 287: DOI 10.0086/s12888-015-0665-9.

- Sørheim, T.A. (2004). The impact of gender on parental response to children with disabilities: A study of Pakistani families in Norway. In: Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Stein, L. (1995). Systeemaanpak van ernstig zieke chronische psychiatrische patiënten. In: G. Pieters & J. Peuskens, *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapsgeneeskunde*. Leuven: Garant.
- Stepanikova, I. & Oates, G.R. (2017). *Perceived Discrimination and Privilege in Health Care: The Role of Socioeconomic Status and Race*. *American Journal of Preventive Medicine*, 52(1): 86-94.
- Stockman, R. (2000). *Van nar tot patiënt. Een geschiedenis van de zorg voor geesteszieken*. Leuven: Davidsfonds.
- Sudhinaraset, M., Treleaven, E., Melo, J., Singh, K. & Diamond-Smith, N. (2016). *Women's status and experiences of mistreatment during childbirth in Uttar Pradesh: a mixed methods study using cultural health capital theory*. *BMC Pregnancy and Childbirth*, 16: 332-344.
- Summerfield, D. (2008). *How scientifically valid is the knowledge base of global mental health?* *The British Medical Journal*, 336: 992-994.
- Swinnen, S. G.H.A. & Selten, J-P. (2007). *Mood disorders and migration. Meta-analysis*. *British Journal of Psychiatry*, 190: 6-10.
- Szasz, T. (1978). *The Myth of Psychotherapy*. Syracuse: Syracuse University Press.
- Titchkosky, T. & Michalko, R. (2012). The body as the problem of individuality A phenomenological disability studies approach. In: D., Goodley, B., Hughes, & Davis, L. (eds.) *Disability and Social Theory. New Developments and Directions* (pp. 127-142). Basingstoke: Palgrave Macmillan.
- Traustadóttir, R. & Kristiansen, K. (2004). Introducing gender and disability. In: K. Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.

- Van Baarsen, B. (2013). Religie in de praktijk van de gezondheidszorg. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 119-136). Bussum: Countinho.
- Van Beelen, N. (2013). Migratie en migranten in Nederland. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 45-58). Bussum: Countinho.
- Vandekinderen, C. & Roets, G. (2016). *The post(hu)man always rings twice: Theorising the difference of impairment in the lives of people with 'mental health problems*. Disability & Society.
- Van den Muijsenbergh, M., Wolffers, I., van den Oever, H. & Tjitra, J. (2013). Insluiting en uitsluiting van migranten in de gezondheidszorg. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 107-118). Bussum: Countinho.
- Van der Kwaak, A. & Wolffers, I. (2013). Interculturele communicatie in de zorg. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 87-106). Bussum: Countinho.
- Vandeuren, J. (2010). *Beleidsplan Geestelijke gezondheidszorg Vlaanderen*. Brussel: Vlaamse regering.
- Vandeuren, J. (2014). *Beleidsnota 2014-2019: Welzijn, volksgezondheid en gezin*. Brussel: Vlaamse regering.
- Van de Velde, S., Bracke, P. & Leveque, K. (2010). *Gender differences in depression in 23 European countries. Cross-national variation in the gender gap in depression*. Social Science & Medicine, 71: 305-313.
- Van de Velde, S., Huijts, T., Bracke, P. & Bambra, C. (2013). *Macro-level gender equality and depression in men and women in Europe*. Sociology of Health & Illness, 35(5): 682-698.
- Van Weeghel, J. & Zeele, J. (1990). *Arbeidsrehabilitatie in een vernieuwde geestelijke gezondheidszorg*. Utrecht: Lemma.

- Vardar, A., Kluge, U. & Penka, S. (2012). *How to Express Mental Health Problems: Turkish Immigrants in Berlin Compared to Native Germans in Berlin and Turks in Istanbul*. *European Psychiatry*, 27: 50-55.
- Veling, W., Selten, J-P., Susser, E., Laan, W., Mackenbach, J.P. & Wijbrand Hoek, H. (2007a). *Discrimination and the incidence of psychotic disorders among ethnic minorities in The Netherlands*. *International Journal of Epidemiology*, 36: 761-768.
- Veling, W., Selten, J-P., Mackenbach, J.P. & Wijbrand Hoek, H. (2007b). *Symptoms at first contact for psychotic disorder: Comparison between native Dutch and ethnic minorities*. *Schizophrenia Research*, 95: 30-38.
- Wade, T.D. & Halligan, P.W. (2004). *Do Biomedical Models of Illness Make for Good Healthcare Systems?* *BMJ*, 329: 1398-1401.
- West, C. & Fenstermaker, S. (1995). *Doing Difference*. *Gender and Society*, 9(1): 8-37.
- West, C. & Zimmerman, D.H. (1987). *Doing Gender*. *Gender and Society*, 1(2): 125-151.
- Wolffers, I, van Beelen, N., & van der Kwaak, A. (2013). Allochtoon, autochtoon; waar praten we over? In Wolffers, I., van der Kwaak, A& and van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 29-43). Bussum: Coutinho.
- Ytterhus, B. (2004). Everyday life and gender in Norwegian nursery and primary schools. In: Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Zorg en Gezondheid (2017). *Centra voor geestelijke gezondheidszorg*. Consulted on 24 juni 2017 via <https://www.zorg-en-gezondheid.be/centra-voor-geestelijke-gezondheidszorg>.
- Zorgnetvlaanderen (2011). *Goede zorg bij etnisch-culturele diversiteit*. Brussel: Zorgnet.

Chapter 2⁸

Racism, migration and mental health: Theoretical reflections from Belgium

Elise Rondelez, Sarah Bracke, Griet Roets & Piet Bracke

Published in Subjectivity, 9(3): 313-332.

Abstract

Migrant communities who identify as Muslim are underrepresented in mental healthcare across Western Europe. At the same time they are particularly at risk of suffering from mental health problems. We seek to explore this underrepresentation in theoretical terms, and do so through a critical analysis of sociological literature focused on Muslim and mental healthcare in a context of migration to Europe. Pursuing the Foucaultian insight that mental health institutions shape subjects that pass through them, we reframe this underrepresentation in terms of subjectivity and the failure to be ‘good’ subjects of Western bio-medical regimes. This article aims to sharpen the critical lenses required for such an investigation, in order to use those lenses to discern mechanisms of ‘othering’ within the relevant sociological scholarship. These mechanisms consist of both universalising and essentialising particular experiences, and need to be understood in relation to colonial frameworks. As both mechanisms are premised on disregarding agency, we conclude by arguing in favour of taking the agency of subjects with mental health issues into account.

Critical theory, Intersectionality, Subjectification, Mental Health(Care), Muslim Migrants, Agency

⁸ American English

Racism, migration and mental health: Theoretical reflections from Belgium

1. Introduction

There is striking evidence that diasporic communities from various countries who identify as Muslim, some of these being first and second generation, are underrepresented within mental healthcare institutions across Western Europe (Doornbos et al., 2013, Gailly et al., 1988).⁹ At the same time, the existing body of scholarship suggests that precisely these subjects are particularly at risk of suffering from mental health problems (Buytaert et al., 2009, Colaço Belmonte, 1976, Inhorn & Serour, 2011). Hence we are confronted with somewhat of a conundrum, and its concomitant questions: Where do diasporic communities from various countries who identify as Muslim and settle in Belgium go with their mental health concerns? Do they find their way to the existing mental health services? If not, where do they take their mental health concerns? If yes, how do their contacts with, and trajectories through, the established mental health services look like? And what does their underrepresentation within mental health services reveal about the social organization of mental healthcare?

This article is part of a larger study that seeks to address such questions. Our study draws upon qualitative research to map out existing frames of mental healthcare among a wide spectrum of mental healthcare providers in the city of Ghent, Belgium, as well

⁹ It is difficult to present empirical (epidemiological) data to support this observation, because of the limited research done about this topic and the lack of a systematic registration system of the origin of clients in (mental) healthcare and social welfare services (Lodewyckx et al., 2005). Yet we can present some indications of the Belgian situation. A study (Fossion et al., 2002) in a Brussels psychiatric emergency department indicates that Moroccan patients of the second generation less often came to the hospital by themselves, but more often with pressure of their family (18% vs. 7% of the Belgian patients) or the police (14% vs. 6%). Finally, Moroccan patients of diasporic communities in a Brussels psychiatric emergency department (Fossion et al., 2004) seem to be less often registered by a referral psychiatrist (45% vs. 57%).

as to conduct biographical research with diasporic communities from various countries, existing out of first and second generations, who identify as Muslim and settle in Belgium, seeking mental healthcare.¹⁰ As an ethnic and religious minority, situated in particular intersections with class and gender, Muslims coming from diasporic communities who settle in Belgium are faced with multiple processes of racism and exclusion.¹¹ This raises important questions, since research in Europe and the US indicates that racism and racial stratification can result in mental health problems (Brown, 2003; Chakraborty et al., 2010; Karlsen et al., 2005).

While we acknowledge the importance of clinical practice as a source of knowledge production, our study has a sociological character and does not take a clinical dimension on board. That said, we do recognize resonances between our questions and certain clinical approaches within critical psychiatry (see e.g. Blackman, 2001) or ethnopsychiatry (Nathan, 2001).¹² And while qualitative empirical research is crucial to our project at large, the questions we seek to address are in dire need of

¹⁰ The title of the project is ‘Identity constructions at the intersection of mental health, religion, ethnicity and gender in Belgium’ and it is funded by the FWO, the Research Foundation Flanders.

¹¹ For a specific account of the Belgian situation, see Buytaert et al., 2009; Fadil et al., 2014; Reniers, 1999; Verhaeghe et al., 2012. In Belgium the overwhelming majority of Muslims are the descendants of post-1964 workers who came from Morocco and Turkey, mostly from rural and traditional backgrounds, either through a labour contract in low-skilled working class jobs or through family reunions (Buytaert et al., 2009; Fadil et al., 2014; Reniers, 1999; Verhaeghe et al., 2012). This labour migration, moreover, is marked in terms of gender: at first, the migrants were male low-skilled workers between 25 and 40 years of age, who were subsequently joined by spouses and families when initial dreams of return were exchanged for a more permanent settlement in Belgium, notably after migration policies had been tightened (Reniers, 1999; Verhaeghe et al., 2012). Initially characterized in terms of socio-economic status, as ‘guest workers’, gradually this population was designated in cultural, ethnic, and religious terms: guest workers became ‘allochtonous’, Moroccans and Turks, and ‘Muslims’ – the latter shift coinciding with a renewed importance of Islam in the lives of these migrants and more significantly their children and grandchildren (Fadil et al., 2014).

¹² Critical psychiatry refers to the approach that questions the assumptions that lie beneath traditional psychiatric knowledge and practice. They question among other things the practice of diagnosis, the role of contexts and meanings in the practice and theory of psychiatry, and the historical and philosophical basis of psychiatric knowledge and practice. Ethnopsychiatry, as Nathan (2001) suggests, is a psycho-therapeutical approach that deliberately considers people in terms of their attachments and thus as part of collectives, and works with the language and frames that people bring to the therapeutical encounter.

theoretical investigation. In this article we propose some of the theoretical legwork that facilitates attending to the conundrum sketched above. We approach the underrepresentation at the heart of this conundrum through foregrounding the question of the constitution of the subject. Pursuing the Foucaultian insight that mental health institutions shape the subjects that pass through them in particular ways (Rose, 1999), we reframe the abovementioned underrepresentation as a question of diasporic communities from various countries who identify as Muslim, are of the first and second generation, and settle in Belgium not being the ‘good’ or ‘proper’ subjects of the Western bio-medical regimes of mental health.¹³ In other words, we are interested in how processes of subjectification matter to the question of underrepresentation, and seek to explore, in a theoretical inquiry that looks at the sociological literature relevant to this underrepresentation, *how* particular subjects end up being positioned at odds with existing institutions of mental healthcare.

Following a Foucaultian understanding of subjectification, and more in particular Nikolas Rose’s approach to subjectivity, we understand subjectification as the process through which the subject is constituted, and take this process of becoming to have ontological pre-eminence on the subject (Rose, 1998). Or as Rose puts it, “The subject and ‘its’ attributes now appear as *an effect* of a range of processes that give rise to the human being assuming or taking up a certain position of subject – a position that is not universal but always particular (Rose, 1998: 8; our emphasis)”. Rose’s theory also builds on the Foucaultian insight that “the ethics of subjectivity are inextricably locked into the procedures of power (Rose, 1998: 78-79)”. Modern power, Foucault famously argued, does not function by repression and domination alone, but is productive: it actively produces certain subjects, shapes psyches and fabricates persons with certain desires (Blackman et al., 2008; Rose, 1998). Rose’s approach to the subject and power seems particularly useful to us to explore how particular subjects, such as diasporic communities from various countries who identify as Muslim and settle in Belgium,

¹³ The invocation of good and bad subjects relies on an Althusserian understanding of interpellation and its centrality in the constitution of subjects.

find themselves at odds with the ‘good subject’ of mainstream mental healthcare services, that underlies prevailing processes of subjectification within those services and shapes the accessibility of mental healthcare. Through thinking about subjectification and mental health through a particular minority group that has hardly been discussed in the scholarship of Rose and Foucault, we also hope to contribute to that scholarship.

Our discussion is structured as follows. In the first part of the article we gather and sharpen a number of critical lenses centred on the positionings of the underrepresented subject as ‘other’. We specifically consider the lenses of disability, religion, ethnicity, migration and gender, from a critical theoretical perspective. Relying on these critical lenses, the second part seeks to discern mechanisms of ‘othering’ within the sociological scholarship on Muslims, migration, and mental health in a European context. A third part reflects on how these mechanisms of ‘Othering’ relate to what Bhambra (2007) has called the absent ‘missing revolution’ of postcolonial theory within sociology. By way of conclusion we consider how anchoring sociological studies on mental health and Muslim migrants more firmly on the concept of agency might further enable us to unpack the initial conundrum.

2. At the cross-roads of social relations of power

The conundrum at the heart of this article, and our framing of it in terms of the constitution of the subject, is situated at a particular cross-roads of social relations of power that has only just begun to attract the attention of social sciences, namely the intersection of disability, religion, ethnicity, migration, and gender (Goodley, 2011; McCall, 2005; Shaw et al., 2011). In this section, we present a set of critical lenses, which emerge from the interdisciplinary bodies of critical knowledge grafted on the different social relations of power that shape the particular subject of this inquiry – diasporic communities who identify as Muslim and settle in Belgium and mental health problems.

Our point of departure is disability as a critical lens, as it materialises within a growing tradition of (critical) disability studies as an interdisciplinary field that fosters

various paradigmatic shifts in relation to the ontological and epistemological grounds of disability in existing theory, policy, research, and practices (Goodley et al., 2012). Here disability is defined as a fundamentally social, cultural, political, historical, and relational phenomenon (Barnes & Mercer, 2003; Corker & Shakespeare, 2002; Devlieger et al., 2010; Gustavsson et al., 2005). In that vein, critical disability theory has radically challenged bio-medical and individual approaches to disability and impairment (Barnes & Mercer, 2003), which most often adopts a pathological take on mental health problems (Beresford, 2000). Rather than reaffirming a Cartesian vision of disability that renders disabled bodies and minds as biological, pre-social and essentialist essences, critical disability studies challenge the idea that “biology is destiny (Linton, 1998: 532)”. In this vein, disabled bodies and minds are, according to an anti-essentialist frame of reference, reframed and captured as non-dualistic, dynamic, relational, and fundamentally social phenomena in our societies (Roets & Braidotti, 2012). Nevertheless, some prominent disability scholars have argued that the relation of mental health problems to (critical) disability studies is complex and contested (Beresford, 2000; Kristiansen, 2004; Vandekinderen & Roets, 2016). As Kristiansen (2004) puts it:

“A central finding (...) indicates that ‘something’ exists, which we have called being crazy, but also that the social consequences are numerous and often more devastating, as well as complex (Kristiansen, 2004: 388)”.

In critical disability studies, however, these questions have generated a sustained interest in theorising the difference of impairment while embracing a social approach to mental health. As Vandekinderen and Roets (2016: 35) assert recently, “these scholars address and embrace the complexity of conceptualising interpretations of mental health issues where the predicament of impairment can imply, in theoretical as well as in practical real-life terms, both a limitation and potential that matters”.

This brings us to a second important critical lens in our approach to the initial conundrum: religion. The relationship between religion and mental health is an

ambiguous one, and the scholarship on the relation between religion and mental health remains inconclusive: some studies indicate that religion and spirituality have positive influences on mental health and identity constructions (Schieman et al., 2013; Wood et al., 2011)¹⁴, while others present a more differentiated picture and find that only the attendance of masses and not the amount of prayers is associated with fewer depressive feelings (Van de Velde & Van der Bracht, forthcoming). Studies also show that, when a religious community is rather hostile to a member (with mental health problems), the generally inverse relationship between attendance of masses and distress can reverse, with negative consequences for that person's mental health (Schieman et al., 2013).

Yet it should be noted that many studies on religion and mental health deal specifically with Western Christianity, and thus there is a danger that research findings on mental health and Christianity are generalized as insights about mental health and religion. While more recent work seems to indicate similar patterns of religiosity and mental health within Islam (Utz, 2012), studies also show that Muslims often appeal to religious practices in cases of psycho-emotional problems (Ali & Aboul-Fotouh, 2012). A second critical remark pertains to the category of religion, and its relation to culture and ethnicity. What in a context of Western modernity has been firmly delineated as religion is often not easily distinguishable from questions of ethnicity and culture. A case in point is the belief in supernatural creatures called *jinn* and the possibility of being possessed by them. While the belief in *jinn* is strongly connected to Islamic cultures, with a marked prevalence within Pakistani, Middle-Eastern or North-African communities (Khalifa & Hardie, 2005), certain contemporary tendencies within Islam and notably those who seek to redeem a more 'pure' religious practice, purified from cultural and ethnic elements, are more adverse towards the belief in *jinn*. Yet an inquiry into Muslims and mental health does have to reckon with the subject of *jinn*.¹⁵ One of the first articles in the Low Countries on Muslims who

¹⁴ In the case of ethnopsychiatry, religious traditions, attachments, and rites are crucial tools within the therapeutical encounter (Nathan, 2001).

¹⁵ This is precisely what happens in the therapeutical practice in ethnopsychiatry (Nathan, 2001).

are also mental health patients and believe their condition is caused by possession was published in 1976 (Colaço Belmonte, 1976). More recent estimations of the belief in *jinn* state that 80% of Muslim migrants diagnosed with a psychotic disorder make reference to *jinn* in explaining their condition (Blom et al., 2010).

This raises the question of how distinct paradigms, such as the dominant Western bio-medical, a traditional Moroccan and an Islamic one, each approaching mental health in different ways, relate to each other. The Western paradigm holds a universal pretence and a widespread assumption that an Islamic perspective on mental health is largely irreconcilable with Western psychotherapies (Carter & Rashidi, 2003). In many ways, however, such an assessment seems too categorical and generalizing. Some studies show that Muslims particularly seek refuge in (Western) biomedicine (Ali & Aboul-Fotouh, 2012; Inhorn & Serour, 2011), while other show that one often turns to biomedical care and only when patients are unsatisfied, traditional caregivers are consulted (Patel, 2001). In other words, it is safe to assume that those struggling with mental health issues might draw upon a variety of perspectives on mental health and healing that are available to them, even if these belong to significantly different paradigms. Once more the belief in *jinn* is a case in point as it draws attention to the difficult interactions between minority and Western biomedical worldviews. While classical biomedicine labels visions and ‘imaginary’ voices as hallucinations (Blackman, 2001), within some Middle-Eastern, North-African, and Islamic environments such phenomena are taken as relatively normal, and are met with specific healing practices (Nathan, 2001). There is, however, still little knowledge about how these different discourses and practices interact (Abdullah & Brown, 2011; Mellor et al., 2013). And while some doctors and scholars advocate collaborations between biomedical practitioners and religious counsellors (Khalifa & Hardie, 2005), most Western professionals continue to interpret mental health conditions within established biomedical frameworks, and refer to experiences which some Muslims might ascribe to *jinn* in terms of hallucinations and psychotic disorders (Blom et al., 2010).

Given the instability of religion as a category, and its intertwinement with ethnicity, we also take on ethnicity as a critical lens. Sociological studies of mental

health (care) often lack attention to ethnicity or culture (Abdullah, 2007; Doornbos et al., 2013; Inhorn & Serour, 2011; Missinne & Bracke, 2012), as notably the critique of how epidemiologic estimations are often based only on western clinical pictures has shown. The WHO Studies of Schizophrenia, and their seemingly contradicting results, are a case in point. A pervasive criticism of the WHO study holds that, from a cultural point of view, the most interesting patients were left out, as the study only considered participants who already complied with its 'schizophrenia prototype', which implies that the samples were restricted and constructed (Burns, 2009; Kleinman, 1987). A second criticism contends that the WHO studies underemphasise cultural differences observed in case of symptomatology and help-seeking behaviour (Kleinman, 1987). Most epidemiological research is still based on the assumption that mental health problems are biomedical and universal (Patel, 2001). Yet cross-cultural measurements of depression reveal that the central place attributed to mood changes in the clinical picture seems to point at a Western cultural configuration and loses much of its applicability in other, non-Western, contexts. This results in lower rates of depressions when the measurements are based on so-called Western biomedical classifications, like the DSM (Patel, 2001).¹⁶ Causes for these kinds of systematic bias include methodological difficulties to recruit participants with a migration and/or minority background for studies on the sensitive topic of mental healthcare (Doornbos et al., 2013); the lack of cross-cultural valid measuring instruments (Missinne & Bracke, 2012); or negative attitudes towards ethnic minorities and religion (Abdullah, 2007). Moreover, mental problems among ethnic minorities and migrants are commonly underreported whenever these problems are considered as signs of moral weakness (Beauboeuf-Lafontant, 2007; Kleinman, 1980; 1987; Missinne & Bracke, 2012).

The question of migration, moreover, adds a significant layer to this discussion. Migration influences identity constructions and potentially provokes 'psycho-emotional' problems, and diasporic communities are often confronted with factors

¹⁶ The purported universal and homogenous character of Western biomedicine needs to be unpacked (Blackman, 2001). Often cultural aspects or subjective positions are not taken into account and those result in much more variation than is often assumed (Gailly et al., 1988).

such as precarity and poverty, which can aggravate these experiences (Borba et al., 2012; Kleinman & Benson, 2006). In addition, studies show that in many European countries North-African migrants have higher risks of depressive feelings than other migrants (Missinne & Bracke, 2012). While the authors could not explain this result, there are indications that acculturation and discrimination lead to more stress and mental health problems (Inhorn & Serour, 2011). In addition, some studies point to cultural variance related to race and ethnicity in mental illness stigma and suggest that stigmatizing attitudes influence racial and ethnic disparities in the use of mental health services (Abdullah & Brown, 2011). And while people with mental health problems in general often report feelings of not being taken seriously and experiences of paternalism (Kleinman, 1988; Mestdagh & Hansen, 2014), such experiences are even more manifest with service users with an ethnic minority and/or diasporic background (Inhorn & Serour, 2011; Patel, 2001). This includes a marked tendency to consider their complaints as somatic (Patel, 2001).¹⁷

Last but not least, the question of mental health needs to be considered through the critical lens of gender. From a gender studies perspective, higher depression rates among women have been accounted for by the silencing paradigm (Beauboeuf-Lafontant, 2007), which highlights how social expectations and cultural standards of femininity refrain women from expressing their experiences and ideas. The limited research that puts Muslim women's accounts central is marked by an incongruity. On the one hand, some women within ethnic minorities and/or migrant communities consider emotional problems as the norm, as part of what being a woman within their community implies (Doornbos et al., 2013; Inhorn & Serour, 2011). On the other hand, other women within the same communities seemingly deny their emotional problems

¹⁷ This is connected to the rather contradictory observation that in some European countries individuals of diasporic or ethnic minority background are overrepresented in special education or in statistics about diagnoses of mental and developmental illnesses (Blackman, 2001). Social or medical professionals usually account for these problems in terms of the impact of migration experiences of mothers on children (Verhaeghe et al., 2012).

(Beauboeuf-Lafontant, 2007).¹⁸ In addition, the diminished accessibility of reliable mental healthcare, as well as the fear of rumours, often lead ethnic minorities and migrants, particularly women, to seek to solve their (socio-emotional) problems by themselves (Doornbos et al., 2013). Although information about the kind of help they seek is scarce, religious practices and individual therapy seem to be considered as the most useful (Abdullah, 2007; Doornbos et al., 2013). Studies show that demands for alternative counselling forms as ethnic minorities and migrants often remain suspicious of traditional (Western) mental healthcare (Doornbos et al., 2013; Inhorn & Serour, 2011).

3. Mechanisms of ‘Othering’ and/in mental health

These critical lenses, referring to the different subject positions that matter to the underrepresentation we seek to address, bring us to the question of subjectification within mental healthcare. Following Foucault, we understand subjectification as the process through which the subject is constituted, and take this process to have ontological pre-eminence on the subject (Foucault, 2006). Moreover, we consider that mental health institutions and services shape the subjects that pass through them in particular ways (Rose, 1999), and notably through normalization techniques.

Normalization techniques are at the heart of how Foucault understood the operation of modern disciplinary power and its relationship with the subject; they are grounded in the demarcation between ‘the normal’ and ‘the abnormal’, which is pervasive within modern society and its institutions (Foucault, 2006). Foucault was inspired by Georges Canguilhem who situated the body and its hard, essentialist existence as a historically contingent phenomenon, with an emphasis on adaptation over deviation. Canguilhem (1989: 239) raised a sharp critique on practices of normalization and consequently devaluation:

¹⁸ However, that what is called depression in Western societies is not necessarily absent in other societies. Where we approach society from a specific individual point of view, in other societies the ‘we’ is more important and can color the way we approach depression for example.

“A norm, or rule is what can be used to right, to square, to straighten. To set a norm (normer), to normalize, is to impose a requirement on an existence, a given whose variety, disparity - with regard to the requirement - present themselves as a hostile indeterminacy”.

This demarcation between ‘the normal’ and ‘the pathological’, Braidotti (2013) argues, effectively operates as one of the most powerful analytic resources for displaying how West-European societies have constructed human categories and subject positions that we then assume to be unitary and universal.

This insight is particularly relevant for the field of mental health, as normalizing techniques are at the heart of Western biomedical approaches to mental healthcare, which position some human beings as ‘abnormal’ and deviant from the abstract standard of ‘normal man’ (Appignanesi, 2008; Blackman, 2001; Tremain, 2005). The bio-medical community indeed constructs its subject(s) – the human body with its mental illnesses, disorders, and disabilities – through what has been called the ‘tyranny of the normal’ (Hahn & Kleinman, 1983; Kleinman, 1980). It is therefore important to challenge ‘natural’ constructions of the ‘constitutive other’ that circulate in West-European societies, and uncover the processes through which they come into being (Roets & Braidotti, 2012).

In what follows we attend not to actual normalization techniques within mental health services, an inquiry that requires empirical study, but rather to discursive strategies within the sociological literature that rely on the abovementioned demarcation and subsequently frame the subject of mental health in particular ways. We call these discursive strategies mechanisms of ‘Othering’, which point to a dense power/knowledge nexus and align with the construction of the ‘good subject’ of Western biomedical regimes of mental healthcare, and hence are in need of uncovering if we seek to account for the underrepresentation of other subjects. Without claiming to be exhaustive, we found two mechanisms of ‘Othering’ to be pervasive in much of the sociological studies related to mental health and Muslim migrants in Europe.

A first mechanism of ‘Othering’ consists of ignoring the particular experiences and livelihoods of religious and ethnic minorities with mental health problems. In other

words, too often experiences of those finding themselves in majority positions, such as white, middle-class, and male, are universalized and taken to represent conditions of mental health in general. This notably implies that minority experiences too often are disregarded within the production of knowledge about mental health. Hence a critical approach to the question of universality is crucial in unpacking our initial conundrum.

As many strands of critical theory have argued, within the Western symbolic system, including its sciences, majoritarian subject positions such as white and male are often invisible or unmarked positions, precisely because they are taken to be universal. This universality, however, has been subject of critique, notably within feminist theory and feminist science studies, where it has been deconstructed as a pseudo-universality, which bears the marks of the male, white, and heterosexual subject (Harding, 2008) – even, or especially, as this bearing is disavowed. For Braidotti universalism refers to the classical ideals of Man which “uphold a specific view of what is human about humanity (...) [and] assert with unshakable certainty the almost boundless capacity of humans to pursue their individual and collective perfectibility (Braidotti, 2013: 13)”. This universalism can be seen as the emblem of Humanism, Braidotti argues, which is a doctrine that combines the biological, discursive, and moral expansion of human capabilities into an idea of rational progress, and developed historically into a civilizational model based on a particular and hegemonic Eurocentric worldview. This Eurocentric paradigm implies “the dialectics of self and other, and the binary logic of identity and Otherness” which leads to the notion of difference as pejorative (Braidotti, 2013: 15).

The effect of this universalism can be traced in Western biomedical regimes, and in their particular understanding of the human body and mind (see e.g. Hahn & Kleinman, 1983). Mental healthcare developed within such a perspective regularly fails to take into account that different socialisation processes co-exist and interact with each other, often creating new cultural formations and socializations. When migrants arrive in a new country and cultural environment, moreover, they often become immersed in these (new) socialisation processes and later generations construct their

own hybrid forms of mental health knowledge systems. Moreover, while Western biomedical regimes have been exported around the world through processes of colonisation and globalisation, they also interact in various ways with different socio-cultural contexts, thus creating their own (hybrid) forms of the biomedical system (Harding, 2008).¹⁹

Meekosha (2011) developed a version of this argument about universalizing and power differentials with respect to disability and North-South relations: the literature on disability, she argues, is generally characterized by a dominance of universalist and totalising tendencies that she connects to the global North. She argues that ideas and cases from the South are either omitted or incorporated within a Northern frame of reference, and the internal diversity within communities in the global South or more hybrid cultural environments is often overlooked (Meekosha, 2011). In her work, Meekosha (2011) draws attention to how the global South remains marked by the disabling memories of colonialism as well as more recent disabling power relations between the global North and South. While (critical) disability studies seek to challenge the normativity of ablism, Western universalism emerges, Meekosha argues, when experiences of people with disabilities in the global South are elided (Meekosha, 2011).

While Meekosha's argument is focused on North-South relations, it points to a dynamic of universalizing tendencies that can be traced between a given Western nation-state and its ethnic minorities and diasporas from the global South.

A second mechanism of 'Othering' might be considered as the other side of the same coin of universalism, and consists of *essentialist* notions of human subjects. As Braidotti asserts, when subjectivity is equated with universal rationality and self-regulating ethical behaviour, "Otherness is defined as its negative and specular

¹⁹ In an earlier article Kleinman (1980) does recognise this, while stating that one cannot consider the patient-doctor relationship as a simple transaction: Kleinman (1980; 1988; Kleinman & Benson, 2006) emphasizes that practitioners too become influenced by the contacts with their patients, that their explanatory models are also influenced by their ethnicity, social class, and so on, and show significant cultural patterning, like the models of their patients.

counterpart. In so far as difference spells inferiority, it acquires both essentialist and lethal connotations for people who get branded as ‘others’ (Braidotti, 2013: 15)”.

Essentialising Muslims and/or ethnic minorities as fundamentally different is one of these lethal disqualifications. To belabour this point, we turn to the seminal work of Edward Said (1981; 2005). Relying on a Foucaultian understanding of discourse, Said identified Orientalism as a historical and systematic discipline by which Europe produced the ‘Orient’, thus further unpacking the intricacies of power/knowledge through laying bare the intimate relationships between colonialism and the scholarly study of the ‘Orient’. At the heart of Orientalism, Said argues, lies the production of an ontological and epistemological distinction between the ‘Orient’ and the ‘West’ – a distinction that is essentialised. More recently, and notably in the context of the reshuffling of the geopolitical landscape, the notion of the ‘Orient’ has increasingly come to coincide with Islam resulting in the well-known oppositional framing of the West and Islam in which superior values are attributed to the West and inferior ones to Islam (Said, 2005; Sayyid, 2003). The epistemological structures of Orientalism obscure the profoundly dialectical ways in which identities of, and knowledges about, ‘self’ and ‘other’ are constructed (Mohanty, 1988).

These mechanisms of essentialising can be subtle, as in the case of the aforementioned WHO studies on schizophrenia, where ‘Orientalist’ mechanisms can be traced in the ways in which culture is often taken to be synonymous with ethnicity or nationality. This is baleful considering the associated stereotyping (Kleinman & Benson, 2006), the fact that it does not make sense from an analytical point of view to conflate these concepts, and the tendency to put every ‘Oriental person’, i.e. Muslim, on a par with Islam, without distinctions (Said, 1981; 2005). Such generalizing tendencies cannot be helpful for psychological care. Another, perhaps more subtle, manner in which essentialising dynamics are at play can be found in the assumption that a therapeutic relationship benefits from racial, ethnic, or cultural similarity.²⁰ A

²⁰ It should be noted that in the case of patients coming of diasporic communities from various countries who identify as Muslim in West-European societies, these conditions are often

lack of resemblance within a therapeutic relationship might trigger a presumed lack of understanding, it is argued, because practitioners have more problems to accurately assess the emotions of patients with a different background (Bhui & Bhugra, 2004).²¹ We might also speculate, however, that a shared ethnic background between counsellors and clients could create specific problems, such as the client's concern about the counsellor passing personal information on to the shared ethnic community (Tsang et al., 2011). In any case, there is evidence that differences other than ethnic or religious background play out within therapeutic relationships (see e.g. Blackman, 2001; Groen, 2009). This critique of essentialising as an 'Othering' mechanism points us, once again, to the relevance and importance of an intersectional way of thinking.

4. The absent 'missing revolution' of postcolonialism in sociology

Before we move to our conclusions we want to pause on what these two mechanisms of 'Othering' point to, and relate them to what Gurminder Bhambra (2007) calls the paradoxical absence of the 'missing revolution' of postcolonialism within sociology. Sociological engagement with postcolonial critique remains strikingly absent, while the emergence of sociology as a discipline, and hence its conceptualization of the social, coincided with the crux of Western imperialism (Bhambra, 2007). One of the things these mechanisms of 'Othering' point to, we believe, is the systematic misrecognition of the role of colonisation, both historical colonisation as well as persisting colonial dynamics, within the construction of 'madness' in the West.

This misrecognition persists despite the seminal critical work of Frantz Fanon, who has written extensively on the relationship between mental health and racial

missing: in Belgium, for instance, there are only a handful of Muslims with a migration background among professional therapists.

²¹ Our point here is not to argue that differences in subject positions between a counsellor and a client are intrinsically problematic; as cases have been documented where differences in background of psychiatrist and patient does not hinder the construction of a therapeutic alliance (Bhui & Bhugra, 2004). Rather, we are interested in how these differences are framed and evaluated, as occurs in statements that counsellors and clients ideally should, or should not, have the same ethnic background.

oppression as well as colonialism. In *Peau noir, masques blancs* (1952) Fanon documents the devastating psychological effects of racism in the search for Black identity, while in *L'an cinq, de la révolution algérienne* and *Les damnés de la terre* (1961) he attends to the dehumanization of colonial domination. Fanon's work analyses Algerian culture and society under conditions of French colonisation, attending, among other things, to the role of biomedicine under French rule. Trained as a psychiatrist, Fanon came to believe that it was impossible to be mentally healthy in a sick society, which is how he understood societies marked by colonialism, both as coloniser and colonised. These analyses pushed him into the direction of psychoanalysis, with its particular approach to the making of the subject, while rejecting the universalist claims of classical psychoanalysis in favour of a therapeutical approach that takes the context of colonisation into account.

Beyond Fanon's great influence within postcolonial theory, his work is also increasingly taken up within (critical) disability studies and notably in scholarship that takes the global South as its point of departure. In this vein, the construction of disability in the global South has been linked with the domination of racial and gender ideologies in the global North (McCall, 2005; Meekosha, 2011; Patel, 2001; Said, 2005).

In relation to mental health and ethnic or religious minorities in the West, however, Fanon's insights beg to be further developed. We might, for instance, question Blom et al. (2010) or Sheikh's (2005) recommendations of cooperating with imams who are believed to grant less value to *jinn*: is it necessary that patients of diasporic communities from various countries who identify as Muslim are convinced that their symptoms are not caused by *jinn*? For whom is this necessary, for the (benefit of the) patient or for the therapist? Moreover, many studies (a.o. Blom et al., 2010; Colaço Belmonte, 1976; Sheikh, 2005) often seem to rely on implicit (Orientalist) assumptions that non-western societies and individuals are 'by nature' more traditional and non-scientific and that an 'Occidental' explanatory model is capable and necessary to overrule and regulate 'Oriental' explanatory models (Patel, 2001; Said, 1981; 2005; Sayyid, 2003).

5. Conclusion

We began with the following conundrum: the mental health of diasporic communities from various countries who identify as Muslim and settle in Belgium, some of these being first and second generation seems to be particularly at risk, yet these subjects are strikingly absent from mental healthcare institutions in Europe. While acknowledging the complexity and multi-dimensional character of processes of exclusion, we centered our theoretical exploration on processes of subjectification as we take on a Foucaultian point of departure that the mental healthcare system shapes the subjects that pass through its institutions in particular ways. To further explore the question of subjectification, we rely on the notion of normalization techniques, which is essential to how Foucault understood modern disciplinary power and its relationship to the subject, and which is grounded in the demarcation between ‘the normal’ and ‘the abnormal’.

In this article we have looked at discursive strategies within the sociological literature that rely on the abovementioned demarcation and frame the subject of mental health in particular ways, and have called those strategies mechanisms of ‘Othering’.

The first mechanism of ‘Othering’ we identified is a process of universalising that is based on the elision of minorities’ mental health experiences. We also identified, as the other side of the same coin, processes of essentialising Muslims and/or ethnic minorities as fundamentally different. By way of conclusion we would like to highlight the fact that both of these mechanisms are characterised by a relative lack of attention to the *agency* of Muslims with mental health problems. This is the case in the older work, like Colaço Belmonte’s article (1976) that strongly focuses on socio-cultural dimensions at the expense of overlooking the patients’ agency, and remains present in more recent work, like in Abdullah and Brown (2011) suggestion that cultural aspects related to peoples ethnic ties are deeply entrenched, sometimes even *unconsciously* so.

A more sustained attention to agency can be found in the ‘silencing paradigm’ as it was theorized within gender studies. Yet the silencing paradigm is mostly based on the experiences of white, North-American women (Beauboeuf-Lafontant, 2007), and

more research is needed to investigate whether this paradigm holds true for women who are racialized as ‘other’, as well as ethnic, cultural or religious minorities in general. It might indeed be that people of diasporic communities develop (psycho-emotional) problems as a consequence of cultural displacement and loss, and of aspiring too much to live up to social expectations. Yet the silencing paradigm comes with another set of problems: following Braidotti (2013), we would argue that it exchanges one criticized identity for another ‘more authentic’ identity and question this attribution of ‘authenticity’. And while the silencing paradigm does recognise women’s agency within the recovery process, it also fails to recognise that identities and subjectivities are always in process and that they are affected by social perceptions, resources and contexts. Identity constructions, moreover, are very complex in contexts of migration and of belonging to an ethnic or religious minority (Buytaert et al., 2009).

If, in sum, othering mechanisms rely on the failure of recognizing the agency of those with mental health issues, taking agency as a point of departure might lead us beyond those mechanisms of ‘Othering’. This conclusion is a call for more research ‘from below’ that effectively follows the trajectories of diasporic communities from various countries who identify as Muslim through established mental healthcare provisions as well as explores the other places and practices, and notably religious healing practices, that people with mental health issues pursue. Moreover, a pronounced focus on agency could possibly also shed light on the abovementioned incongruity in the different reactions of migrant women to mental illness (cf. Beauboeuf-Lafontant, 2007); an incongruity that requires more research: is this a case of the tactic use of different registers among participants, or simply a question of different world-views and interpretations between the participants and (social) scientific researchers?

We would like to end, however, by acknowledging that such a sustained attention to agency in and of itself is not enough. Following Bhambra’s (2007) argument about the situated formulation of sociology’s core concepts, the notion of agency might also be in need of rethinking, in line with a larger intellectual project of decolonizing theory. Here we are reminded of Saba Mahmood’s (2005) critique of ‘the turn to

agency' in the field of gender and religion. Relying on ethnographic work in the women's piety movement in Egypt, Mahmood examines the assumptions and elisions that attend the focus on agency within the study of gender and religion, and how these assumptions constitute a barrier to account for women involved in non-liberal religious movements. Within feminist theory, Mahmood argues, 'women's agency' is most often understood as the realization of one's own interests against the weight of custom, tradition or transcendental will, yet this notion of agency fails to account for the agency of pious women. Mahmood offers a re-conceptualization of agency as a capacity for action enabled and created, sometimes paradoxically, by historically specific relations of subordination rather than in opposition to them. While Mahmood's work is specifically developed in the context of scholarship on gender and religion, we follow her argument in favour of reconstructing local and situated registers and practices of agency, and the implications that has for reconceptualizing agency.

References

- Abdullah, S. (2007). *Islam and Counseling: Models of Practice in Muslim Communal Life*. *Journal of Pastoral Counseling*, 42: 42-55.
- Abdullah, T. & Brown, T. L. (2011). *Mental Illness Stigma and Ethnocultural Beliefs, Values, and Norms: An Integrative Review*. *Clin Psychol Rev*, 31: 934-48.
- Ali, O. M. & Abdoul-Fotouh, F. (2012). Traditional Mental Health Coping and Help-Seeking. In S. Ahmed & M. M. Amer (eds.) *Counseling Muslims. Handbook of Mental Health Issues and Interventions*. New York: Routledge.
- Appignanesi, L. (2008). *Gek, slecht en droevig. Een geschiedenis van vrouwen in de psychiatrie van 1800 tot heden*. Amsterdam: De bezige bij.
- Barnes, C. & Mercer, G. (2003). *Disability*. London: Polity.
- Beauboeuf-Lafontant, T. (2007). *You Have to Show Strength: An Exploration of Gender, Race, and Depression*. *Gender & Society*, 21: 28-51.
- Beresford, P. (2000). *What Have Madness and Psychiatric System Survivors Got to do with Disability and Disability Studies?* *Disability & Society*, 15: 167-172.

- Bhambra, G. K. (2007). *Sociology and Postcolonialism: An Other 'Missing' Revolution?* *Sociology*, 41: 871-884.
- Bhui, K. & Bhugra, D. (2004). *Communication with Patients from Other Cultures: The Place of Explanatory Models*. *Advances in Psychiatric Treatment*, 10: 474-478.
- Blackman, L. (2001). *Hearing Voices. Embodiment and Experience*. London: Free Association Books.
- Blackman, L., Cromby, J., Hook, D., Papadoulos, D. & Walkerdine, V. (2008). *Editorial: Creating Subjectivities*. *Subjectivity*, 22: 1-27.
- Blom, J. D., Eker, H., Basalan, H., Aouaj, Y. & Wijbrand Hoek, H. (2010). *Klinische les: Hallucinaties toegedicht aan djinns*. *Nederlands Tijdschrift voor Geneeskunde*, 154: 1-4.
- Borba, C. P., Depadilla, L., McCarty, F. A., Von Esenwein, S. A., Druss, B. G. & Sterk, C. E. (2012). *A Qualitative Study Examining the Perceived Barriers and Facilitators to Medical Healthcare Services among Women with a Serious Mental Illness*. *Womens Health Issues*, 22: e217-224.
- Braidotti, R. (2013). *The Posthuman*. Cambridge: Polity.
- Brown, T. N. (2003). *Critical Race Theory Speaks to the Sociology of Mental Health. Mental Health Problems Produced by Racial Stratification*. *ProQuest*, 44: 292-301.
- Burns, J. (2009). *Dispelling a Myth: Developing World Poverty, Inequality, Violence and Social Fragmentation are not Good for Outcome in Schizophrenia*. *Afr J Psychiatry*, 12: 200-205.
- Buytaert, E., Vandedrinck, E. & Lemmens, G. M. D. (2009). *Psychiatrische stoornissen bij migranten: feiten en hypothesen*. *Tijdschrift voor Geneeskunde*, 65: 1-8.
- Canguilhem, G. (1989). *The Normal and the Pathological*. Brooklyn: Urzone, Inc.
- Carter, D. J. & Rashidi, A. (2003). *Theoretical Model of Psychotherapy: Eastern Asian-Islamic Women with Mental Illness*. *Health Care for Women International*, 24: 399-413.

- Chakraborty, A. T., McKenzie, K. J., Hajat, S. & Stansfeld, S. A. (2010). *Racism, Mental Illness and Social Support in the UK*. *Social Psychiatry and Psychiatric Epidemiology*, 45: 1115-24.
- Colaço Belmonte, J. A. F. (1976). *Klinische lessen: Jnun, een vorm van katatone psychose?* *Nederlands Tijdschrift voor de Geneeskunde*, 120: 1925-1927.
- Corker, M. & Shakespeare, T. (2002). *Disability/Postmodernity: Embodying Disability Theory*. New York: Bloomsbury Academic Press.
- Devlieger, P., Rush, F. & Pfeiffer, D. (2010). Rethinking Disability as Same and Different! Towards a Cultural Model of Disability. In P., Devlieger, F., Rusch & D., Pfeiffer (eds.) *Rethinking Disability. The Emergency of New Definitions, Concepts and Communities*. 3rd ed. Antwerpen: Garant.
- Doornbos, M. M., Zandee, G. L., Degroot, J. & Warpinski, M. (2013). *Desired Mental Health Resources for Urban, Ethnically Diverse, Impoverished Women Struggling with Anxiety and Depression*. *Qualitative health research*, 23: 78-92.
- Fadil, N., Asri, F. E. & Bracke, S. (2014). Islam in Belgium. Mapping an Emerging Interdisciplinary Field of Study. In J., Cesari (ed.) *The Oxford Handbook for European Islam*. Oxford: Oxford University Press.
- Fanon, F. (1952). *Peau noir, masques blancs*. France: Éditions du Seuil.
- Fanon, F. (1961). *Les damnés de la terre*. Paris: Éditions Maspéro.
- Fossion, P., Ledoux, Y., Valente, F., Servais, L., Staner, L., Pelc, I. & Minner, P. (2002). *Psychiatric disorders and social characteristics among second-generation Moroccan migrants in Belgium: An age-and gender-controlled study conducted in a psychiatric emergency department*. *European Psychiatry*, 17: 443-450.
- Fossion, P., Servais, L., Rejas, M.-C., Ledoux, Y., Pelc, I. & Minner, P. (2004). *Psychosis, migration and social environment: an age-and-gender controlled study*. *European Psychiatry*, 19: 338-343.
- Foucault, M. (2006). *History of Madness*. London: Routledge.
- Gailly, A., et al. (1988). *Psychische klachten bij Turken en hun benadering*. Brussel: Cultuur en Migratie v.z.w.

- Goodley, D. (2011). *Disability Studies. An Interdisciplinary Introduction*. London: SAGE Publications Ltd.
- Goodley, D., Hughes, B. & Davis, L. (eds.) (2012). *Disability and Social Theory. New Developments and Directions*. Basingstoke: Palgrave Macmillan.
- Groen, S. (2009). *Recognizing Cultural Identity in Mental Health Care: Rethinking the Cultural Formulation of a Somali Patient*. *Transcult Psychiatry*, 46: 451-62.
- Gustavsson, A., Sandvin, J., Traustadóttir, R. & Tossebro, J. (2005). *Resistance, Reflection and Change. Nordic Disability Research*. Lund: Studentlitteratur.
- Hahn, R. A. & Kleinman, A. (1983). *Biomedical Practice and Anthropological Theory: Frameworks and Directions*. *Annual Review of Anthropology*, 12: 305-333.
- Harding, S. (2008). *Sciences From Below. Feminisms, Postcolonialities, and Modernities*. Durham: Duke University.
- Inhorn, M. C. & Serour, G. I. (2011). *Islam, Medicine, and Arab-Muslim Refugee Health in America After 9/11*. *The Lancet*, 378: 935-943.
- Karlsen, S., Nazroo, J. Y., McKenzie, K. J., Bhui, K. & Weich, S. (2005). *Racism, Psychosis and Common Mental Disorder among Ethnic Minority Groups in England*. *Psychol Med*, 35: 1795-803.
- Khalifa, N. & Hardie, T. (2005). *Possession and Jinn*. *Journal of the Royal Society of Medicine*, 98: 351-353.
- Kleinman, A. (1980). *Patients and Healers in the Context of Culture. An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Berkeley: University of California Press.
- Kleinman, A. (1987). *Anthropology and Psychiatry. The Role of Culture in Cross-Cultural Research on Illness*. *The British Journal of Psychiatry*, 151: 447-454.
- Kleinman, A. (1988). *The Illness Narratives. Suffering, Healing & the Human Condition*. New York: Basic Books.
- Kleinman, A. & Benson, P. (2006). *Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It*. *PLoS Med*, 3: e294.

- Kristiansen, K. (2004). Madness, Badness and Sadness Revisited: Ontology Control in “Mental Health Land”. In K., Kristiansen & R., Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Linton, S. (1998). *Claiming Disability: Knowledge and Identity*. New York: New York University Press.
- Lodewijckx, I., Janssens, A., Ysabee, P. & Timmerman, C. (2005). *Allochtone en autochtone jongeren met psychische problemen en gedragsproblemen: Verschillende trajecten naar de hulpverlening?* Drukkerij Peten.
- Mahmood, S. (2005). *Politics of Piety: The Islamic Revival and the Feminist Subject*. Princeton: Princeton University Press.
- McCall, L. (2005). *The Complexity of Intersectionality*. Signs: Journal of Women in Culture and Society, 30: 1771-1800.
- Meekosha, H. (2011). *Decolonising Disability: Thinking and Acting Globally*. Disability & Society, 26: 667-682.
- Mellor, D., Carne, L., Shen, Y.-C., McCabe, M. & Wang, L. (2013). *Stigma Toward Mental Illness: A Cross-Cultural Comparison of Taiwanese, Chinese Immigrants to Australia and Anglo-Australians*. Journal of Cross-Cultural Psychology, 44: 352-364.
- Mestdagh, A. & Hansen, B. (2014). *Stigma in Patients with Schizophrenia Receiving Community Mental Health Care: A Review of Qualitative Studies*. Social Psychiatry and Psychiatric Epidemiology, 49: 79-87.
- Missinne, S. & Bracke, P. (2012). *Depressive Symptoms Among Immigrants and Ethnic Minorities: A Population Based Study in 23 European Countries*. Social Psychiatry and Psychiatric Epidemiology, 47: 97-109.
- Mohanty, C. T. (1988). *Under Western Eyes: Feminist Scholarship and Colonial Discourses*. Feminist Review, 30: 61-88.
- Nathan, T. (2001). *Nous ne sommes pas seuls au monde. Les enjeux de l'ethnopsychiatrie*. Paris: Le Seuil.
- Patel, V. (2001). *Cultural factors and International Epidemiology*. British Medical Bulletin: 33-45.

- Reniers, G. (1999). *On the History and Selectivity of Turkish and Moroccan Migration to Belgium*. *International Migration*, 37: 679-713.
- Roets, G. & Braidotti, R. (2012). Nomadology and Subjectivity: Deleuze, Guattari and Critical Disability Studies. (pp. 161-178). In D., Goodley, B., Hughes & L., Davis (eds.) *Disability and Social Theory. New Developments and Directions*. Basingstoke: Palgrave Macmillan.
- Rose, N. (1998). *Inventing Ourselves. Psychology, Power, and Personhood*. Cambridge: Cambridge University Press.
- Rose, N. (1999). *Governing the Soul. The Shaping of the Private Self*. London: Free Association Books.
- Said, E. W. (1981). *Covering Islam. How the Media and the Experts Determine How We See the Rest of the World*. London: Routledge.
- Said, E. W. (2005). *Orientalism*. Amsterdam: Mets & Schilt.
- Sayyid, B. S. (2003). *A Fundamental Fear. Eurocentrism and the Emergence of Islamism*. London: Zed Books Ltd.
- Schieman, S., Bierman, A. & Ellison, C. (2013). Religion and Mental Health. In C. S., Aneshensel, J. C., Phelan & Bierman, A. (eds.) *Handbook of The Sociology of Mental Health. 2nd ed.* New York: Springer.
- Shaw, L. R., Chan, F. & McMahon, B. T. (2011). *Intersectionality and Disability Harassment: The Interactive Effects of Disability, Race, Age, and Gender*. *Rehabilitation Counseling Bulletin*, 55: 82-91.
- Sheikh, A. (2005). *Jinn and Cross-Cultural Care*. *Journal of the Royal Society of Medicine*, 98: 339-340.
- Tremain, S. L. (ed.) (2005). *Foucault and the Government of Disability*. Ann Arbor: MI University of Michigan Press.
- Tsang, A. K. T., Bogo, M. & Lee, E. (2011). *Engagement in Cross-Cultural Clinical Practice: Narrative Analysis of First Sessions*. *Clinical Social Work Journal*, 39: 79-90.

- Utz, A. (2012). Conceptualizations of Mental Health, Illness, and Healing. In: S., Ahmed & M. M., Amer (eds.) *Counseling Muslims. Handbook of Mental Health Issues and Interventions*. New York: Routledge.
- Van de Velde, S. & Van der Brackt, K. (forthcoming). *The Relation between Religion and Depression in Europe*.
- Vandekinderen, C. & Roets, G. (2016). *The post(hu)man always rings twice: Theorising the difference of impairment in the lives of people with 'mental health problems*. *Disability & Society*, 31(1): 33-46.
- Verhaeghe, P.-P., Van der Bracht, K. & Van de Putte, B. (2012). *Migrant zkt toekomst. Gent op een keerpunt tussen oude en nieuwe migratie*. Antwerpen: Garant.
- Wood, E., Watson, R. & Hayter, M. (2011). *To What Extent are Christian Clergy Acting as Frontline, Mental Health Workers? A Study From the North of England*. *Mental Health Religion and Culture*, 14: 769-783.

Chapter 3²²

Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent

Elise Rondelez, Sarah Bracke, Griet Roets, Caroline Vandekinderen & Piet Bracke

Published in DiGeSt, 4(1): 63-84.

Abstract

The mental health of Muslims with a migration background in Belgium seems to be particularly at risk. Inspired by the work of Nikolas Rose on the question of subjectivity, our sociological research analyses processes of subjectification that occur within existing mental health services, and the subsequent ‘proper’ subject of mental health that is created along the way, as the central assumption of our study. We focus on how mental healthcare professionals approach and construct diasporic Muslims in Ghent, a middle-sized city in the north of Belgium. The article consists of three sections. We first lay out how our study is grounded in the work of Rose and his attention to subjectivity. The second section presents our methodology, and the empirical material that grounds our analysis. In the third section, we apply Rose’s approach to subjectivity to our empirical data. Our research venture challenged us to illustrate and discuss different aspects of the subjectivity dimension as explained by Rose, and to enlarge our analytical approach and identify a logic of cultural difference by relying on the work of Edward Said. However, we come to the conclusion that the work of Rose and Said allows a critical deconstruction of this binary dialectic between

²² American English

ontologically different categories of 'self' and 'other', yet does not enable us to go beyond a negative appreciation of professionals in mental healthcare and to (re-)imagine a non-deterministic and non-dualistic framing of the human subject formation of diasporic Muslims.

Mental health (care), Muslim migrants, Rose, Qualitative interviews, Subjectivity

Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent

1. Introduction

The mental health of Muslims with a migration background in Belgium seems to be particularly at risk (Buytaert et al., 2009; Colaço Belmonte, 1976; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour, 2011), as a result of intersecting power relations that shape the position of many diasporic Muslims in Belgium.²³ Diasporic Muslims are considered ethnic-religious minorities, who are positioned in particular intersections with class and gender relations (see Rondelez et al., 2016), and who are systematically confronted with the racism and social exclusion that characterise Belgian society and that potentially impact their mental health. As studies in the United States and Europe show, racism and social exclusion can result in mental health problems (Brown, 2003; Chakraborty et al., 2010; Karlsen et al., 2005). Diasporic Muslims are nevertheless largely underrepresented in or even absent from mental healthcare institutions in Belgium (Doornbos et al., 2013; ZorgnetVlaanderen, 2011).

This leaves us with somewhat of a conundrum, which we have started to explore and unpack from the perspective of the question of subjectivity (Rondelez et al., 2016).

²³ The concept of ‘diaspora’ is used as an analytical interpretive frame for the cultural, economic, and political ways of historical particular ‘genealogies’ of migrancy and to examine the relations between different migrancies across fields of social relations, subjectivity, and identity. What regimes of power inscribe the formation of a specific diaspora? The concept of diaspora also critiques discourses of fixed origins, because not every diaspora goes with an ideology of return. Diasporas often exist out of different journeys to different parts of the world, each with its own history and particularities. The notion of diaspora focuses on formations of power which distinguish diasporas internally as well as situate them in relation to each other. These different migrancies can come together in one journey through the convergence of narratives that are individually as well as collectively (re-)lived, (re-)produced, remembered, and transformed. By consequence, the identity of the diasporic imagined community is not pre-given (Brah, 1996).

This approach is inspired by the work of Nikolas Rose (1998; 1999), and his study of the ways in which the ‘self’ has been shaped by prevailing ways of thinking. Rose has extensively examined the regimes of knowledge whereby individuals have come to identify themselves as certain beings, the regulations and tactics that are interconnected with these knowledge regimes, and the relationships that individuals have developed with themselves in considering themselves as subjects. Rose’s work is particularly relevant for our study as he further elaborates a Foucaultian approach to subjectivity within a sociological framework, that includes empirical research. Moreover, he specifically attends to the role of the psy-disciplines (psychology, psychotherapy, and psychiatry) in the construction of the modern ‘self’.

It goes without saying that the question of underrepresentation can be approached in a variety of ways. It might be considered from the perspective of the material and cultural factors that render access to healthcare more difficult for ethnic-religious minorities, or from the perspective of existing mental health practices within ethnic-religious minority groups that reduce the need of minorities to rely on the established mental health services. More concretely, the focus might be on epidemiological data (Kluge et al., 2012; Lodewyckx et al., 2005), the unequal distribution of mental health problems (Aichberger et al., 2012; Kleinman, 2012; Siller et al., 2015; Vardar et al., 2012), institutional dynamics and implicit biases (Heinz & Kluge, 2012; Kluge et al., 2012; Rechel et al., 2013; Vardar et al., 2012) or the socio-culturally constructed character of mental health problems (Bäärnhielm & Mösko, 2012; Crammond & Carey, 2016; Heinz & Kluge, 2012; Kapilashrami et al., 2015; Kluge et al., 2012; Vardar et al., 2012). A focus on subjectivity offers another kind of contribution to this discussion. It enables us to trace processes of subjectification that occur within existing mental health services, and the subsequent ‘proper’ subject of mental health that is created along the way. The ‘proper’ subject of the established mental health services might indeed be shaped in such a way that renders both the access of diasporic Muslims to, as well as their trajectory through established mental health services more difficult. This is indeed a central assumption of our study, which offers additional insight into the understudied interactions between mental healthcare professionals and diasporic

Muslims (Buytaert et al., 2009; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour, 2011).

This article is part of a larger study, in which we consider different aspects of the processes of subjectification that are involved in those interactions. Here we focus on mental healthcare professionals, and how they perceive their work with Muslims with a migration background. More precisely, we ask: how do mental healthcare workers in Ghent, a middle-sized city in Belgium, approach and construct diasporic Muslims as subjects and service users of mental healthcare? The article consists of three sections. We first lay out how our study is grounded in the work of Rose and his attention to subjectivity. The second section presents our methodology, and the empirical material that grounds our analysis. In the third section, we apply Rose's approach to subjectivity to our empirical data.

2. The subject of mental health

Rose's sociological interest in subjectivity builds on the Foucaultian insight that "the ethics of subjectivity are inextricably locked into the procedures of power (Rose, 1998: 78-79)". Modern power, Foucault famously argued, does not function by repression and domination alone, but is productive: it actively produces certain subjects, shapes psyches, and fabricates persons with certain desires (Rose, 1998). This shaping of the subject occurs through particular discourses, which should be considered in their particularity. The critical impulse propelling Rose's analysis can be summarized as follows: "Where, how, and by whom are aspects of the human being rendered problematic, according to what systems of judgment and in relation to what concerns (Rose, 1998: 25-26)?" This critical impulse, moreover, leads him to examine those regimes of knowledge and expertise that are focused on the subject's psychology and mental health: the psy-disciplines.

In *Governing the Soul* (1999 [1989]) and *Inventing Ourselves* (1998), Rose offers an account of the rise of psychology in modern society. Since the end of the nineteenth century, Rose argues, the development of psychological intellectual and practical technologies is related to developments in the political structures in present-day

European and North-American liberal democracies, and to changes in prevailing conceptions of personhood (Rose, 1998). More precisely, the regulatory component of psychology, i.e. the way in which humans regulate ‘others’ and ‘themselves’, is connected, according to Rose, to the (re)organization of political powers and government.²⁴ Psychology, in other words, is particularly well-suited for the administration and social control that modern governmentality requires (Rose, 1998).

The work of Rose demonstrates how the exercise of modern political power has become fundamentally connected to the knowledge of human subjectivity (Rose, 1998). As Rose asserts, “to address the relations between subjectivity, psychology, and society from this perspective is to examine those fields in which the conduct of the ‘self’ and its powers have been linked to ethics and morality, to politics and administration, and to truth and knowledge (1998: 48-49)”. Advanced liberal democratic states, in sum, are confronted with some particular problems to which psy-disciplines propose solutions—an alignment that, at least partly, resides in a shared individualism (Rose, 1998). More specifically, modern democratic rule can be considered as a government through freedom, choices, and solidarities. In a liberal democracy, humans are understood as individual, autonomous selves with self-responsibility and choice, equipped with a psychology aspiring to self-fulfilment, running their lives as enterprises (Rose, 1998). This implies, first, that democratic government requires an extensive knowledge about its subjects, and second, that its rule is partly indirect. The psy-disciplines help to chart the terrain of the subject’s choices and their rationale, which enables subsequent governmental interventions. Take, for instance, the domain of health: the health of its subjects is vital to the national successes of the democratic state, which equally constructs and affirms many health-related decisions as ‘private’ and individual choices. The most efficient way to govern

²⁴ Following Foucault, government is to be understood in a broad sense as “all those more or less rationalized programs, strategies, and tactics for ‘the conduct of conduct’, for acting upon the actions of others in order to achieve certain ends (Rose, 1998: 11-12)”. Government, for Rose (1998: 29), thus refers to a “certain perspective from which one might make intelligible the diversity of attempts by authorities of different sorts to act upon the actions of others in relation to objectives”, such as, notably, health.

such ‘private’ domains, Rose insists, is through autonomy and responsibility (Rose, 1998).

Besides Rose’s detailed discussion of the rise and significance of the psy-disciplines in relation to established democratic rule, he also draws attention to new forms of government as they developed in the post-welfare states in the West at the end of the twentieth century. These forms of government, which we can call neoliberal, depend even more on the properties of their subjects, to the extent that it would be impossible to understand them without incorporating a new understanding and enacting of ‘ourselves’ and ‘others’ as ‘free and choosing’ selves (Rose, 1998). In the context of the emergence of such neoliberal forms of governmentality, we are particularly interested in the recovery paradigm, which scholars, policymakers, and practitioners in the last decades have considered as a promising framework for mental healthcare services, both internationally and in Belgium (see Deegan, 2003; Slade, 2012). In recovery-oriented practice, an attempt is made to “reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event (Ridgeway, 2001: 335)”, and priority is given to embracing strengths rather than weaknesses, hope rather than despair, and engagement and active participation in life rather than withdrawal and isolation (Leamy et al., 2011; Secker et al., 2002). We argue, however, that it is necessary to theorize underlying notions of the human subject when studying how service users are approached in recovery-oriented mental healthcare (see Vandekinderen et al., 2012). When people with mental healthcare problems are expected to become self-responsible citizens, the responsibility for leading a fulfilling life is individualized (Craig, 2008). As Vandekinderen et al. argue, it becomes particularly tricky and even impossible to provide high-quality mental healthcare “when this ideology of individual choice and opportunity denies the fact that some citizens have few available choices and resources (2012: 3)”. Unsurprisingly, the recovery paradigm has been critiqued, with an increasing number of authors arguing for a truly social approach to recovery, in which people with mental healthcare problems and professionals have an alliance and share responsibility in

shaping care and support practices in a continuous dialogue (Beresford & Croft, 2004; Vandekinderen et al., 2012).

3. Mental healthcare professionals in Ghent

Our exploration of the question of subjectivity in the realm of mental health services and ethnic-religious minorities focuses on how mental healthcare workers approach and construct these minorities as subjects and service users. Our empirical case study is situated in Belgium, where the conundrum that we alluded to in the introduction remains unaccounted for.²⁵ Most Muslims in Belgium are of Turkish and Moroccan descent, which is the result of labour migration, structured by bi-lateral agreements between Belgium and Turkey and between Belgium and Morocco in the 1960s, and subsequent family-reunions and marriages (Fadil et al., 2015). By ‘diasporic Muslims’ we understand those Muslims with a migration experience in their own life, or in the lives of their (grand)parents. Turks and Moroccans are the largest groups of migrants in Belgium and they have a particular work-related or family-related migration history. This motivates our choice to begin this preliminary research with those groups. An additional reason why we focus on these particular groups is that, as Muslims, they are, according to Said (2005), considered the ‘other’. Mental health professionals, who are often not diasporic Muslims, might be expected to make a distinction between ‘us’ and ‘them’, influencing mental healthcare. In the city of Ghent, where our case study is situated, most Muslims with a migration background are of Turkish and, to a lesser extent, Moroccan descent. A first analysis of our data shows that Muslims of Turkish

²⁵ There have been studies in other national contexts that offer some insights into the conundrum. A Dutch study shows that ethnic minority groups have more police referrals, crisis contacts, and compulsory admissions (see de Wit et al., 2012; Fassaert et al., 2016). In the United States studies show that diasporic migrants have more trouble accessing (mental) healthcare (Tabb et al., 2016) for a variety of reasons such as discomfort to talk to someone about personal problems, fear that someone would find out, trouble to get an appointment, a desire to solve their problems on their own, bad experiences with treatment, different conceptions of the nature, causes or cure of mental illnesses, and language difficulties (see Cai & Robst, 2016; Leong & Kalibatseva, 2011; Sorkin et al., 2016).

descent more often go to counsellors than those of Moroccan descent, but it is not clear why.

We set up a qualitative interpretative study and engaged with local network analysis (Turrini et al., 2009). This allowed us to make a cartography²⁶ of social problem constructions in the field of mental healthcare in Ghent. We selected and recruited 24 local actors in mental healthcare in Ghent, such as social-cultural workers, psychologists, psychiatrists, therapists, community (health) professionals, welfare professionals, nurses, and general practitioners, based on their experience with diasporic Muslims with mental health problems or the expectation that they would be able to formulate a well-founded opinion about the possible issues in this field. We began by contacting local actors who were related to a few umbrella organizations. We then dug deeper in the field of mental healthcare organizations. Following a snowball-sampling strategy (Esterberg, 2002), all participants were asked if they knew other interesting contacts for our study. Biomedical professionals ended up being underrepresented in our sample, as many of them responded to our request to participate by pointing out that they did not have enough Muslims in their institutions to be of interest for the study. This seems to indicate that diasporic Muslims are most underrepresented on the institutional and biomedical side of the spectrum of mental healthcare. It also implies that biomedical views are underrepresented in our analysis. On the other hand, community care centres and system therapists are overrepresented. This can explain the focus on culturally sensitive ways of treating patients and the dominance of the family in the conducted interviews. Snowball sampling runs the risk of taking participants out of the same pool of participants, which can result in too much similarity between participants. Both factors influence the results of the analysis.

We used qualitative, semi-structured interviews to explore the personal meanings that our participants gave to their experiences with diasporic Muslims. The interviews were semi-structured to allow the participants enough space to articulate their own

²⁶ We decided to call this a cartography because of two important characteristics. The first one is that it is politically normative: selecting is also always appreciating. The second one has to do with its link with subjectivity, our main focus of research (Braidotti, 2002).

insights. The duration of the interviews varied between 45 minutes and slightly over 2 hours. All interviews were recorded with a voice recorder and fully transcribed.

We subsequently sought to relate our data to the theory of Rose and Rose's theory to our data. Instead of focusing on a specific theoretical framework or theorist, Jackson and Mazzei (2012) argue that researchers can rely on particular concepts, which are part of an assemblage of 'texts' that constitute one another and create something new. As such, analytical questions become possible by referring to, and hence activating, a specific theoretical concept. Although Rose is reluctant to turn his Foucaultian commitment to studying power, knowledge, and the subject into a formal methodology (1999: xi), he does discern four dimensions in an analysis focused on subjectivity: an ontological, epistemological, ethical, and technical dimension.

4. Shedding light on emerging insights

We now turn to our empirical material, and analyse and discuss the narratives of mental healthcare practitioners through the lens of these four aspects.

4.1. Ontological

The first aspect Rose discerns when it comes to subjectivity is the ontological one, that is, the views on the nature of being of subjects, in this case diasporic Muslims with mental health issues. Here we found that, most of the time, our participants considered the subjects to be lacking knowledge about themselves. Many expert professionals seem to consider diasporic Muslims as largely unknowing about their health, bodies, and mind.²⁷ This is notably reflected in how they are seen to frame mental health problems as psychosomatic complaints.

The intercultural counselor is sometimes called in. But most often when we try to deal with people with a migration background... Why? Because ... they often know little about their own body. We grow up with

²⁷ Some of the participants make a distinction between the older and the younger generations. The younger generations generally grew up in Belgium and incorporated the prevailing system of knowledge.

knowledge about our body, as a result of which we know how everything works ... how many times do you learn about this, you learn about it in secondary education, you learn about it in elementary school ... we really grow up with that. Over there, there are a lot of people who know little or almost nothing about the way their body functions, and as a result it might be supportive to explain a bit so they do not panic when something happens. We also notice that in healthcare in general, especially for people with children, when the children have a fever, we do not have a problem with that, ... but the people here can sometimes totally panic because “once there was someone with a high fever and he died”. People are completely panicking, they do not know ... so you see that as a result of the lack of, or little knowledge of the way their own body functions etcetera, there is a lot of concern ... we sometimes have the feeling that people get into a panic mode ... because of things that are quite trivial to us. So we try to impart some knowledge, some knowledge about the body, also some knowledge about how our health system functions. We call that, without being condescending, our educational task (interview 8, social cultural worker, community health centre).

In the scholarship on Western mental healthcare, a distinction is made between lay knowledge and expert knowledge: mental health service users are often ascribed experiential knowledge about their own body and experiences, but they are seen as lacking knowledge about disease processes or the process of diagnosis that only medically trained people have (Prior, 2003). In this excerpt we see how modern normalization processes are premised on, and further construct, a binary dialectic of ‘self’ and ‘other’, as Said (2005) has analysed in detail. The ‘other’ is considered as different and inferior, whereby everything that diasporic Muslims with (mental) health problems say or do is considered as ‘non-sense’ instead of meaningful. ‘Unknowing’, moreover, seems to mean unknowing of Western medicine. This also implies a devaluing of the knowledge the ‘other’ might have—this is not the ‘right’ kind of knowledge.

Research has also indicated that stereotype endorsement is stronger among those who grew up in (rural) towns or regions than those who grew up in (urban) cities. Their

attitudes towards, for example, schizophrenia are also more negative and rejectionist. This is supposedly due to the fact that inhabitants of towns are more loyal to their culture, values, and the judgements of their communities (Gur & Kucuk, 2016; Sarikoç & Öz, 2016). Another study shows that stigmatization most often takes the form of a paternalistic and benevolent view of the persons with mental health problems (Gur & Kucuk, 2016). In Ghent, Muslims came mostly from the Turkish rural town Emirdağ or from the urban Arabic regions in North-Morocco and the Berber regions of the Rif mountains (Fadil et al., 2015; Verhaeghe et al., 2012). It is known that individuals living in rural areas, or those with lower socio-economic status, are less likely to seek help (Gur & Kucuk, 2016). There is, moreover, a link between the level of education and stigmatization. How lower the education level and income, how higher the internalized stigmatization (Gur & Kucuk, 2016; Sarikoç & Öz, 2016). The inverse relationship, however, has also been found: educated people or the higher economic classes have more negative attitudes toward persons with mental health problems (Gur & Kucuk, 2016).

The narratives of our participants were profoundly shaped by ‘Orientalist’ tendencies. These have typically cast the scientific, modern West in opposition to a childish, magical, ‘Oriental other’, in need of education (Said, 2005). Counsellors then see it as their task to educate clients, and turn them into autonomous citizens. Within a neoliberal view, clients without such knowledge are not considered as deserving, autonomous clients and are rejected (Wiebe, 2009). Yet the depth of the distinctions that the community health worker here establishes cannot be understood without recognizing the operation of a logic of cultural difference that profoundly culturalizes both the distinction between knowing professional versus unknowing patient, as well as good (autonomous) client versus bad client.

Modern, Western knowledge, moreover, has special bearing in this context on the biomedical approach, which does not recognize its own cultural or situated dimensions but rather considers these as universal (Gailly, 1988). Some mental health professionals explicitly take this approach to Muslim clients, we found, while others do take cultural aspects into consideration and follow a more culturally sensitive

approach (cf. *infra*). We found the latter to be rather widespread among the professionals we interviewed. And while in some respects this might be an improvement in relation to a logic that universalizes its own cultural bearings, very often culturally sensitive approaches continue to be marked by a logic of cultural difference which is premised on an ‘us’-‘them’ separation as well as the presentation of the ‘other’ as superstitious and unknowing. The latter characterization, moreover, amplifies the construction of a ‘bad’ or problematic subject for Western (mental) healthcare within a neoliberal logic (Wiebe, 2009).

I do not want to draw a caricature, but for example last year we heard a couple of times about exorcism in the news. One also finds other solutions for a problem that one wants to solve in the community itself. These are of course really extreme examples, but they exist. And they will probably still be present. While we, Western healthcare practitioners, think about other solutions than devil exorcism. But, those are things that... I believe one looks for other kinds of solutions than you and I would look for if we would have problems. So yes, many problems (interview 3, social cultural worker, umbrella organization body).

There is also too little knowledge about the body. Too little knowledge about the notion of depression etcetera ... Even in our society this is a taboo. Let alone in the Turkish, Moroccan community. It is also a taboo. You are rejected. No, that is too extreme. I am telling it in terms of prejudices ... Because that is to fall short of God etcetera. Yes. (interview 11, general practitioner, community health centre).

A Turkish general practitioner, however, when asked if he saw a difference in the way diasporic Muslims perceive mental health, responded:

No, no. I think that has all changed. I would say that it is also seen as normal, mental healthcare. So the approach of mental health problems used to be more: “yes, is this one possessed?” or something similar. And they need to go to someone else than a doctor. But we see now that it becomes more and more accepted as an illness. And that they want to be treated. Sure, sure. It is an evolution, it is changing. So people see things,

are reading, are following things and nowadays it is all with social media etcetera ... (interview 20, general practitioner, private practice).

Or as another participant, a psychologist in a private practice, said:

I think that by bringing mental healthcare in the public sphere through the announcement of days such as 'too insane' days and the day of mental healthcare and the way that centres of mental healthcare come out with their assistance nowadays. And that much more figures in the media, in different programmes—not only in Libelle [a lifestyle magazine], on different aspects of psychiatric problems. Nowadays, there is something on television about mental healthcare every day, and ten years ago that was not the case. But also the generations of Turkish people change; in a sense, they become more and more integrated in our way of thinking about mental healthcare. And the current generations are informed of how it works. In the past, twenty, thirty years ago, that was not the case, because, the people were not in Belgium as long as is now the case and they had no need to or insight in how it all functions. I notice that is a big difference (interview 25, psychologist, private practice).

Here a psy-logic, and the biomedical model it rests on take the upper-hand. The problems are identified as illnesses in need of treatment by a doctor. This general practitioner is also aware that his patients become more and more educated. Lay knowledge is sometimes ambiguous about scientific biomedicine and can consist out of intuitive, individuated, and personalized knowledge. Lay knowledge and expert knowledge need to be considered more and more as a continuum and not as polarized positions (McClellan & Shaw, 2005).

A second finding is the important role our participants attributed to the family and community of the subjects.

The pressure of the family. And being confined to the family, also the taboo on asking for help ... Not wanting that problems and stuff come out in the public sphere. And that they need to stay within the family, but that is a cultural fact. That has nothing to do with discrimination, exclusion, etcetera. Or... Yes, still also a cultural aspect. I do not want to hyper-

culturalize but... (interview 1, social cultural worker, community health centre).

These narratives almost tend to overrule the individuality of the subjects. Here we can identify the logic of cultural difference that juxtaposes so-called collectivist cultures to so-called individualist Western cultures. According to our participants, collectivistic cultures are characterized by a strong tendency to gossip and the difficulty of keeping secrets. This is supposed to be more the case in the Turkish community than in the Moroccan community, and older generations are supposed to have more problems with this than younger generations, who are already more individualistic.

Community. For example, in the Turkish or Moroccan one probably, but especially in Turkish culture, there is an enormous culture of gossip, everything goes around very fast. And there is also a prejudice against people with psychiatric problems, so that is not ok. And I believe that also among Flemish people this is not always ok.... But you notice that there is still more pressure from the community. The belief that we can keep something a secret within our family. I believe that that is much more complicated within other cultural communities, there everything is passed on. And that is also often the fear when you work with interpreters, that they will not keep their mouths shut. And that is also very difficult, I know from the people who work here as cultural interlocutors, as interpreters, that they really are asked questions by their communities. I believe that those people sometimes get into very difficult situations (interview 5, psychologist, city service).

Those were people with an atypical country of origin, so they did not have a community that could watch, he or she has help, while being here in Ghent. For example, among the Turks ... there are many differences. Islam will also play a role in it, because that is really their religion. Take care of your parents. We also have that, but maybe still a little less than it should be. Or I believe that the pressure is still a little different (interview 10, social cultural worker, welfare organization).

Another purported characteristic of collectivist cultures is the pressure to keep the care of family members in the community. Within a cultural logic, this characteristic is most often attributed to ‘a different culture’. That for some minority populations community or family might at least appear to be safer than existing mental healthcare institutions—notably because of how racism characterizes and shapes existing institutions, including mental health institutions, in Belgian society—is not part of the equation. From a psy-logic, moreover, the tendency to seek help within the community is assumed to be an impediment to care.

It is also important to take the literature on stigma into account. The influence of the community might also be explained by a higher level of anticipated self-stigma. Research has shown that seeking help from general practitioners and psychiatrists, but not from psychologists, is more difficult when self-stigma is more pronounced (Pattyn et al., 2014). It also seems to be the case that hospitalization is linked with higher self-stigma (Sarikoç & Öz, 2016). On the other hand, the fear that the community would gossip can be associated with a higher level of perceived public stigma. In that case, one is afraid of devaluation and social discrimination by one’s social network (Ciftci et al., 2013; Pattyn et al., 2014). This is also the reason why many persons with mental health problems are reluctant to seek treatment (Sarikoç & Öz, 2016). One can also speak of label avoidance: “instances in which individuals choose to not seek help for mental health problems in order to avoid negative labels (Ciftci et al., 2013)” which could, for example, form an impediment for marriage candidates. So, the bonds with the immediate family improve, but the relation to society gets worse (Sarikoç & Öz, 2016).

4.2. Epistemological

The epistemological aspect of subjectivity concerns the question: ‘How can we know the subject?’ The more culturally sensitive actors among our participants emphasized that they wanted to really listen to the stories of people who seek their help, instead of relying on a more traditional consultation model. They offered critiques on organizations that approach mental health problems primarily in a biomedical way,

and that prioritize the organizational structures over the well-being of their clients. We encountered mental health practitioners who criticized the neoliberal logic, and sought to work with people on a case-by-case base, instead of being driven by organizational values that value efficiency, time-concerns, and standardization over people.

It is the organization, and the organization of the system, yes yes. They are creating such barriers for their organization that they say, already on the phone, “yes but they will not get there, they do not know the language enough, that will not go smoothly. We will not take that one”. Systematically, they do not look at the people, not at the needs, they look at the values and norms of their organization. And that is no longer human. And there we will need to change something. And we go back to policy (interview 9, social cultural worker, city service).

In this particular instance a cultural logic, i.e. recognizing that people might not speak the prevalent language within the organization, served to reject neoliberal imperatives and resulted in a constructive and creative culturally sensitive approach. This logic, moreover, was infused by an awareness that prevailing procedures within current Western biomedicine do not suffice.

So the art is, finding entrances in which you, in a culturally sensitive way—to use the word—succeed in digging up the sensitivities and there where you suspect that people are stuck by problems they have, to bring them to the surface. This will still require a lot of searching, but I believe that that is indeed the way we will need to go about it. That we can’t just copy and paste from the white people so, we are doing that... It will require more skills. (interview 2, social cultural worker, umbrella organization).

These practitioners prefer a way of working that reaches out to clients, uses interpreters, is life-world oriented, and allows for exceptions to the rules.

We are actually quite used to rely on the consultation model ... You have a problem, someone sits there, you go to that person, you have a consultation. But this is a quite Western model that we use. The way it

happens in other cultures is not at all like that, this is very noticeable. Do not let your clients come to you at consultation, but the other way around. Go to their homes. Travel around yourself. Or go much closer, where the people dwell and live, and into the community (interview 2, social cultural worker, umbrella organization).

I believe that you need to work with the time people have, and that means demand-oriented working. And that is what we at the service really try to do. We take liberties with the standard structures, standard rules. That is the general view in the service, through which we also reach those people. In a Community Mental Health centre, I believe, sometimes one attaches more importance to certain guidelines or certain structures, for example, clients need to be motivated, need to be at appointments. If we get a referral and the client is absolutely not motivated, then it is our job to get him motivated for therapy. If the client does not like the sound of coming to the centre, than we go on a house call. So disregarding the origin of the client or the problem, our goal is to take care of those people who otherwise do not get to the psychologist. And I believe that this also implies that we can reach those people with a migration background, because we use those methods in any case. We will not say, when someone with a Russian background does not show up, that we cannot give therapy. Then we are already happy with everything that we can offer at that moment that the client is with us. (interview 5, psychologist, city service).

While the last quote represents an exception in this respect, we found a general tendency to hyper-culturalise, while the participants precisely claimed not to do so. Instead of considering people in their particularity, which of course includes cultural aspects, many practitioners approached ‘culture’ in a homogeneous sense, and operated under the assumption that ‘others’ are almost completely determined by ‘their’ culture, and that every individual is a representative of its culture, unmediated by personal or contextual elements. And while this cultural logic functions as a ground of critique in relation to the biomedical and neoliberal logic the practitioners felt pressured by, it did so through fostering a very essentialised view of ‘us’ versus ‘them’

—a view that aligned quite seamlessly with Said’s understanding of Orientalism (Said, 2005).

4.3. Ethical

A third aspect of subjectivity that Rose highlights is the ethical aspect. Here ethics pertains to the kind of selves that are valued as ‘good subjects’ and to which one should aspire. As already discussed at the outset of this article, Rose’s work helps us to understand how neoliberal governmentality relies on the expectation of free, independent, autonomous civilians, and how the psy-disciplines have been instrumental in creating those free subjects that are necessary in a liberal democracy (Rose, 1998).

The most important values and traits of ‘good subjects’ that we were able to identify in our interviews are: recovery, activation, responsibility, and independence. In the last decades, marked by the deinstitutionalization of residential services and the development of community-based services, ‘recovery’ became popular in mental healthcare in Flanders (Vandekinderen et al., 2012). ‘Recovery’ is defined as “enabling people with mental health problems to ‘regain control over their lives, and ... be responsible for their own individual journey of recovery’ (Deegan in Vandekinderen et al., 2012: 2)”.²⁸ Recovery was mentioned by our participants as an important frame of reference, which they understood as clients taking responsibility for their own healing process and formulating their own goals while taking into account their vulnerability.

But there is also some philosophy behind the concept of recovery: I am the expert of my life. I know what is best for me at this moment and also later I will know what is best. And you caregivers, you have studied for that, help me with that, the route that I am mapping out for myself, help

²⁸ In the literature we can find two different approaches to recovery: an individual and a social one. Both are linked to different notions of citizenship. The individual notion of recovery is connected to a normative perspective on citizenship and the social notion of recovery is connected to a relational and inclusive notion of citizenship (Vandekinderen et al., 2012).

me to walk that way (interview 2, social cultural worker, umbrella organization).

This approach to ‘recovery’ is simultaneously marked by the psy-logic and the logic of neoliberalism. To be a good citizen means being a healthy autonomous individual. The figure of the autonomous individual emerges both from a neoliberal and a therapeutic discourse, as a consequence of the ‘responsibilisation’ and the ‘autonomisation’ of the ‘self’ (Brunila, 2014).²⁹ The concept of recovery is thus also linked with the emergence of a set of new ideas about citizenship, based on the assumption that people with mental health problems have the right to live their life *in* society just as everybody else does (Vandekinderen et al., 2012). The value of activation and responsibility is stressed while the importance attached to the learning process included within counselling is also emphasized. It is through subjectification processes that occur within these conversations that one is supposed to learn how to behave at work and in society at large (Rose, 1999).

Showing or not showing up is an item in counselling. Because it is also about the activation of people, about acquiring responsibility, about the development of an identity. I am someone, and I am someone who keeps his or her appointments, I am someone. That is something that we find very important, so not showing up or showing up is an item as such in counselling. You also have people who are always half an hour late. Good, I am glad you are here. In that case you do not speak about that half hour. Do you notice that it is because it does not bother them to be on time? Then you discuss that and you notice if there is a problem or not. If people had to summon up all their courage to get here, yeah, then they are half an hour late. But then you can say when they are a little bit earlier the next time “ah I see that you are a little bit earlier, that you managed.” You work with that. So we do a lot to let the clients come to us, but we also expect that they take responsibility, there is a line, there

²⁹ The therapeutic ethos is formed by the permeation of the language of disorder, addiction, vulnerability, and dysfunction together with associated practices from different branches of therapy in popular culture as well as in political systems (Brunila, 2014).

is a difference between meeting people where they are and patronizing. Some responsibility remains with the client, and when you have a longer trajectory with people, then you work towards that. That is the ultimate goal, that they come to counselling, without you having to phone them, without missing an appointment, that they are on time, that they call when they are not able to come. That is a goal, because those attitudes are also needed in society, they also need them when they go to work, when they have to go to their children's schools. You just need them. I believe that sometimes this is also due to cultural stuff, keeping appointments (interview 5, psychologist, city service).

For some of our interlocutors, the values of recovery, self-responsibility, and independence seem to be the most important objectives of the counselling process, almost more important than the client's mental health. These values are central in our contemporary neoliberal society. The dominant discourse implies that citizens have the responsibility, the social obligation, to realize those values (Rose, 1998; 1999; Vandekinderen et al., 2012).

4.4. Technical

Finally, Rose (1999) draws attention to the technical aspect of subjectivity, which revolves around the question: 'What do subjects need to do to change or improve themselves?' In the answers to this question we can observe that, in line with a predominant neoliberal spirit, the responsibility for the recovery process is the clients'.

I work very systemically, circularly. And I very often got people who perceive their problem as linear. See, that is the cause, that need to get over it and be done with it, that need to be fixed. You have to do it for me. They see me as an expert, while I consider myself as someone next to the person who is the expert of his or her own life (interview 7, psychologist, community health centre).

According to our participants, clients have to prove that they are good citizens by curing themselves, and when necessary they can appeal to the psy-disciplines for help. The underlying assumption seems to be that good and full citizens are autonomous,

rational, healthy, and economically independent (Rose, 1998; 1999; Vandekinderen et al., 2012). Rose calls this pressure to ‘do it yourself’ the ‘therapeutic imperative’ (Rose, 1998; 1999). Nowadays, this therapeutic imperative combines a psy-logic and a neoliberal logic.

Recovery refers to the idea that people with psychiatric problems have to formulate goals for themselves. I have, here and now, these kinds of problems. And these are the kinds of solutions, or those are the problems I want a solution for. And caregivers help me with solving it or guide me in the search for solutions for those kinds of problems (interview 2, social cultural worker, umbrella organization).

That has to do with capacity and mental capacity. There are people whom it does not bother and there are people who simply drown. That does not make it okay that such things happen, but it is still the responsibility of the people with a migration background themselves with a certain issue to deal with it in a certain way. It is not because you are wronged that you have no responsibility. Your responsibility is to deal with it in a good way. And then I believe you can support people to make them more resilient. It does not make things right, but it is what it is in this context, people have to live in it. And then I believe it is the job of the caregivers to be aware of the fact that people live in it and to help them to find tools to deal with that (interview 5, psychologist, city service).

Throughout this approach to recovery, there is a strong tendency to neglect social and cultural circumstances and structural inequalities that hinder people with mental health problems (Vandekinderen et al., 2012). In the case of diasporic Muslims with mental health problems, we can speak of a double stigma, which results from their ethnic-religious background as well as their problems. Here it is important to take an intersectional approach that takes the entanglement of power relations and identities into account. The stigma will not only differ in degree but also in quality with different effects on the individual. So there is a strong sense of shame among families with a Turkish background. This shame can be so strong that the persons with mental health problems remain in the house and avoid the public sphere. Often fathers would blame

mothers for giving birth to such a child. Even when diasporic Muslims hold positive opinions towards mental healing, social stigma is strong, because of the concern for the family's social standing. The disclosure of mental health problems is still considered shameful (Ciftci et al., 2013).

People with no severe mental health problems typically distance themselves more from their diagnosis than people with a more severe diagnosis. One can explain this by the fact that their symptoms do not look like the social stereotypes of mental health problems. Also people with no previous history of treatment are more likely to distance themselves from their diagnosis because they often believe that their problems are limited in time, recoverable, and manageable with medication or therapy. Stigma also influences the way people will deflect their identity as a person with mental health problems. The greater the perceived stigma, the greater the chance people will reject the characteristics linked to mental health problems. Finally, the number of conventional role identities one holds, influences the likelihood of deflecting an identity as a person with mental health problems: the more conventional role identities one holds, the less important the identity as a person with mental health problems is (Thoits, 2016).

5. Conclusion

In an attempt to gain insight into the dynamics at stake in the underrepresentation of diasporic Muslims in mental healthcare services in Ghent, we explored and analysed the perspectives of mental healthcare practitioners. We asked: 'How do mental healthcare workers in Ghent, a middle-sized city in Belgium, approach and construct diasporic Muslims, as subjects and service users of mental healthcare?' We relied upon the work of Nikolas Rose (1998; 1999) to do so and turned more specifically to his method of studying subjectivity in relation to therapeutic practices and logics.

This analysis challenged us not only to illustrate and discuss different aspects of the subjectivity dimension, as laid out by Rose, but also to enlarge our analytical approach. First, our data required more attention to the neoliberal context. At the heart of the neoliberal approach to a psy-logic lies the responsibility to be a free and healthy

subject, with a 'self' that objectifies itself and constructs a hermeneutic of the 'self', whereby one learns to interpret oneself and to construct a narrative about the real 'self' in psychological and medical terms (Rose, 1999). Rose's work has drawn attention to the political economy of neoliberalism that began its rise to hegemony in the 1980s and involves the application of liberal market principles to other, non-economic spheres of life (Rose, 1998; 1999). Yet the ways in which neoliberalism has prompted new modes of subjectification, revolving around the individual, its interests, freedom, and regulation of the 'self', have been particularly intense, and require more (specific) analytical attention.

Second, we discerned another potent logic running through the narratives of our participants, which proved to be a crucial one in accounting for the views the mental healthcare workers we spoke to held about diasporic Muslims, i.e. a logic of cultural difference.³⁰ In order to further operationalize the logic of cultural difference, we turn to Edward Said's seminal work *Orientalism* (2005 [1978]). Relying on a Foucaultian understanding of discourse, Said (2005) defines Orientalism as a historical and systematic discipline by which Europe produced the 'Orient', thus unpacking the intricacies of power/knowledge through laying bare the intimate relationships between colonialism and the scholarly study of the 'Orient'. At the heart of Orientalism as a style of thought, Said argues, lies the production of an ontological and epistemological distinction between the 'Orient' and the 'West', a distinction that is essentialised. More recently, and notably in the context of the post-1989 reshuffling of the geopolitical landscape, the notion of the 'Orient' has increasingly come to coincide with Islam resulting in the well-known oppositional framing of the 'West' and Islam in which superior values are attributed to the 'West' and inferior ones to Islam. The epistemological structures of Orientalism obscure the profoundly dialectical ways in which identities of, and knowledges about, 'self' and 'other' are constructed (Rondelez et al., 2016).

³⁰ We are not referring to the whole debate about norms and values in the sector of mental health. We only refer to ethnic culture here, but are aware that there are also other norms.

However, as we are teasing out the relevance of the work of Rose (1998; 1999) and Said (2005) to make sense of our empirical data, we also come to the conclusion that their work not only allows us to *select* and gain insights, but also to *deflect* crucial insights concerning underlying rationales and views of professionals in mental healthcare services. Their theoretical contribution enables us to challenge binary and categorical thinking, that is reflected in oppositional dichotomies between the ‘self’ and ‘other’ that often function as underlying and implicit assumptions in the field of mental healthcare. Their views enabled us to analyse how Muslims with a migration background are perceived as unknowing subjects, and how mental health professionals exercise authority over and use their expert knowledge on these subjects (Prior, 2003), developing an idea that the culture of Muslims with a migration background is homogeneous although they claim that they use a culturally sensitive approach. The work of Rose and Said, nonetheless, also created blind spots in our analytical grid, and only allowed for a critical deconstruction of this binary dialectic between ontologically different categories of ‘self’ and ‘other’ (see Foucault, 1978; Butler, 2004). The analytical grid did not enable us to go beyond a negative appreciation of professionals in mental healthcare and to imagine a non-deterministic and non-dualistic framing of the human subject formation of diasporic Muslims with whom they try to work (see Braidotti, 2013; Vandekinderen & Roets, 2016). Our analysis mainly uncovers individual approaches to recovery but does not illuminate a truly social approach to recovery, in which people with mental health issues and professionals have an alliance and share responsibility in shaping care and support practices in a continuous dialogue (Beresford & Croft, 2004; Vandekinderen et al., 2012). This will be of vital importance in future research.

References

- Aichberger, M. C., Bromand, Z., Heredia Montesinos, A., Temur-Erman, S., Mundt, A., Heinz, A., Rapp, M. A. & Schouler-Ocak, M. (2012). *Socio-economic status and emotional distress of female Turkish immigrants and native German women living in Berlin*. *European Psychiatry*, 27: 10-16.

- Bäärnhjelm, S. & Mösko, M. (2012). *Cross-cultural training in mental health care—challenges and experiences from Sweden and Germany*. *European Psychiatry*, 27: 70-75.
- Beresford, P. & Croft, S. (2004). *Service users and practitioners reunited: the key component for social work reform*. *British Journal of Social Work*, 34(1): 53-68.
- Brah, A. (1996). *Cartographies of diaspora. Contesting identities*. London: Routledge.
- Braidotti, R. (2002). *Metamorphoses. Towards a materialist theory of becoming*. Cambridge: Polity Press.
- Braidotti, R. (2013). *The Posthuman*. Cambridge: Polity Press.
- Brown, T. N. (2003). *Critical race theory speaks to the sociology of mental health. Mental health problems produced by racial stratification*. *Journal of Health and Social Behavior*, 44(3): 292-301.
- Brunilla, K. (2014). *The rise of the survival discourse in an era of therapisation and neoliberalism*. *Education Inquiry*, 5(1): 7-23.
- Butler, J. (2004). *Undoing Gender*. London/New York: Routledge.
- Buytaert, E., Vandedrinck, E. & Lemmens, G. M. D. (2009). *Psychiatrische stoornissen bij migranten: feiten en hypothesen*. *Tijdschrift voor Geneeskunde*, 65: 1-8.
- Cai, A. & Robst, J. (2016). *The relationship between race/ethnicity and the perceived experience of mental health care*. *American Journal of Orthopsychiatry*, 86(5): 508-518.
- Chakraborty, A. T., Mckenzie, K. J., Hajat, S. & Stansfeld, S. A. (2010). *Racism, mental illness and social support in the UK*. *Social Psychiatry and Psychiatric Epidemiology*, 45: 1115-24.
- Ciftci, A., Jones, N. & Corrigan, P. W. (2013). *Mental health stigma in the Muslim community*. *Journal of Muslim Mental Health*, 7(1): 17-32.
- Colaço Belmonte, J. A. F. (1976). *Klinische lessen: Jnun, een vorm van katatone psychose?* *Nederlands Tijdschrift voor de Geneeskunde*, 120: 1925-1927.
- Craig, T. K. J. (2008). *Recovery: say what you mean and mean what you say*. *Journal of Mental Health*, 17(2): 125-128.

- Crammond, B. R. & Carey, G. (2016). *What do we mean by 'structure' when we talk about structural influences on the social determinants of health inequalities?* *Social Theory & Health*: doi: 10.1057/s41285-016-0020-3.
- De Wit, M. A. S., Tuinebreijer, W. C., Van Brussel, G. H. A. & Selten, J-P. (2012). *Ethnic differences in risk of acute compulsory admission in Amsterdam, 1996-2005*. *Social Psychiatry and Psychiatric Epidemiology*, 47: 111-118.
- Deegan, G. (2003). *Discovering recovery*. *Psychiatric Rehabilitation Journal*, 26(4): 368-376.
- Doornbos, M. M., Zandee, G. L., Degroot, J. & Warpinski, M. (2013). *Desired mental health resources for urban, ethnically diverse, impoverished women struggling with anxiety and depression*. *Qualitative health research*, 23: 78-92.
- Esterberg, K. (2002). *Qualitative Methods in Social Research*. Boston: The McGraw-Hill Companies.
- Fadil, N., Asri, F. E. & Bracke, S. (2015). Islam in Belgium. Mapping an emerging interdisciplinary field of study. In J. Cesari (Ed.) *The Oxford Handbook for European Islam* (pp. 222-261). Oxford: Oxford University Press.
- Fasseart, T., Heijnen, H., De Wit, M. A. S., Peen, J., Beekman, A. T. F. & Dekker, J. (2016). *The association between ethnic background and characteristics of first mental health treatment for psychotic disorders in the Netherlands between 2001 and 2005*. *Social Psychiatry and Psychiatric Epidemiology*, 51: 1591-1601.
- Foucault, M. (1978). *The History of Sexuality*. New York: Vintage Books.
- Gailly, A. (1988). *Psychische klachten bij Turken en hun benadering*. Brussel: Cultuur en Migratie vzw.
- Gur, K. & Kucuk, L. (2016). *Females' attitudes toward mental illness: A sample from rural Istanbul, Turkey*. *Iran Red Crescent Medical Journal*, 18(5): 1-8.
- Heinz, A. & Kluge, U. (2012). *Editorial. Mental health in different groups of migrants and ethnic minority within Europe and beyond: Regional and cross-national challenges and approaches in research, practice and training*. *European Psychiatry*, 27: 1-3.

- Hilderink, I., Van 't Land, H. & Smits, C. (2009). *Drop-out onder allochtone GGZ-cliënten. Zicht op de onderliggende factoren en aanbevelingen om drop-out te verminderen*. Utrecht: Trimbos-instituut.
- Hoffer, C. (2009). *Psychische ziekten en problemen onder allochtone Nederlanders: beleving en hulpzoekgedrag*. Assen: Van Gorcum.
- Inhorn, M. C. & Serour, G. I. (2011). *Islam, medicine, and Arab-Muslim refugee health in America after 9/11*. *The Lancet*, 378: 935-943.
- Jackson, A. Y. & Mazzei, L. A. (2012). *Thinking with theory in qualitative research: Viewing data across multiple perspectives*. New York: Routledge.
- Kapilashrami, A., Hill, S. & Meer, N. (2015). *What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach*. *Social Theory & Health*, 13(3/4): 288-307.
- Karlsen, S., Nazroo, J. Y., Mckenzie, K. J., Bhui, K. & Weich, S. (2005). *Racism, psychosis and common mental disorder among ethnic minority groups in England*. *Psychological Medicine*, 35: 1795-803.
- Kleinman, A. (2012). *Epilogue*. *European Psychiatry*, 27: 81-82.
- Kluge, U., Bogic, M., Deville, W., Greacen, T., Dauvrin, M., Dias, S., Gaddini, A., Koitzsch Jensen, N., Ioannidi-Kapolou, E., Mertaniemi, R., Pucipinos, I., Riera, R., Sandhu, S., Saravry, A., Soares, J. J. F., Stankunas, M., Straßmayr, C., Weibel, M., Heinz, A. & Priebe, S. (2012). *Health services and the treatment of immigrants: Data on service use, interpreting services and immigrant staff members in services across Europe*. *European Psychiatry*, 27: 56-62.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). *Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis*. *The British Journal of Psychiatry*, 199(6): 445-452.
- Leong, F. T. L. & Kalibatseva, Z. (2011). *Cross-cultural barriers to mental health services in the United States*. Cerebrum:
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3574791/>

- Lodewyckx, I., Janssens, A., Ysabie, P. & Timmerman, C. (2005). *Allochtone en autochtone jongeren met psychische problemen en gedragsproblemen: Verschillende trajecten naar de hulpverlening?* Drukkerij Peten.
- Mcclean, S. & Shaw, A. (2005). *From schism to continuum? The problematic relationship between expert and lay knowledge—An exploratory conceptual synthesis of two qualitative studies*. *Qualitative Health Research*, 15(6): 729-749.
- Pattyn, E., Verhaeghe, M., Sercu, C. & Bracke, P. (2014). *Public stigma and self-stigma: Differential association with attitudes toward formal and informal help seeking*. *Psychiatric Services*, 65(2): 232-238.
- Prior, L. (2003). *Belief, knowledge and expertise: The emergence of the lay expert in medical sociology*. *Sociology of Health & Illness*, 25: 41-57.
- Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P. & Mckee, M. (2013). *Health in Europe 5: Migration and health in an increasingly diverse Europe*. *The Lancet*, 381: 1235-1245.
- Ridgway, P. (2001). *Restorying psychiatric disability: learning from first person recovery narratives*. *Psychiatric Rehabilitation Journal*, 24(4): 335-343.
- Rondelez, E., Bracke, S, Roets, G. & Bracke, P. (2016). *Racism, migration, and mental health. Theoretical reflections from Belgium*. *Subjectivity*, 9(3): 313-332.
- Rose, N. (1998). *Inventing ourselves. Psychology, power, and personhood*. Cambridge: Cambridge University Press.
- Rose, N. (1999). *Governing the soul. The shaping of the private self*. London: Free Association Books.
- Said, E. W. (2005). *Oriëntalisten*. Amsterdam: Mets & Schilt.
- Sarikoç, G. & Öz, F. (2016). *The effects and stigma of mental illness in Turkey*. *Community Ment. Health J*, 52: 353-360.
- Secker, J., Membrey, H., Grove, B. & Seebohm, P. (2002). *Recovering from illness or recovering your life? Implications of clinical versus social models of recovery from mental health problems for employment services*. *Disability & Society*, 17(4): 403-418.

- Siller, H., Renner, W. & Juen, B. (2015). *Turkish migrant women with recurrent depression: Results from community-based self-help groups*. Behavioral Medicine: DOI: 10.1080/08964289.2015.1111858.
- Slade, M. (2012). *Everyday solutions for everyday problems: how mental health systems can support recovery*. Psychiatric Services, 63(7): 702-704.
- Sorkin, D. H., Murphy, M., Nguyen, H. & Biegler, K. A. (2016). *Barriers to mental health care for an ethnically and racially diverse sample of older adults*. Journal of the American Geriatrics Society, 64: 2138-2143.
- Tabb, K. M., Larrison, C. R., Choi, S. & Huang, H. (2016). *Disparities in health services use among multiracial American young adults*. Journal of Immigrant and Minority Health, 18(6): 1462-1469.
- Thoits, P. A. (2016). *"I'm not mentally ill": Identity deflection as a form of stigma resistance*. Journal of Health and Social Behavior, 25(2): 135-151.
- Turrini, A., Christofoli, D., Frosini, F. & Nasi, G. (2009). *Networking literature about determinants of network effectiveness*. Public Administration, 88(2): 528-550.
- Vandekinderen, C., Roets, G., Roose, R. & Van Hove, G. (2012). *Rediscovering recovery: Reconceptualizing underlying assumptions of citizenship and interrelated notions of care and support*. The Scientific World Journal, 2012: 1-7.
- Vandekinderen, C. & Roets, G. (2016). *The Posthuman always rings twice: Theorising the difference of impairment in the lives of people with "mental health problems"*. Disability & Society, 31(1): 33-46.
- Vardar, A., Kluge, U. & Penka, S. (2012). *How to express mental health problems: Turkish immigrants in Berlin compared to native Germans in Berlin and Turks in Istanbul*. European Psychiatry, 27: 50-55.
- Verhaeghe, P.-P., Van der Bracht, K. & Van de Putte, B. (2012). *Migrant zkt toekomst. Gent op een keerpunt tussen oude en nieuwe migratie*. Antwerpen: Garant.
- Wiebe, S. (2009). *Producing bodies and borders: A review of immigrant medical examinations in Canada*. Surveillance & Society, 6(2): 128-141.

ZorgnetVlaanderen (2011). *Goede zorg bij etnisch-culturele diversiteit*. Brussel: Zorgnet.

Chapter 4³¹

Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims

Elise Rondelez, Sarah Bracke, Griet Roets, Caroline Vandekinderen & Piet Bracke

Published online in Social Theory & Health (2018).

<https://doi.org/10.1057/s41285-018-0064-7>

Abstract

Despite indications that the mental health of diasporic Muslims is under pressure, some evidence suggests that they are under-represented in established mental healthcare services. Studies have indicated that, although diasporic migrants are at higher risk for mental health problems, they do not find their way to established mental healthcare services. This issue has been identified, conceptualised and approached from a variety of perspectives. Existing scholarship nevertheless provides no in-depth, dynamic understanding of what happens in the interactions between mental healthcare professionals and diasporic Muslims. In this contribution, we discuss and analyse the perspective of professionals providing mental healthcare services in Flanders (the Dutch-speaking part of Belgium). Based on snowball sampling, we conducted 31 in-depth qualitative interviews. We analysed our data according to a directed approach to content-analysis. Inspired by the work of Goffman, and with the objective of revisiting Goffman's theory on frames in the light of several theoretical sensibilities that inform our empirical material, we attempt to disentangle the frames that professionals use

³¹ British English

when approaching diasporic Muslims with mental health problems. We discuss the most prevalent frames and identify a biomedical, a resocialisation, and a cultural-difference frame.

Mental health, Diasporic Muslims, Mental health professionals, Frames, Goffman

Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims

1. Introduction

Although diasporic Muslims often experience mental health problems³² (see Buytaert et al., 2009; Chakraborty et al., 2010; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour; 2011), research demonstrates that they are under-represented in the established mental healthcare system³³ (Doornbos et al., 2013; Heinz & Kluge, 2012; Vardar et

³² First-generation migrants have a relative risk of 2.7, and second-generation migrants have a risk of 4.5, as compared to the native population (Buytaert et al., 2009). With regard to psychotic disorders, migrants from Morocco are at greater risk compared to the Dutch population, which has a relative risk of 4.5 (Buytaert et al., 2009; Hilderink et al., 2009). In Great Britain, migrants from other ethnic backgrounds have a relative risk ranging from 1.6 and 2.7 with regard to psychosis. As reported in a study conducted in one psychiatric emergency department in Brussels, psychosis is more prevalent amongst Moroccan men (40%) than it is amongst Belgian men (14%) (Buytaert et al., 2009). Migrants of Moroccan or Turkish descent are also more likely to experience generalised anxiety disorders or depression than native Belgians are (19.2% vs. 9.5% and 20.9% vs. 9.4%) (Buytaert et al., 2009; Hilderink et al., 2009). This pattern has not been observed amongst migrants from other European countries. In addition, non-European migrants might be more likely to have suicidal thoughts (12.9% vs. 1%). In the Netherlands, Turkish migrants of both sexes are more likely to experience such minor psychiatric disorders as anxiety, sleeping problems or somatisation, as compared to the general population (36.1% and 27.9% vs. 25%) (Buytaert et al., 2009).

³³ With regard to the under-representation of diasporic Muslims in the use of established mental healthcare services. In the Netherlands, 31.6 of every 1000 men of Moroccan background and 30.0 of every 1000 men of Turkish background make use of mental healthcare services, as compared to 33.0 of every 1000 native Dutch men (Hoffer, 2009). In Amsterdam, people of Turkish and Moroccan background are more likely to visit their general practitioners than they are to seek secondary healthcare. On average, 25% of the general population seeks secondary healthcare, as compared to only 21.1% of the Turkish population in Amsterdam. Moreover, general practitioners pay less attention to advising Turks and Moroccans on issues relating to mental healthcare, and they engage in fewer therapeutic conversations with them, as compared to their interactions with Dutch people. Almost 50% of the respondents in this research (Hilderink et al., 2009) expressed a belief that the likelihood of treatment dropout is higher when professionals lack the cultural expertise needed in order to cope with the cultural differences. Almost 75% of the respondents thought that mental healthcare is not sufficiently adapted to ethnic minorities, and a similar share referred to the numerous problems that

al., 2012; ZorgnetVlaanderen, 2011). Their under-representation has been identified and conceptualised from several distinct approaches. One approach involves examining epidemiological data in order to account for this under-representation, given the lack of records concerning the ethnic origins of clients in mental (and other) healthcare and social-welfare services (Kluge et al., 2012; Lodewyckx et al., 2005). A second approach involves investigating the prevalence of mental health problems within specific segments of the national population, with a focus on the unequal distribution of such problems (Siller et al., 2015; Vardar et al., 2012). A third approach frames under-representation as the result of institutional dynamics and implicit bias within mental healthcare institutions (Heinz & Kluge, 2012; Kluge et al., 2012; Rechel et al., 2013; Vardar et al., 2012). Yet another approach addresses such under-representation in relation to the socio-culturally constructed character of mental health problems, investigating the mental health problems that are specified within the DSM, the differences in explanatory models and the influence of structural and interlocking power relations (e.g. class, ethnicity/race, gender) on the ways in which mental health problems are understood (Bäärnhielm & Mösko, 2012; Crammond & Carey, 2016; Heinz & Kluge, 2012; Kapilashrami et al., 2015; Kluge et al., 2012; Vadar et al., 2012).

Although these approaches provide new insight into issues relating to under-representation, they only scratch the surface of another interesting dimension: the operation of interactions between diasporic Muslims and mental healthcare professionals (Buytaert et al., 2009; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour, 2011). This topic is interesting with regard to internal processes of subjectification (Rondelez et al., 2016), as well as in terms of the frames that shape these interactions. This article is grounded on empirical data acquired as part of a larger study on the under-representation of diasporic Muslims within mental healthcare services in Flanders (the Dutch-speaking part of Belgium; see Buytaert et al., 2009;

migrants face, as compared to the general population. If these problems are not addressed effectively, the likelihood of treatment dropout will be even higher. More than 50% of the professionals interviewed expressed the belief that shame, different expectations and a passive attitude among the diasporic Muslim population keeps them from seeking mental healthcare (Hilderink et al., 2009).

Fadil et al., 2014; Reniers, 1999; see Verhaeghe et al., 2012 for a specific account of the Belgian situation). We apply the term ‘diasporic’ as an analytical interpretive frame for the cultural, economic and political patterns of certain historically sensitive migrant genealogies, using it to examine migrancies across fields of social relations, subjectivity and identity (Brah, 1996). In the project, we focus on two inter-related questions: why do diasporic Muslims in Belgium experience problems accessing mental healthcare and, when they do access them, what is the nature of their contacts with mental healthcare professionals? In this article we explore these questions in relation to mental healthcare services, with specific attention to the types of frames used by the professionals who provide these services when interacting with diasporic Muslims. Cross-fertilisation of theoretical and empirical sources is a specific goal. As argued in a previous issue of *Social Theory & Health*, the adequacy and sense-making value of social theories may emerge from discussing professional rationales “in professionally organised mental health work [...] to make sense of the descriptions offered (Pilgrim & Carey, 2010: 315)”. In our theoretical reflection on and contestation of our empirical research insights, we draw upon the work of Erving Goffman (1956; 1961; 1974) as a highly relevant approach that dwells “more on the micro-social negotiation of lay and professional knowledge (Pilgrim & Carry, 2010: 318)”. We also consider alternative approaches to framing (see Pilgrim & Carey, 2010). Drawing particular inspiration from Butler’s (2009) treatment of framing, we revisit Goffman’s approach according to criticisms of his work, as well as in light of the novel context provided by contemporary predicaments in general, and by our data in particular. We aim to identify and theorise the frames used by mental healthcare professionals when approaching diasporic Muslims. Our particular focus on diasporic Muslims is due to their position at the interface between various materialistic lines of analysis (e.g. education, class), as well as along cultural-religious lines.

2. Framing mental health: An exploration of the work of Erving Goffman

Sociological interest in frames and framing inevitably leads to Erving Goffman (Pilgrim & Carry, 2010). His book *Frames of Analysis: An Essay on the Organization of Experience* (1974) has left a significant mark on the development of framing theory in various theoretical and disciplinary contexts since the 1970s (for an account of framing theory, see Borah, 2011). We rely on Goffman to craft our understanding of frames. According to Goffman (1974), frames are relational aspects of meaning, to express that what happens during social interactions as being governed by often unstated codes that are implicitly set by the nature of an invisible whole in which the interaction takes place. In the presence of ‘others’, individuals try to gather information that will allow them to define the situation and to know what to expect and what ‘others’ expect (Goffman, 1956). When individuals identify and produce discourses about specific events, this implies the emergence of primary frameworks that do not refer to any prior meaning and that assign meaning to something that is meaningless. Goffman (1974) argue that, within these primary frameworks, a distinction can be made between natural and social frames. In this contribution, we focus on social frames, which are composed of events involving the will, aim, and controlling effort of agency. The actions of agents subject them to social evaluation. The agent’s motive and intent are important this regard, as they help determine the social frames that will be applied (Goffman, 1974).

Goffman’s work also lays the groundwork for the sociological study of mental health. In another of his classics, *Asylums: Essays on the social situation of mental health patients and other inmates* (1961), he develops his theory of total institutions based on fieldwork in mental health institutions. He argues that, within such institutions, the ‘self’ is continuously exposed to the institution’s vision, potentially making it difficult to protect the ‘self’ against such influences (Goffman, 1961). Staff members attempt to gain a complete oversight over the life of inmates, Goffman (1961)

emphasises, using sanctioning to ensure that inmates will accept the rules and regulations of the institution uncritically.

Goffman subsequently discerns a variety of *views* – in this paper, ‘frames’ – that regulate life within the mental health institutions he studied. In our understanding, he was already assessing the efficacy of frames within mental health institutions, even though he would not use the term consistently or elaborate the concept of frames until later (see Goffman, 1974).

2.1. A biomedical frame

Goffman (1961) argues that mental health institutions consider mental health problems as disorders from a biomedical standpoint. From this perspective, the patient must passively undergo treatment by the expert (e.g. doctor, psychiatrist). According to Goffman (1961), the premises of a biomedical frame include disregarding of social circumstances and reducing diseases to biological processes. Goffman suggests that, when the social network around an individual perceives that something is abnormal about that individual, the client will be brought to a psychiatrist, who will collect information and observations, establish a diagnosis and suggest a course of treatment.

2.2. A resocialisation frame

As a general perspective on the function of the ward system, Goffman regards the institution as a system of resocialisation. Goffman (1961) describes resocialisation as the attempts of mental health institutions to influence the ‘self’-regulatory mechanisms of inmates, with the intention of ensuring that they will uphold some of the institution’s ideal standards after they have been released (Goffman, 1961). One example is the manner in which inmates are regarded as being responsible for their own recovery. One of Goffman’s central assertions is that individual inmates are thus assigned responsibility for their own behaviour. This underlying assumption overstates the ability and willingness of inmates to play the social game and neglects the point at which inmates will stand up against the resocialisation process (Goffman, 1961). “Typical infractions involved in messing up are: fights, drunkenness, attempted

suicide, failure at examinations, gambling, insubordination, homosexuality, improper leave-taking, and participation in collective riots (Goffman, 1961: 55-56)". Such actions are considered in terms of psychiatric relapse and framed as the personal responsibility of the inmates (Goffman 1961).

3. Re-conceptualising ‘frames’ for contemporary mental healthcare services

In this contribution, we explore how biomedical and resocialisation frames conceptualised by Goffman, when considered in a particular historical and social context, may continue to be relevant to the operations and services of contemporary mental health practitioners and services. Goffman (1961) developed his work as a sharp critique on the dominant policy of institutional segregation for people with mental health problems, implying that they were both physically and symbolically banned from the outside world. This took place at a time when policymakers and politicians were drawing inspiration from the rhetoric of deinstitutionalisation and community care as an alternative to institutionalised healthcare. (Rondelez et al., 2017). Although we are aware that the total institutions and institutional discourses in which Goffman developed his research no longer exist as such in the contemporary Western world (Bachrach, 1995a; 1995b; Pieters & Peuskens, 1995; Rissmiller & Rissmiller, 2006; Rondelez et al., 2017; Stein, 1995; Stockman, 2000; Traustadóttir & Kristiansen, 2004; Vandeurzen, 2010), we argue that his work remains relevant as a means of capturing the underlying professional rationales and frames used in micro-social interactions in contemporary mental healthcare services (Pilgrim & Carey, 2010). Applying them to this setting requires a critical treatment of Goffman’s conceptualisation of frames, however, in order to refine our understanding of frames and ensure its proper application to our own research. First, based on two inter-related critiques, we distance our arguments from a number of theoretical premises in which Goffman’s understanding of frames is embedded. We then justify our reconceptualization of ‘frames’ in the context of this article.

3.1. A totalitarian notion of power and an essentialist notion of the subject

Goffman seems to rely on a somewhat monolithic and totalitarian notion of power. He is convinced that the performances of individuals are constrained by organisational principles that govern their actions (Brickell, 2003). In general, we might say that Goffman describes the situation as follows: professionals use their power in a rational, cognitive manner, seemingly intent upon discrediting the potential agency of the inmates, who are treated as objects of intervention. For example, with reference to admission procedures, he argues that such practices “might better be called ‘trimming’ or ‘programming’ because in thus being squared away the new arrival allows himself to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations (Goffman, 1961: 25-26)”.

In his focus on the relatively negative side of power, Goffman seems to neglect the historical and social influences on the underlying assumptions of professional practice. Taking these aspects into account, it becomes conceivable that professionals might have good intentions in their efforts to cure and/or resocialise people with mental health problems. Even professional practices that might seem oppressive or as having negative consequences from a contemporary perspective might have been initiated with good intentions. We can identify the origins of notions of professional practice in the modern history of psychiatry, which began with the rise of asylums. The function of these institutions was focused on security, protecting the outside world from people with mental health problems, while protecting these individuals from the cruel and dangerous world outside (Barnes et al., 1999; Kristiansen, 2004; Rondelez et al., 2017; Stockman, 2000; Vandeurzen, 2010). The rise of scientific medicine led to new forms of social surveillance and discipline for people with mental health problems (Barnes et al., 1999). After the Second World War, more attention was devoted to the care, humanisation and rehabilitation of this population. The focus shifted towards the possibility that individuals with mental health problems could fully reintegrate as

citizens (Bachrach, 1995b; Stein, 1995; Stockman, 2000; Vandeurzen, 2010). All of this was contingent upon the ability of people with mental health problems to adjust to society in what could be called a process of normalisation. This view emerged from critiques of the institutions, as a symbol of human rights violations. This shift should be considered in a changing vision on citizenship: the aim is to extend welfare provisions and citizenship rights to the entire population (Bachrach, 1995a; Rondelez, et al., 2017; Stein, 1995; Traustadóttir & Kristiansen, 2004).

The counterculture of the 1960s, with its protests against political, sexual and racial injustices, was accompanied by the notable rise of anti-psychiatry. The earliest seeds of this movement can be identified in Goffman's *Asylums*: he describes psychiatric institutions as total institutions, in which the circumstances are as pathogenic as the individuals who are completely adapting to the system. From this perspective, personal reality is regarded as independent of hegemonic definitions of normality that, in this case, would be imposed by psychiatric, economic and cultural interests (Rissmiller & Rissmiller, 2006; Stockman, 2000).

Second, as argued by Stone (2005) and other authors (Allen, 1998; Brickell, 2003), Goffman maintains an essentialist notion of the subject, as adopting a notion of a rational 'self' that is formed by stable social arrangements (Goffman, 1961). Essentialism implies that invariable and fixed properties are attributable to human beings. More specifically, it refers to deterministic and fixed biological, psychological and social characteristics that may lead to hierarchical social-power dynamics within and between societies (Grosz, 1994). As construed in Western modernity (Appignanesi, 2008; Bracke & Fadil, 2008; Braidotti, 2006), this essentialist understanding of the subject, is devoid of physical, social and historical context (Sermijn, 2008).

3.2. Goffman revisited

Our critical engagement with Goffman's insights relies on post-structuralist and ethnomethodological approaches to questions of power and the formation of the subject. More specifically, it is based on a Foucaultian, contextualised and dynamic

understanding of power and disciplinary society (Allen, 1998; Brickell, 2003; Butler, 1993; 1997; Lawler, 2014; Stone, 2005). While Goffman suggests that individuals are relatively free of surveillance in the backstage realm, others have questioned this understanding of power and subjectivity. For example, West and Zimmerman (in Brickell, 2003) are convinced that we also ‘do gender’ with the virtual presence of ‘others’ in mind. Notably, Butler (1993; 1999) argues that power regulates the actions of ‘others’ and determines what can be regarded as knowledge.

In contrast to Goffman’s relatively essentialist notion of the human subject,³⁴ the human subject can be conceptualised as anti-essentialist and performative. As argued by Goffman, universal claims about essential properties pertaining to all human subjects are unreliable and oppressive to individuals “who fail to exhibit those characteristics that are supposedly ‘universal’ (Stone, 2005: 4)” (Brickell, 2003; Lawler, 2014; McNay, 2000). Lawler (2014) is another author who regards ‘identities’ as social and collective processes³⁵ and, hence, as a social product rather than an (essentialist) element of the individual. Lawler also asserts that focusing on identity troubles, which could be considered prevalent among people with mental health problems, tells more about what is considered the norm. According to Butler (1988), the subject is constituted by performative actions, and that the idea of an essentialised interiority is a public construction. Consequently, no identity exists prior to the act or attribute. This contradicts Goffman’s view that people play roles that express their interior ‘selves’. Analogous to Butler’s account of the performativity of gender, the

³⁴ Some authors (Brickell, 2003; Lawler, 2014) do not agree with this critique, being instead convinced that Goffman intended to say that essentialism was in the eye of the beholder – the other individuals in the interaction.

³⁵ Lawler (2014) further argues that Goffman conceptualised identity as a process that is done instead of something that is owned. The lack of consensus amongst the various critics is possibly due to the fact that Goffman names three kinds of identities: the personal identity, which consists of the unique characteristics of the actual person (this view may be understood as somewhat essentialist) and in terms of relationships; the social identity, which results from an individual’s affiliation with a social category; and the ego identity, which is an individual’s subjective sense of ‘self’. The latter aspects of identity can be seen as more consistent with a socially oriented conceptualisation of identity. Furthermore, Goffman’s totalitarian notion of power, paired with the idea that individuals can be free from power in the backstage realm is often accompanied by a more essentialist notion of the subject.

reality of mental health problems can be deemed performative; “it is real only to the extent that it is performed (Butler, 1997: 411)”. According to this performative requirement, mental health problems exist to the extent that corporeal activity is structured and performed in accordance with normative ideas concerning its meaning. This “makes norms ever vulnerable to reinterpretation, for corporeal activity always enacts norms in variable ways that alter their meanings (Stone, 2005: 4)”.

In this regard, such approaches allow examination of the performative power of frames and the ways in which subjectivity emerges through framing. In this vein, Butler’s notion of frames can be defined as ontological, epistemological and ethical relations of power that influence affective and ethical dispositions. Phenomena are thus both constituted and understood (Roets & Braidotti, 2012). At the same time, Butler acknowledges that the content of a frame always breaks out of the frame as it is most likely to be reproduced under different circumstances. According to this reasoning, what is assumed in one context may be incomprehensible in another. Butler (2009) underlines the importance of focusing on the content that shifts back and forth between the inside and the outside.

Building on Goffman, and inspired by Butler and other post-structural approaches, we conceptualise frames as interactive and co-constructed – as tools for interpreting relations and issues in social interactions. We do not see frames merely as cognitive representations, but also as socio-communicative and affective devices that exploit a common language, taking into account the social settings, institutions or communities of practice in which they are created. In this sense, “frames may be seen as socially produced structures for selecting, organizing, interpreting, and making sense of a complex reality to provide guidelines for knowing, analysing, persuading, and acting (Schön & Rein, in Ponzoni, 2016:46-47)”. In other words, frames are dynamic and changeable, rather than fixed.

4. Research methodology

4.1. Research context

We conducted a qualitative interpretative study (Denzin & Lincoln, 2013) with the objective of identifying frames in the field of mental healthcare in Ghent (a medium-sized city in the Flemish part of Belgium). In 2015, Muslims comprised 13.7% of the total population of Ghent. Of these, Moroccans comprised 1.4%, with 7.7% being of Turkish descent (Kruispuntbank Sociale Zekerheid, 2017, data for 2015). Most of these Muslims have friends or family who migrated to Belgium between 1964 and 1974 as labour migrants (Fadil et al., 2014; Verhaeghe et al., 2012). No clear data are available with regard to the number of diasporic Muslims receiving mental healthcare services. This is due to the limited research on this topic, as well as to the lack of any systematic registration of the origins of people with mental health problems who are receiving mental (or other) healthcare and social welfare services (Lodewyckx et al., 2005). There are nevertheless some indications of the Belgian situation. According to a study (Fossion et al., 2002) conducted in a Brussels psychiatric emergency department, Moroccan migrants of the second generation with mental health problems were less likely than Belgian people to go to the hospital voluntarily, but they were more likely to do so under pressure from their family (18% vs. 7% of Belgian patients) or the police (14% vs. 6%). Finally, as reported in another study conducted in the same facility (Fossion et al., 2004), diasporic Moroccans with mental health problems are apparently less likely to have been referred by a psychiatrist (45% vs. 57%).

4.2. Data-collection strategies

We recruited and selected local mental healthcare professionals based on their experiences with diasporic Muslims with mental health problems. The data were collected between November 2014 and August 2016. We interviewed social and cultural workers (9), psychiatric nurses (1), psychologists (13), psychiatrists (3) and general practitioners (5). Every participant was asked to suggest other interesting contacts for our study, thus allowing a snowball sample to unfold (Esterberg, 2002).

The participants included local actors in mental healthcare services and umbrella organisations in the context of mental health (and mental healthcare) (2), city services (2), community health centres (5), mental health services (1), group practices (5), private practices of general practitioners (2), psychiatrists (2) or psychologists (5), welfare organisations (3), general hospitals (2) and psychiatric hospitals (2). We chose the snowball method due to the large number of people and institutions who had initially refused to participate in our research. This was due in part to privacy issues associated with working with people with mental health problems. Other reasons for not participating included having no Muslim clients with mental health problems in their care and, finally, our explicit interest in mental healthcare professionals who have had experience working with diasporic Muslims. Such experience is rare, especially within the established mental healthcare sector. In other words, mental healthcare professionals treating Muslim clients with mental health problems can be regarded as a sort of hidden population. Snowball sampling was therefore a good method for our purposes (Billiet & Waeghe, 2006; Esterberg, 2002). This sampling method nevertheless has several disadvantages. In addressing some of these disadvantages, it is important to begin snowballs in different social locations – in our case, community health centres, established mental healthcare institutions, general practitioners, private psychiatrists, private psychologists and professionals in social welfare. Some of these points of entry yielded more participants than others did: private psychiatrists and psychologists and general practitioners were better represented in our sample than were professionals in large established institutions. The main reason that these institutions gave for refusing to participate was the fact that they served hardly any Muslims with mental health problems. In our sample, therefore, the participants might have been too similar to one another to provide the diverse perspectives that we sought to obtain. Of all participants, 25 had a more culturally sensitive perspective, and 6 had a more biomedical perspective. It is important to note that this may have resulted in bias, possibly distorting our conclusions (Esterberg, 2002).

We conducted qualitative semi-structured interviews that enabled us to identify the meanings that participants attached to their experiences with diasporic Muslims

(Esterberg, 2002). The interviews started with several general questions (e.g. What is your function within the organisation? Have you experienced any problems with diasporic Muslims receiving mental healthcare?). We subsequently followed up on those questions (e.g. If you have experienced problems with diasporic Muslims receiving mental healthcare, what were those problems? If you have not experienced such problems, what do you think might be the reason?). In all, we conducted 31 interviews, all with informed consent. The interviews were conducted either in the workplace or in the participant's home, where we could speak with the participant privately. In most cases, we conducted one interview per person. The interviews were conducted by the first author of this article in the context of a doctoral research project, assisted by a Master's student, who used the research as a thesis topic.³⁶ The duration of the interviews ranged from 46 minutes to two hours. They were all recorded and transcribed in full. Our sample included 10 men and 21 women, of whom 24 were ethnic Belgians, with 7 being of Turkish or Moroccan descent.

4.3. Strategies of data analysis

We chose to conduct a qualitative content analysis, understood as 'the subjective interpretation of the content of text data' (Hsieh & Shannon, 2005:1278). This form of analysis is intended to make sense of qualitative data and to identify its meanings and core consistencies. We opted for a directed approach to content analysis (Hsieh & Shannon, 2005). This approach is interesting for cases in which previous studies or theories are available that could benefit from a detailed analysis of empirical data with the aim of validating, refining, enriching or extending the theory. The existing theory could help in the process of refining the research question, formulating the initial coding scheme and discussing the results. As previously mentioned, we developed a conceptual elaboration of a post-structuralist reading of the theoretical perspectives of Goffman, with the goal of identifying dominant frames in the field of mental healthcare. The perspective developed through repeated readings of the transcripts of

³⁶ We are grateful to Audrey D.R. for her contribution to the data-collection process.

our data in the context of our particular conceptualisation of frames allowed us to identify the following frames: a biomedical frame, a resocialisation frame and a cultural difference frame. When we began coding, we highlighted every opinion that could express a frame used by professionals in their interactions with diasporic Muslims. The first two frames to be identified were inspired by the work of Goffman, although the second one has undergone a slight change in the direction of the rhetoric of recovery. Finally, the cultural difference frame is an additional frame revealed by our data analysis, and it was essential to making sense of the data. In the following section, we present our results by offering examples and descriptive evidence for each code/frame, as is customary in the application of a directed approach to content analysis.

5. Research findings

Although we discuss and illustrate each frame separately, we do so purely for analytical purposes. In reality, the frames interact. Some participants used multiple frames simultaneously.

5.1. A biomedical frame

The biomedical frame has changed since it was originally described by Goffman. At present, the scholarship on this frame consists of five propositions. We discuss the propositions that are most relevant to our research. The first is the doctrine of specificity, which holds that every disease can be explained by a biological cause (Engel, 1977; Wade & Halligan, 2004). The second proposition is that the body and the mind should be treated separately (Borrell-Carrió et al., 2004; Engel, 1977; 1980; Wade & Halligan, 2004). The final proposition is the implied reductionism that ignores socio-psychological explanations (Borrell-Carrió et al., 2004; Engel, 1977; 1980; Wade & Halligan, 2004). The biomedical frame has been the subject of criticism. One criticism is that this frame disregards socio-economic influences on diseases (Borrell-Carrió et al., 2004; Engel, 1977). Another criticism concerns the manner in which patients are treated as passive objects (Borrell-Carrió et al., 2004; Engel, 1977; 1980;

Wade & Halligan, 2004). These criticisms could be linked to the more performative post-structuralist subject notion. In its current propositions, including the additional critiques, the biomedical frame has been mentioned in several interviews with mental healthcare professionals. For example, some of these professionals assume that diasporic Muslims have more psychosomatic complaints than Western clients do, as ‘they’ lack awareness of problems relating to the mind, instead attributing any mental health problems ‘they’ might have as being of a physical nature. This could explain why ‘they’ are more likely to consult their general practitioners or general hospitals than ‘they’ are to approach psychologists or other mental healthcare professionals:

Psychosomatisation has a negative undertone (...) But eventually that is ‘their’ expression of psychological complaints, and the reason why a lot of patients go to the general practitioner with complaints. (interview 7, psychologist, community health centre)

Especially medication. ‘They’ think in a very biomedical manner [...] ‘We’ have conversations with ‘them’, but ‘their’ reasoning often takes the form of, ‘the doctor will give me a pill so that my complaints will pass. (interview 24, psychiatric nurse, general hospital)

The following quotation also invokes some characteristic propositions of the biomedical model:

‘They’ often interpret physical complaints in terms of, ‘I am doing something wrong according to my religion’. I remember one Moroccan woman who was experiencing constant stomach pain. She went to the gynaecologist, but there was nothing to find. We performed every possible examination, when she came to me and told me that she had a child with a man with whom she was living. [...] But she was not married to that Moroccan man here. She had a constant feeling that she was living in sin, and this was translated into her complaints. (interview 22, general practitioner, group practice)

The professional's initial search for a biological cause might reflect some degree of reductionism, possibly rooted in the perceived need to treat the body and mind separately. The quotation presented above refers to the biomedical proposition that the woman is suffering from a disease that should be treated rather than appealing to her agency, meaning-making and psycho-social well-being. It is not until the woman discloses the nature of her problems that the professional's repertoire of interpretation evolves in a manner that is more culturally sensitive than biomedical. This illustrates how the dominant biomedical frame is repeated but, in situations where it seems insufficient, there is room for agency, which is subsequently reconciled in terms of religion.

5.2. A resocialisation frame

The idea of resocialisation has changed since it was initially described by Goffman. At present, this frame is largely reflected and revised within the currently popular recovery paradigm (Edgley et al., 2012; Pelters & Wijma, 2016). In this view, 'recovery' is defined as "enabling people with mental health problems to "regain control over their lives, and (...) be responsible for their own individual journey of recovery" (Deegan in Vandekinderen et al., 2012: 2)."

This shift can also be explained by the idea that regulatory schemes are historically transformable. In this case, it also refers to the fact that mental health problems exist only when corporeal activity is performed according to normative ideas. Such norms are thus highly vulnerable to reinterpretation, as they are enacted in different ways that can alter their interpretations. In the following quotations, the mental healthcare practitioner refers to the importance of individual responsibility as a central aspect of recovery:

Because it also involves the activation of people and taking responsibility. This is something that 'we' consider very important. [...] So 'we' do a lot to enable clients to come to 'us', although some responsibility does remain with the client. In longer processes with people, you work towards

this responsibility as a goal, because those attitudes are also needed in society. (interview 5, psychologist, city service)

'They' expect that 'they' will change by taking a pill, without doing anything 'themselves'. We observe it often with foreigners: the moment you start speaking about the willingness to change or when you let 'them' work 'themselves', 'they' drop out. (interview 16, psychiatrist, general hospital and private practice)

In some cases, the focus on responsibility and activation appears to be more important than the mental health of the clients. This is clearly illustrated in the following quotations, in which the psychologist interprets the behaviour of some diasporic Muslims with mental health problems as attempts to avoid their own responsibility.

I find it very remarkable that people are asking for a more directive kind of therapy, in which you say what 'they' have to do. But I don't have the answers. (interview 14, psychologist, private practice)

'Yes, we are sick. Hence, it is not our fault.' And pills, yes medication. A doctor, someone external, who says 'It's not your fault'. [...] I think that, for a lot of 'them', it feels safe. Maybe this is also more acceptable, because otherwise, it would be your fault. (interview 17, psychologist, group practice)

Most participants expect diasporic Muslims to prove that 'they' can be good citizens by curing 'themselves'. Agency appears to be an important value in the frames adopted by the professionals.

Other participants question the recovery frame. In the following quotation, the participant addresses the conditionality that is at stake in the recovery frame, as recovery seems to imply that people with mental health problems are motivated and assume responsibility for 'their' own individual journey of recovery; if 'they' do not accept this, 'they' no longer deserve mental healthcare. In this case, the participant is sharply critical of the expectation that the patient must speak Dutch.

They are installing such barriers in their organisation. They start by saying on the phone 'yes, but she will not get there, her language skills are not good enough; it won't go as smoothly as it should. We cannot accept that person'. (interview 9, social cultural worker, city service)

5.3. A frame of cultural difference

A third frame that mental health professionals use in their work with diasporic Muslims is that of cultural difference. This frame refers back to the fact that regulatory schemes are dependent upon history and context. Given its influence on modern Western societies, migration also affects the manner in which frames or regulatory schemes are applied in the field of mental healthcare. In this case it generates a frame of cultural difference. According to our participants, one important reason that diasporic Muslims fail to access established mental healthcare institutions is the cultural disparity existing between clients and counsellors. Some participants construct cultural differences as an indicator of a progressive, independent 'we', as opposed to a religious, dependent 'they'. The participants admitted that, for this reason, they would rather refer diasporic Muslim clients to diasporic Muslim counsellors. Another reason that our participants suggested for why diasporic Muslims fail to access mental healthcare services involves the pressure from within their communities, in which solving one's own problems is believed to be a religious obligation, with asking for care and support remaining a taboo.

Experience has shown that people from 'their' culture view mental health problems in a different way, and that 'they' try to solve these problems within the family as long as possible, until it is no longer sustainable. (interview 31, social cultural worker, psychiatric hospital)

Another reason has to do with the spiritual healing practices existing within these communities. Our participants referred to magical frames that are embedded within the religious views of diasporic Muslims.

*Yes, the Koran is more important for 'them' than the advice of the doctor.
(interview 11, general practitioner, community health centre)*

In this case as well, we observe that it is the professionals who define what is to be considered intelligible. Expertise and methods of dealing with mental health problems of diasporic Muslim clients are often dismissed.

Some mental healthcare professionals do believe that the biomedical and magical frames could complement each other:

*Not many people say that, but a few do assert that the two can exist
alongside each other. (interview 19, psychologist, private practice)*

Ignorance of socio-cultural influences on the perception of mental health problems has indeed been a subject of criticism.

*If a Muslim comes here and says, 'I have contact with ghosts', but that
person can interact with me, (...) (c)an 'we' then consider that person
pathologically ill? I don't know. According to 'our' Western thinking, this
person would probably be seen as someone who is psychotic. (interview
23, psychologist, welfare organisation)*

In contrast, other participants acknowledged that they raise barriers for diasporic Muslims, focusing excessively on their own norms and values instead of embracing the perceptions and interests of their prospective clients. In this case, professionals become aware of their own power relative to that of people with mental health problems. Although this demands far more time and effort, some participants stressed the importance of working in a culturally-sensitive and creative way.

*The trick is thus to find entrances in which you can be sensitive in
embracing sensitivities. (...) 'We' just cannot copy and paste what we are
doing. It requires a bit more skill. (interview 2, social cultural worker,
umbrella organisation)*

6. Conclusion

Studies on the under-representation of diasporic Muslims in mental healthcare institutions (in Belgium) lack an in-depth and dynamic understanding of what happens in the interactions between mental healthcare professionals and diasporic Muslims. For this reason, this article explores one dimension of such interactions: the ways in which mental healthcare professionals experience such interactions and the frames they use when approaching diasporic Muslims. Inspired by Goffman, we have elaborated a more post-structuralist approach based on his work. This approach allows us to conceptualise frames as both cognitive and affective devices, while taking into account the complex social contexts in which they are created, and providing guidelines for knowing, analysing, persuading and acting. Our objective was to revisit and actualise Goffman's conceptualisation of frames by considering some of the criticisms of his notion of frames, particularly an adapted notion of power and the subject. We have identified and discussed three prevalent frames in the narratives of our participants: a biomedical frame, a resocialisation or recovery frame, and a frame relating to cultural difference. The first two frames were also identified by Goffman. Changes in these frames and the emergence of the third frame have led to the identification of several characteristics of theories by other scholars. We assume that the changes are the result of revisions to the regulatory schemes, which we have conceptualised as historically transformable. The frames reveal that mental healthcare practitioners – who can be seen as a dominant group – play an important role in conceptualising the knowledge surrounding mental health. In contrast to Goffman, however, our quotations also indicate that the notion of power is more dynamic than it is totalitarian. Finally, our analysis shows that the agency of diasporic Muslims deserves more attention; we regard this as an important development.

Professionals who primarily rely on a biomedical frame to make sense of their work with diasporic Muslims assume that these clients lack awareness of problems relating the mind, assuming instead that any mental health problems they might have are of a physical nature. In the resocialisation frame, the responsibility to recover is

imposed people with mental health problems. The problem is rooted in the fact that the recovery frame does not correspond to the frame (or frames) of diasporic Muslims. As mentioned, the distinction between these frames is purely for analytical purposes. Our empirical data indicate that the frames occur in concert and interact with each other.

We are aware that our results may also be applicable to other groups in society, (e.g. people in poverty and people with less education). We chose to focus on diasporic Muslims, however, as we consider them to be situated at the intersection of all of these different lines of analysis. For example, research (Lay et al., 2006; Lorant et al., 2007; Nieuwenhuijsen et al., 2015) shows that diasporic Muslims are more likely to live in poverty and have lower levels of education. Once these intersections have been disentangled, our results might also be applicable to these and other groups as well. Furthermore, diasporic Muslims are also situated at the intersection of culture and religion. This is in addition to other intersections that tend to be more materialistic in nature. The selected organisations and individuals may disproportionately represent the more culturally sensitive organisations and individuals rather than biomedically-oriented actors. Although our data were gathered from a broad selection of participants, the response rate was low, due to the scarcity of professionals who have had experience with diasporic Muslims with mental health problems. Professionals in the biomedically oriented context of the established mental healthcare system are most likely to lack such experience – they were simply unable to provide us with any information. This indicates the restrictive aspect of our selection. It would be interesting to develop additional studies involving professionals from the biomedical side of the spectrum and to explore whether such an orientation would alter our findings, thus bringing new frames to the foreground. In the study reported in this article, we have chosen to focus on the perspectives of mental health professionals. There is nevertheless a clear necessity to develop research that focusing on the perspectives of the diasporic Muslims with mental health problems, along with the frames that they use in their interactions with the mental healthcare establishment.

References

- Allen, A. (1998). *Power Trouble: Peformativity as Critical Theory*. *Constellations*, 5(4): 456-471.
- Appignanesi, L. (2008). *Gek, slecht en droevig. Een geschiedenis van vrouwen in de psychiatrie van 1800 tot heden*. Amsterdam: De bezige bij.
- Bäärnhielm, S. & Mösko, M. (2012). *Cross-cultural Training in Mental Health Care – Challenges and Experiences from Sweden and Germany*. *European Psychiatry*, 27: 70-75.
- Bachrach, L. (1995a). Aspecten van deinstitutionalisering. In: G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapspsychiatrie*. Leuven: Garant.
- Bachrach, L. (1995b). Psychosociale rehabilitatie en psychiatrische begeleiding in de zorg voor chronische patiënten. In: G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapspsychiatrie*. Leuven: Garant.
- Barnes, C., Mercer, G. & Shakespeare, T. (1999). *Exploring Disability. A Sociological Introduction*. Cambridge: Polity Press.
- Billiet, J. and Waege, H. (2006). *Een samenleving onderzocht. Methoden van sociaal-wetenschappelijk onderzoek*. Antwerpen: De Boeck.
- Borah, P. (2011). *Conceptual Issues in Framing Theory: A Systematic Examination of a Decade's Literature*. *Journal of Communication*, 61: 246-263.
- Borrell-Carrió, F., Suchman, A.L. & Epstein, R.M. (2004). *The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry*. *Annals of Family Medicine*, 2(6): 576-582.
- Bracke, S. & Fadil, N. (2008). *Islam and Secular Modernity under Western Eyes. A Genealogy of a Constitutive Relationship*. San Domenico di Fiesole: European University Institute.
- Brah, A. (1996). *Cartographies of diaspora. Contesting identities*. London: Routledge.
- Braidotti, R. (2006). *Transpositions: On Nomadic Ethics*. Cambridge: Polity Press.

- Brickell, C. (2003). *Performativity or Performance? Clarifications in the Sociology of Gender*. *New Zealand Sociology*, 18(2): 158-178.
- Butler, J. (1988). *Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory*. *Theatre Journal*, 40(4): 519-531.
- Butler, J. (1993). *Bodies that Matter: On the Discursive Limits of Sex*. London: Routledge.
- Butler, J. (1997). *Excitable Speech: A Politics of the Performative*. London: Routledge.
- Butler, J. (1999). *Gender Trouble: Feminism and the Subversion of Identity*. London: Routledge.
- Butler, J. (2009). *Frames of War. When is Life Grievable?* Brooklyn: Verso.
- Buytaert, E., Vandedrincq, E. & Lemmens, G. M. D. (2009). *Psychiatrische stoornissen bij migranten: feiten en hypothesen*. *Tijdschrift voor Geneeskunde*, 65: 1-8.
- Chakraborty, A. T., McKenzie, K. J., Hajat, S. & Stansfeld, S. A. (2010). *Racism, Mental Illness and Social Support in the UK*. *Social Psychiatry and Psychiatric Epidemiology*, 45: 1115-24.
- Crammond, B.R. & Carey, G. (2016). *What do we mean by 'structure' when we talk about structural influences on the social determinants of health inequalities?* *Social Theory & Health*, doi: 10.1057/s41285-016-0020-3.
- Denzin, N.K. & Lincoln, Y.S. (2013). *Collecting and interpreting qualitative materials*. Los Angeles: Sage.
- Doornbos, M. M., Zandee, G. L., Degroot, J. & Warpinski, M. (2013). *Desired Mental Health Resources for Urban, Ethnically Diverse, Impoverished Women Struggling with Anxiety and Depression*. *Qualitative health research*, 23: 78-92.
- Edgley, A., Stickley, T., Wright, N. & Repper, J. (2012). *The politics of recovery in mental health: A left libertarian policy analysis*. *Social Theory & Health*, 10(2): 121-140.
- Engel, G.L. (1977). *The Need for a New Medical Model: A Challenge for Biomedicine*. *Science*, 196(4286): 129-136.

- Engel, G.L. (1980). *The Clinical Application of the Biopsychosocial Model*. The American Journal of Psychiatry, 137(5): 535-544.
- Esterberg, K.G. (2002). *Qualitative Methods in Social Research*. Boston: McGraw-Hill.
- Fadil, N., Asri, F. E. & Bracke, S. (2014). Islam in Belgium. Mapping an Emerging Interdisciplinary Field of Study. In J., Cesari (ed.) *The Oxford Handbook for European Islam*. Oxford: Oxford University Press.
- Fossion, P., Ledoux, Y., Valente, F., Servais, L., Staner, L., Pelc, I. & Minner, P. (2002). *Psychiatric disorders and social characteristics among second-generation Moroccan migrants in Belgium: An age- and gender-controlled study conducted in a psychiatric emergency department*. European Psychiatry, 17: 443-450.
- Fossion, P., Servais, L. Rejas, M.-C., Ledoux, Y., Pelc, I. & Minner, P. (2004). *Psychosis, migration and social environment: an age-and-gender controlled study*. European Psychiatry, 19: 338-343.
- Goffman, E. (1956). *The Presentation of Self in Everyday Life*. Edinburgh: University of Edinburgh Social Science Research Centre.
- Goffman, E. (1961). *Asylums. Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.
- Goffman, E. (1974). *Frames of analysis. An essay on the organization of experience*. Boston: Northeastern University Press.
- Grosz, E. (1994). *Volatile bodies: Towards a corporeal subjectivity*. Bloomington, IN: Indiana University Press.
- Heinz, A. & Kluge, U. (2012). *Editorial. Mental Health in Different Groups of Migrants and Ethnic Minority Within Europe and Beyond: Regional and Cross-national Challenges and Approaches in Research, Practice and Training*. European Psychiatry, 27: 1-3.
- Hilderink, I., Van 't Land, H. & Smits, C. (2009). *Drop-out onder allochtone GGZ-cliënten. Zicht op de onderliggende factoren en aanbevelingen om drop-out te verminderen*. Utrecht: Trimbos-instituut.

- Hoffer, C. (2009). *Psychische ziekten en problemen onder allochtonen Nederlanders: beleving en hulpzoekgedrag*. Assen: Van Gorcum.
- Hsieh, H.F. & Shannon, S.E. (2005). *Three Approaches to Qualitative Content Analysis*. *Qualitative Health Research*, 15(9): 1277-1288.
- Inhorn, M. C. & Serour, G. I. (2011). *Islam, Medicine, and Arab-Muslim Refugee Health in America After 9/11*. *The Lancet*, 378: 935-943.
- Kapilashrami, A., Hill, S. & Meer, N. (2015). *What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach*. *Social Theory & Health*, 13 (3/4): 288-307.
- Kluge, U., Bogic, M., Deville, W., Greacen, T., Dauvrin, M., Dias, S., Gaddini, A., Koitzsch Jensen, N., Ioannidi-Kapolou, E., Mertaniemi, R., Pucipinos, I., Riera, R., Sandhu, S., Saravry, A., Soares, J.J.F, Stankunas, M., Straßmayr, C., Weibel, M., Heinz, A. & Priebe, S. (2012). *Health Services and the Treatment of Immigrants: Data on Service Use, Interpreting Services and Immigrant Staff Members in Services Across Europe*. *European Psychiatry*, 27: 56-62.
- Kristiansen, K. (2004). Madness, badness, and sadness revisited: Ontology control in 'mental health land'. In: K. Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Kruispuntbank Sociale Zekerheid (2017). *Aantal personen van buitenlandse herkomst 2015 – Gent*. <https://gent.buurtmonitor.be/>, accessed 15 September 2017.
- Lawler, S. (2014). *Identity. Sociological Perspectives. Second edition*. Cambridge: Polity Press.
- Lay, B., Laubner, C., Nordt, C. & Rössler, W. (2006). *Patterns of inpatient care for immigrants in Switzerland: A case control study*. *Social Psychiatry & Psychiatric Epidemiology*, 41: 199-207.
- Lodewyckx, I., Janssens, A., Ysabie, P. & Timmerman, C. (2005). *Allochtone en autochtone jongeren met psychische problemen en gedragsproblemen: Verschillende trajecten naar de hulpverlening?*, Drukkerij Peten.

- Lorant, V., Depuydt, C., Gillain, B., Guillet, A. & Dubois, V. (2007). *Involuntary commitment in psychiatric care: what drives the decision?* Soc Psychiatry Psychiatr Epidemiol, 42: 360-365.
- McNay, L. (2000). *Gender and Agency. Reconfiguring the Subject in Feminist and Social Theory*. Cambridge: Polity Press.
- Niewenhuijsen, K., Schene, A.H., Stronks, K., Snijder, M.B., Frings-Dresen, M.H.W. & Sluiter, J.K. (2015). *Do unfavourable working conditions explain mental health inequalities between ethnic groups?; cross-sectional data of the HELIUS study*. BMC Public Health, 805: DOI 10.1186/s12889-015-2107-5.
- Pelters, B. & Wijma, B. (2016). *Neither a sinner nor a saint: Health as a present-day religion in the age of healthism*. Social Theory & Health, 14 (1): 129-148.
- Pieters, G. & Peuskens, J. (1995). Inleiding: Gemeenschapspsychiatrie en rehabilitatie. In G. Pieters & J. Peuskens (Eds.) *Rehabilitatie van de Chronische Psychiatrische Patiënt*. Leuven: Garant.
- Pilgrim, D. & Carey, T. A. (2010). *Contested professional rationales for the assessment of mental health problems: Can social theories help?* Social Theory & Health, 8: 309-325.
- Ponzoni, E. (2016). *Reframing Cooperation: Challenges in Overcoming Tensions between Professional Services and Volunteer Organizations Providing Parenting Support in Immigrant Communities*. Social Service Review, 89(1): 40-76.
- Rechel, B., Mladovsky, P., Ingleby, D., MacKenbach, J.P. & MCKee, M. (2013). *Health in Europe 5: Migration and Health in an Increasingly Diverse Europe*. The Lancet, 381: 1235-1245.
- Reniers, G. (1999) *On the History and Selectivity of Turkish and Moroccan Migration to Belgium*. International Migration, 37: 679-713.
- Rissmiller, D.J. & Rissmiller, J.H. (2006). *Evolution of the Antipsychiatry Movement Into Mental Health Consumerism*. Psychiatric Services, 57: 863-866.
- Roets, G. & Braidotti, R. (2012). Nomadology and Subjectivity: Deleuze, Guattari and Critical Disability Studies. (pp. 161-178). In D., Goodley, B., Hughes & L., Davis

- (eds.) *Disability and Social Theory. New Developments and Directions*. Basingstoke: Palgrave Macmillan.
- Rondelez, E., Bracke, S., Roets, G. & Bracke, P. (2016). *Racism, migration, and mental health. Theoretical reflections from Belgium*. *Subjectivity*, 9(3): 313-332.
- Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P. (2017). *Diasporic Muslims, Mental Health, and Subjectivity: Perspectives and Experiences of Mental Healthcare Professionals in Ghent*. *DiGeSt*, 4(1): 63-84.
- Sermijn, J. (2008). *Ik in veelvoud. Een zoektocht naar de relatie tussen mens en psychiatrische diagnose*. Leuven: Acco.
- Siller, H., Renner, W. & Juen, B. (2015). *Turkish Migrant Women with Recurrent Depression: Results from Community-based Self-help Groups*. *Behavioral Medicine*, DOI: 10.1080/08964289.2015.1111858.
- Stein, L. (1995). *Systeemaanpak van ernstig zieke chronische psychiatrische patiënten*. In: G. Pieters and J. Peuskens, *Rehabilitatie van de Chronische Psychiatrische Patiënt: Op weg naar een gemeenschapspsychiatrie*. Leuven: Garant.
- Stockman, R. (2000). *Van nar tot patiënt. Een geschiedenis van de zorg voor geesteszieken*. Leuven: Davidsfonds.
- Stone, A. (2005). *Towards a genealogical feminism: A reading of Judith Butler's political thought*. *Contemporary Political Theory*, 4: 4-24.
- Traustadóttir, R. & Kristiansen, K. (2004). *Introducing gender and disability*. In: K. Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Vandekinderen, C. & Roets, G. (2016). *The post(hu)man always rings twice: Theorising the difference of impairment in the lives of people with 'mental health problems'*. *Disability & Society*, 31(1): 33-46.
- Vandeurzen, J. (2010). *Beleidsplan Geestelijke gezondheidszorg Vlaanderen*. Brussel: Vlaamse regering.
- Vardar, A., Kluge, U. & Penka, S. (2012). *How to Express Mental Health Problems: Turkish Immigrants in Berlin Compared to Native Germans in Berlin and Turks in Istanbul*. *European Psychiatry*, 27: 50-55.

- Verhaeghe, P.-P., Van der Bracht, K. & Van de Putte, B. (2012). *Migrant zkt toekomst. Gent op een keerpunt tussen oude en nieuwe migratie*. Antwerpen: Garant.
- Wade, T.D. & Halligan, P.W. (2004). *Do Biomedical Models of Illness Make for Good Healthcare Systems?* *BMJ*, 329: 1398-1401.
- Zorgnetvlaanderen (2011). *Goede zorg bij etnisch-culturele diversiteit*. Brussel: Zorgnet.

Chapter 5³⁷

“But that is a cultural given.”: Diasporic Muslims, mental healthcare professionals and the cultural- difference frame

Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P.

Submitting to Ethnography

Abstract

Studies on various theoretical, methodological and empirical backgrounds have indicated that diasporic Muslims are under-represented in established mental healthcare services. The literature nevertheless offers no in-depth and dynamic understanding of what takes place in the interactions between mental healthcare professionals and diasporic Muslims. In this article, we discuss how professionals frame culture and cultural difference within these interactions. Our research methodology entails a snowball sample that resulted in 31 qualitative in-depth interviews with professionals, which were analysed according to a directed approach to content analysis. Our research findings reveal three different tropes concerning how cultural difference is framed as being linked with different conceptualisations of culture: pressure from the community, with culture as a set of norms and values; spiritual healing, with culture as a way of life; and psychosomatisation, with culture as schemes of interpretation.

³⁷ British English

“But that is a cultural given.”: Diasporic Muslims, mental healthcare professionals and the cultural-difference frame

1. Introduction

The pressure from the family, the taboo on asking for help. ... But that is a cultural given, which has nothing to do with discrimination, exclusion. [...] I think that is an important aspect, which makes ... access to mental healthcare more difficult. (Interview 1, social cultural worker, community health centre)

Medical encounters within the mental healthcare system are informed by cultural assumptions. In this article, we explore such cultural assumptions in the case of diasporic Muslims in Belgium, and more particularly in mental healthcare services in the city of Ghent. In Belgium, most Muslims are of Turkish or Moroccan background. In 2015, Muslims comprised 13.7% of the total population of Ghent, with Moroccan Muslims accounting for 1.4% and Turkish Muslims accounting for 7.7% (Kruispuntbank Sociale Zekerheid, 2017). We apply the term ‘diasporic Muslims’ in order to capture the cultural, economic and political patterns of historically particular ‘genealogies’ of migrancy, using it to examine the relationships between various migrancies across fields of social relations, subjectivity and identity. The concept of diaspora also stands in opposition to discourses of fixed origins. Diasporas often consist of a variety of journeys to different parts of the world. The notion of diaspora focuses on formations of power that distinguish diasporas internally, while situating them in relation to each other. The identity of the imagined diasporic community is thus not specified in advance (Brah, 1996).

When diasporic Muslims with mental health problems seek appropriate healthcare services, they often encounter assumptions held by mental healthcare

professionals (as illustrated in the quotation at the beginning of this article). Professionals tend to *know* that diasporic Muslims struggling with mental health issues must cope with family pressure and a taboo on seeking help outside of the community *in ways that are significantly different from the majority of the population in Belgium*.

In this article, we address such assumptions (including with regard to ethnicity, religion or gender), approaching them in terms of ‘frames’. We are also interested in issues concerning the accessibility (or inaccessibility) of mental healthcare, motivated by the observation that diasporic Muslims are significantly under-represented in public mental healthcare services. Our current research project investigates why this is the case (Rondelez et al., 2016; Rondelez et al., 2017; Rondelez et al., 2018).³⁸

Such under-representation (Rondelez et al., 2018) can be approached in several different ways. The approach that we adopt recognises that the manner in which mental healthcare is organized is accompanied by its own processes of subjectification (Rondelez et al., 2016; Rondelez et al., 2017). Such processes shape ‘human subjects’ with mental health problems. Drawing upon the work of Goffman (1956; 1961; 1974) and the subsequent framing theory that it inspired, our study approaches the assumptions that play a role in these processes of subjectification in terms of ‘frames’. Our results identify ‘cultural difference’ as a particularly salient frame that mental healthcare professionals use in order to make sense of Muslim clients in general, and the under-representation of diasporic Muslims in particular (Rondelez et al., 2018). We further unpack this cultural-difference frame and examine how and when it is used. After presenting a number of methodological details concerning our study, we discern various meanings and usages of ‘culture’, followed by a discussion of the different tropes concerning cultural difference that were revealed in our empirical material.

³⁸ The title of the project is *Identity constructions at the intersection of mental health, religion, ethnicity and gender in Belgium*. It is funded by the Research Foundation Flanders. The aim of this research project is to generate additional insight into the accessibility (or inaccessibility) of mental healthcare services for diasporic Muslim migrants with mental health problems in Flanders (the Dutch speaking part of Belgium).

2. Research methodology

In this qualitative interpretive study (Denzin & Lincoln, 2013), we created an overview of the ways in which the under-representation of diasporic Muslims in established mental healthcare services is constructed and given meaning in the field of mental healthcare in Ghent. In this process, we identified several frames that professionals use in their contacts with diasporic Muslims with mental health problems. We recruited the research participants through snowball sampling (Esterberg, 2002), given the scarcity of professionals with such experience. This group can thus be regarded as a hidden population. After obtaining informed consent, we conducted 31 qualitative semi-structured interviews, which were transcribed in full (Esterberg, 2002). The data were collected between November 2014 and August 2016. We analysed our data using a directed approach to content analysis (Hsieh & Shannon, 2005). This approach is considered interesting for research contexts in which earlier theory is available that might benefit from validation, refinement, enrichment or extension. Our analysis proceeded from a circle of inductive and deductive movements.

First, it is important to note that we did not ask our participants directly about the signifier of culture. As an inductive finding, the responses of the professionals reflected a variety of notions about culture. They expressed these notions within the context of the under-representation of diasporic Muslims in mental healthcare services, the ways in which they express their symptoms, their focus on gender relationships within the diasporic communities³⁹ and the fact that they sometimes use culture as a motivation.

Second, as mentioned in the introduction, we were inspired by a conceptualisation of frames as socially produced structures for “selecting, organizing, interpreting, and making sense of a complex reality to provide guidelines for knowing, analysing, persuading, and acting (Schön & Rein in Ponzoni, 2016: 46-47)”. We applied this

³⁹ This can be linked to an Orientalist mechanism that presents the Orient as ‘dangerous’ or ‘fascinating’ and thus as something that requires constant supervision. Presented in this manner, with its unrestrained sexual liberties, exoticism and the occult, Eastern society was regarded as a threat to the expanding Western sexual morale and rationality (Said, 2005; Turner, 2011).

notion of frames to the analysis of ways in which mental healthcare professionals frame cultural difference, as well as to the development of the coding scheme, based on rich empirical research insights. In the initial phase of coding, we highlighted every opinion that expressed a reference to culture by professionals. We then applied the various notions of culture to these quotations.

3. Culture: What's in a name?

What do we mean by 'culture'? Laermans distinguishes two major sociological approaches to culture: mentalist and symbolic (Laermans, 1999). Within a mentalist approach, culture can be regarded as a compulsory, collective unconsciousness (Albrecht, 2003). In other words, culture revolves around shared representations, which are shaped according to interdependent binary classifications, representing a group's social relationships (Barnes et al., 1999). In the mentalist understanding, culture is thus often regarded in terms of *norms and values*. Such an understanding of culture is reflected in the quotation at the beginning of this article, in which the importance attached to family, and the effects of taboo stand for a collective unconscious and shared representations of diasporic Muslims in Belgium, thereby serving as a foundation for cultural differences. Another participant spoke of psychiatric diagnoses as being more aligned with the 'values' of Belgian society, in implicit contrast to the 'values' of diasporic Muslims. Although she found it interesting, this participant noted that she preferred to avoid an excessive focus on culture. In contrast, another participant focused on 'norms and values' that were assumed to be typical of Turkish and Moroccan culture, which she qualified as 'cultures of shame'. The interviews revealed many other values, with some participants drawing attention to the importance of community within Turkish culture, as well as to the related habit of gossiping.

Turkish culture is more a community culture. Collectivistic, a culture of gossiping. [...] Maybe we believe that that is problematic, but maybe it is perfectly normal in that culture. (Interview 7, psychologist, community health centre)

In other interviews, the value of community was more linked to the attribution of responsibility to other people – in this case, mental healthcare professionals (Rondelez, et al., 2018). According to the following participant, this might help Belgian mental healthcare professionals consider their own dominant cultural values:

And that is also such a principle: people need to take their responsibility for their own suffering. Within a collectivist culture, however, that is difficult to grasp. We are inclined to think that they want us to solve their problems, but that is a reflection on our own values and norms (Interview 23, psychologist, welfare organisation)

It should be noted that not all of our participants made such blunt and sometimes absolute distinctions between the ‘norms and values’ of the established mental healthcare system and those of diasporic Muslims. For example, some participants insisted that Turkish people are capable of adopting Western norms and values, or that they might hold the same norms and values as ‘we’ do:

At some point, we offered help to a man and his mother. We observed that he did nothing but give orders. [...] But we thought that it had to do with his culture. [...] At some point, we raised the issue with him. The man told us that he had previously done a lot for his mother, [...] but that he had adapted to the Belgian culture, in which men do not contribute to the housekeeping. (Interview 6, social cultural worker, welfare organisation)

Other participants were aware of the essentialising tendencies of discourses of ‘norms and values’, and they tried to avoid them all together.

This brings us to a second sociological approach to culture: the symbolic or ‘interpretive’ approach. From this perspective, culture is understood as a collection of meanings expressed in material symbols, which are related. Culture emerges through the process of assigning concrete meanings to reality. Such combinations of different individual interpretations generate a ‘working consensus’ (Laermans, 1999). In other words, culture can be understood in terms of *schemes of interpretation*. As such, culture is explicitly linked to language as a means of perceiving the world (Wolffers,

2013). For example, and relevant to our study, different languages and different cultural formations elaborate distinct taxonomies for health and illness. A specific term for an illness in one language or cultural formation cannot necessarily be translated precisely into another linguistic or cultural context (Grinker, 2007). Culture and language can thus be regarded as systems and constructions, as attempts to find a shared consensus or as the results of finding such consensus.

And that you need to formulate a description with which to clarify the concept of schizophrenia, as we understand it [...] This is something that, for many years, was included in our language and our way of thinking. In maybe 20, 30 years, it might also be included in the Arabic and Turkish cultures. (Interview 2, social cultural worker, umbrella organisation)

In this vein, culture can be perceived as a story. The following participant insisted that mental healthcare professionals should consider the context and the cultural story in order to develop a better perspective on the problems of diasporic Muslims. Later in the interview, she again referred to the importance of the context, as well as to the fact culture can be perceived in terms of ‘the way(s) people stand in the world’.

I believe that this is very important – that you can imagine how you would handle things if you had been raised in such circumstances. But I believe, with regard to the biomedical model, that it is real and can be regarded as a story. [...] And putting it into context and against the background of the culture is very important to me. (Interview 4, psychologist, community health centre)

Another participant applied this understanding of culture to the context of biomedicine, which she regards as a framework with which to conceptualise the world. According to this participant, cultures can evolve from ‘cultures of taboo’ to become ‘cultures of biomedicine’ (Bhambra, 2007). Many other participants also insisted that ideas about health are a combination of different interpretations of previous generations, resulting in a working consensus about the situation.

Your origins determine your thinking about many things – about different diseases. (Interview 11, general practitioner, community health centre)

Throughout the interviews, the participants linked such schemes of interpretation to language and ethnicity, as well as to religion, regarding them as ways in which to regulate one's life. For example, one participant was convinced that Belgian people think more about the end of life than Turkish people do. She explains this in terms of 'their' culture/religion.

Different conceptualisations of culture have been elaborated beyond the discipline of sociology. The concept plays a crucial role in the field of anthropology, where it is also conceptualised in a variety of ways, while often understood in general terms as *a way of life*. In this vein, culture can be considered a signifying system that structures the ways in which practices, meanings and values are "communicated, reproduced, experienced and explored (Williams in Barnes et al., 1999)". Various participants referred to customs when speaking of cultural differences.

Different cultures have different customs. This means that individuals have different patterns. In many cases, the clients are the one who get stuck in certain patterns. (Interview 23, psychologist, welfare organisation)

Customs and patterns constitute a recurring way of referring to cultural differences. According to one participant, this is problematic only when people get stuck in those patterns. Another participant made a more explicit reference to 'way of life'.

Those people are more vulnerable. Because of the migration, the strange customs and ways of life. Yes, the culture is different, [...] and that necessarily results in a negative effect on present issues. (Interview 28, psychologist, group practice)

Culture as way of life can also be invoked with regard to the way in which diasporic Muslims handle their children, as well as with regard to the difference between Muslims in Turkey and Morocco and diasporic Muslims in Belgium. It thus also

concerns the ways in which culture is passed on. Some of this becomes clear in the following quotation, in which the participant suggests that the way of life of diasporic Muslims would not fit well within the Belgian context.

But people often have the feeling that they are not full members of society. This is because they are living with a different cultural background within an environment that does not have that background. (Interview 14, psychologist, private practice)

Some participants go even further, asserting that Belgian culture is universal and the benchmark for the evaluation of ‘others’ (who are assumed inferior). Negative experiences with diasporic Muslims tend to be generalised to the entire group, and their positive characteristics are regarded as exceptions (van den Muijsenbegh et al., 2013).

An initial analysis of the ways in which ‘culture’ is mobilised and cultural difference is understood in the narratives of our participants reveals the breadth of what culture can represent. It is important to note that the analytical distinction between these ways of talking about culture does not lead to a categorisation of participants into different groups. Instead, it reflects three distinct ways of invoking culture that could very well be used by the same participant.

Stuart Hall (1992; 1996) suggests that these multiple dimensions and meanings of culture could be understood by considering culture as a ‘floating signifier’, which is constituted by its partially overlapping and contradicting understandings. Presenting a single definition of ‘culture’ thus appears to be arbitrary and unnecessarily restrictive (Hall, 1992; 1996; Hofferberth, 2015). Hall also highlighted ways in which culture has and continues to function as a terrain upon which processes of racialisation occur. ‘Racialisation’ refers to the processes through which ‘race’ emerges as a category and social reality. In other words, it constructs social relationships of race, based on particular distinctions made between people (as expressed by Hall, 1996: differences in ‘color, hair and bone’) and the explanatory grounds that were invoked for these

categorisations, including religious, anthropological and scientific-biological explanations (Hall, 1996).

It is important to note that, in the contemporary European context, questions of race and culture have become particularly entangled (Lentin, 2005; Lentin & Titley, 2011). As noted by several authors (Said, 2005; see notably Lentin 2005; Lentin & Titley, 2011), following the Second World War, the term ‘race’ became a taboo in Europe, and ‘culture’ has gradually become another way of talking about race – and enacting processes of racialisation – without speaking openly about race (Lentin, 2005; Lentin & Titley, 2011). In this vein, much of the discourse on multiculturalism can be regarded as the ‘culturalisation’ of race, while race naturalises culture. Cultural tropes can thus also be regarded as racial signifiers (Hoffer, 2009; Lentin, 2005; Lentin & Titley, 2011). This recalls and recasts an older, colonial history, in which culture operates to establish a hierarchical binary opposition between the ‘West’ and the ‘Orient’, as investigated by the linguist Edward W. Said. In 1978, Said published *Orientalism*, in which he unpacked ‘stern representations of the ‘Orient’ through which the ‘Orient’ was not merely ‘discovered’, but in fact created, as it also involved evaluative judgements that created both the ‘Orient’ and ‘Europe’ (Bhabra, 2007; Said, 2005). ‘Orientalism’ thus creates a cultural opposition between two entities – ‘Western Christianity’ and ‘Eastern Islam’ – an opposition that has indeed become ethnicised and racialised (Lewis, 2003).

4. The cultural-difference frame

Examination of the ways in which our participants constructed the floating signifier of ‘cultural difference’ reveals three tropes/signifieds: pressure from the community, spiritual healing and psychosomatisation. Linking these tropes to the aforementioned conceptualisations of culture, we could say that pressure from the community is related to culture as values and norms, that spiritual healing is related to culture as way of life and that psychosomatisation is related to culture as schemes of interpretation.

In general terms, the cultural-difference frame consists of a separation between ‘us’ and ‘them’, as cast in essentialist terms. In its most explicit formulation, ‘they’

were characterised by irrationality, magic, religiosity, dependency and a lack of biomedical knowledge. In contrast, ‘we’ were characterised by knowledge, progressiveness and independence, being in a position to educate the ‘Oriental other’ (Bhambra, 2007; Said, 2005). ‘Orientalism’ creates epistemological and ontological distinctions between the ‘Occident’ and the ‘Orient’, the ‘West’ and ‘Islam’ (Bhambra, 2007; Said, 2005; Turner, 2011).⁴⁰ While superior characteristics were attributed to ‘the West’, inferior ones were attributed to ‘the East’, and especially to ‘Islam’. Even today, some scholars are convinced that Western modernity originated in Europe, due to its particular historical characteristics (Bhambra, 2007).⁴¹

This is the most common way in which cultural sensitivity emerged in the narratives of our participants: as a way of reaching and handling ‘them’, sometimes accompanied by an awareness of the need to decentre ‘our’ cultural norms. As a result, the categorical distinction between ‘us’ and ‘them’ began to unravel for some participants. In this process, some of our participants began to recognise the agency of people with mental health problems, along with strategies for working around the ‘us vs. them’ distinction.

4.1. Pressure from the community and culture as values and norms

The first trope that we discuss is that of pressure from the community. The professionals we interviewed thought that diasporic Muslims did not come to established mental healthcare services because of the taboo on seeking outside assistance, in addition to the pressure from and gossiping in ‘their’ community. Instead, the professionals believed that they were solving ‘their’ problems on their own (Hoffer, 2009). In this view, the community represents both a negative and a positive aspect, as it entails both controlling and caring for someone. Some of the professionals

⁴⁰ This East-West division, which is also referred to by post-colonial theorists, does not correspond to reality. For example, throughout history, there have been contacts between Indian, Muslim and European scientists (Bhambra, 2007).

⁴¹ Many post-modern and post-colonial thinkers have questioned the dominant ideas of modernity and the equation of Westernisation with progress. Their thinking has also been criticised, however, particularly for their tendency to consider Western modernity as mirror for others (Bhambra, 2007).

we interviewed believed that this was a religious obligation that is not present in the Belgian society (Hoffer, 2009). The link to culture can be regarded as a link to norms and values. The link to family as a compulsory, coercive element can explain its supposed controlling character.

Probably, the mechanism that belongs to that culture and the community – that one should try to handle and follow up on such issues within the context of the family ... One does not call in assistance.” (Interview 3, social cultural worker, umbrella organisation)

Some participants regarded pressure from the community as something that is deeply embedded within diasporic Muslim communities, and some assumed that diasporic Muslims would come to the established mental healthcare services “when they are ready for it.” It is often assumed that people with disabilities are well cared-for within extended families, and that no welfare support is needed. According to research, however, such ‘myths’ can sometimes become a reason for depriving ethnic minority families of health and welfare support (Barnes et al., 1999). According to other participants, pressure from the community is ‘merely’ a cultural thing and that it is possible to work with it. Other studies have also indicated that social support from immediate or extended family members or the ethnic community can form a buffer against stressors that have a negative influence on the mental well-being of immigrants (Jibeen, 2011).

Another observation made by the professionals we interviewed is that few diasporic Muslims request mental healthcare professionals who are members of ‘their’ own communities. The most important reason noted by the participants is an assumed fear of counsellors who might disclose their ‘secrets’ to the community. Our participants also viewed the Turkish and Moroccan diasporic communities as ones in which gossip is very common. This is particularly destructive in combination with a stigma on mental illness.

It is often more interesting to go to a Turkish psychologist. However, some say, ‘No we are able to speak Dutch. We will definitely go to a

Belgian psychologist, because we are afraid of the gossips in our communities' (Interview 27, psychiatrist, general hospital)

Some of the participants were aware of the fact that this does not apply to every diasporic Muslim. Some of the Turkish and Moroccan professionals participating in this study (professionals of these backgrounds constitute a minority in Belgium) also told us that some diasporic Muslims with mental health problems choose them as therapists specifically because of the supposed common ideas. This could also reflect a notion of culture in terms of norms and values. Diasporic Muslims are also influenced by pressure from the community and the fear of gossip. As noted by our participants, some ask their counsellors to make house calls, so that it will not be obvious that they are consulting a therapist. It has also been argued that the lack of resemblance between the client and the therapist is likely to result in a presumed misunderstanding, as mental healthcare professionals would have difficulty assessing the emotions of clients from differing ethnic backgrounds (Bhui & Bhugra, 2004). As indicated in the previous quotation, however, differences in subject positions are not always problematic.

Most of the mental healthcare professionals we interviewed drew a marked distinction between Belgian culture and the supposedly more collectivistic Moroccan and Turkish cultures. According to prevailing assumptions, these cultures are characterised by care for and loyalty to others, as well as by self-representation in terms of 'we' and informal control, with individuals regarded as the embodiment of relationships and roles. This is contrasted with the supposedly more individualistic and impersonal Belgian culture, as characterised by less care for a wide range of people, formal control and a focus on the 'I'. The majority culture is further assumed to be better able to keep mental illnesses private and where such illnesses are less likely to be stigmatised. Instead of being inherently social, individuals are regarded as 'I's', each with a core that is linked to social relationships and kin relations (Bhambra, 2007; Hoffer, 2009; Lawler, 2014).

Well, I think it is more established by most Flemish people. [...] It is easier to talk about certain problems. [...] Most of them are from

collectivistic societies. That is completely different. In that type of society, you cannot simply take decisions, because all of the decisions they make have a major impact on the larger group as well. They also want to be loyal to their families, to their groups. (Interview 12, psychologist, mental health services)

Some of the participants were of the opinion that the negative consequences of familial pressure could be fixed by integrating the community more in the treatment of diasporic Muslims (e.g. through family therapy and house calls), as the entire family is influenced by mental health problems. They noted that these options are lacking in the established mental healthcare system (Rondelez et al., 2018). In the general context of mental healthcare, identify to these matters can be recognised in the context of reducing stigma. In most cases, integration into the family should be combined with psycho-education, according to some participants.

4.2. Spiritual healing and culture as way of life

Spiritual healing is a second trope that we identified within the cultural-difference frame. Non-Western people with mental health problems do not abandon their own culture when they are referred to Western psychiatry. This can often result in miscommunication between the person with mental health problems and the mental healthcare professional (Hoffer, 2009). Moreover, scholars are increasingly questioning the present classification system for psychiatric diseases, which is assumed to be too strongly rooted in a ‘Western’ cultural background, and therefore less applicable to ‘other cultures’ (Missinne & Bracke, 2012).

The professionals we interviewed explained the under-representation of diasporic Muslims in established mental healthcare services by drawing a distinction between a rational Western ‘self’ and a magical ‘other’. Practices of spiritual healing are often evaluated negatively, while Western practices and visions are evaluated more positively (Rondelez et al., 2018). In this case, religion and culture could be regarded as important guidelines for organising one’s life. People with mental health problems need to be able to express their problems in a short time and in terms that the

professional understands. Professionals tend to respond only to those complaints that fit within their frameworks (Wolffers, 2013). This is also substantiated by the refusal to attribute any historical consciousness to non-European cultures, which results in the marginalisation of the knowledge of ‘others’ and a tendency to regard the societies associated with such knowledge as inferior (Bhambra, 2007). It is also clear that the subjects of spiritual healing are not considered real subjects with their own agency. Spiritual healers are apparently regarded as being in control of everything. Mental healthcare professionals apparently also regard spiritual healing as primitive and harmful – an ethnocentric and ‘Orientalist’ way of viewing the case.

But that is also known, about faith healing and exorcism. These things hardly ever happen in the Western world anymore. I therefore think that there is a serious gap between the needs that are supposedly just as great as they are for the classic Western population. But the idea that the offer is not one that they feel they can make use of. (Interview 2, social cultural worker, umbrella organisation)

Although experiences of spiritual healing are currently infrequent, they are not uncommon. Examples can be found within the Christian community (Rosmarin et al., 2015). Culture provides the context in which spiritual or medical healers can do their work.

Mental health also includes a gender element, as such it is regarded as a masculine trait. It also entails adjustment for women: to be healthy, women must adjust themselves to their own behavioural norms, even though they are largely regarded as less socially desirable (Çalışkan, 2016; Wong & Tsang, 2004). For example, for both men and women, madness is perceived as the presentation of the devalued female role or the rejection of the archetype that is linked with their own sex roles. Madness can also be seen as a quest for help, with the help-seeking position regarded as a part of female conditioning. By being mad, an individual challenge the dichotomous capitalistic patriarchal society and hides the distorted relationships in society (Çalışkan, 2016).

Contemporary mental healthcare professionals have a variety of visions on spiritual healing. Some subscribe to the relatively negative view that spiritual healing is not therapeutic, and that it is primitive and even harmful in some cases. More secular professionals see spiritual healing as something religious and, as such, non-scientific (Apostolides & Dreyer, 2008; Bull, 2001; Sax, 2014). This could be perceived as an ethnocentric way of approaching the ways in which evil is addressed in ‘other’ cultures (Apostolides & Dreyer, 2008). In this context as well, our participants appeared to conceptualise culture as the way in which people are able to lead their lives. The two major problems that they attribute to spiritual healing is that religious healers do not have knowledge of psychological dynamics, and the situations in which the healings are performed are often controlling and demeaning for the person being treated, who has few options other than to cooperate in the situation (Bull, 2001). We can formulate a critique on this presentation: the agency of the ‘possessed’ person is neglected in this context. Individuals are always able to exercise their agency (e.g. by choosing to do nothing). In addition to these negative perceptions, however, other mental healthcare professionals took a more positive view of spiritual healing, especially if it is carried out with knowledge of psychology and no coercion. One of their suggestions involved the use of culture-sensitive therapeutic techniques, taking into account the explanatory models used by the person with mental health problems (Bull, 2001). One way of avoiding ethnocentrism is to accept the unique social set-up, reality and world-view of each culture respectfully and to avoid value judgements. One must accept that there is no ‘correct’ view, but only the reality that humans experience within the social frameworks of their communities. When professionals accept differences in cultures as different realities and not as faults, they can help their clients with their problems (Apostolides & Dreyer, 2008). They must accept that, while diagnoses may differ across clinicians within a given culture, they differ even more between different cultures (Grinker, 2007).

Some of the participants acknowledged that diasporic Muslims are able to place magical and biomedical frames side by side, with some even preferring the biomedical frame over the religious frame (Hoffer, 2009; Rondelez et al., 2018). According to

some studies, it is possible that ‘modern’ and ‘traditional’ therapeutic models can even be mutually complementary. Despite any epistemological differences between the two models, there are ways of achieving coexistence and arriving at a situation in which one system enriches the other (Hoffer, 2009). Moreover, it is possible and therapeutically beneficial for the professional – and the person with mental health problems – to be involved with both models. To this end, it is important to know the person’s background, particular with regard to ethnic, cultural and religious roots (Khalifa & Hardie, 2005). The following participant seem to have accepted that the religious and psychological frameworks can exist alongside each other.

I: So, in most cases, they will look for the explanation in something from above?

R: Yes. But as soon as that they notice that there is no progress. [...] There are not many people who say that, but there are a few who say “we can let them exist next to each other.” That also happens. (Interview 19, psychologist, private practice)

In contrast, other professionals argue that it is harmful for spiritual healers to be integrated into modern health systems. According to their reasoning, mainstream medicine continues to uphold a dualism of mind and body that is strongly influenced by individualism, which is assumed to be incompatible with non-European understandings of ‘a person’ (Sax, 2014). Although this seems to reflect a tendency to address the ethnocentric universalism that is present in much thinking, it does present the idea of thinking in terms of ‘us’ and ‘them’ (Bhambra, 2007). The social asymmetries existing between spiritual healers and health workers should make it impossible for them to create a respectful relationship with each other. Finally, neither psychiatry nor the state acknowledges the validity of spiritual healing, as it is not effective (Sax, 2014).

4.3. Psychosomatisation and culture as schemes of interpretation

A final trope that we identified is that of psychosomatisation. Given that psychosomatisation concerns the interpretation of health problems, it can be regarded as a scheme of interpretation. Most of the professionals we interviewed expressed the belief that Muslims of diasporic communities have more psychosomatic complaints than do Western people with mental health problems. Although some studies have indicated that, in every ethno-cultural group, one fourth of the people in primary care have some psychosomatic disorder (de Jong, 2013; Fritzsche et al., 2012). In Western societies, it is common for people to discuss their feelings. In ‘other cultures’, social harmony is more important. This situation can result in the conviction that personal emotional problems are no reason to seek mental healthcare (de Jong, 2013). The participants’ belief in a higher incidence of psychosomatic complaints amongst diasporic migrants is primarily related to a lack of insight. According to our participants, because these groups lack a rational scheme of interpretation, they should appeal to a frame of psychosomatisation. Second, the fact that some of the professionals we interviewed were convinced that diasporic Muslim women are the most likely to have psychosomatic complaints indicates that a gendered dimension is involved as well (Piko et al., 2016; Wong & Tsang, 2004). The participants also distinguished between how these complaints are expressed by women and how they are expressed by men (with men tending to be more aggressive than women).

So, I have the impression that women somatise more often. But you also observe that with men. I believe that they just somatise a lot in the Turkish culture. (Interview 16, psychiatrist, general hospital + private practice)

Third, many of the professionals we interviewed felt that the psychosomatisation of complaints of a psychological nature was related to the taboo on mental health problems that is assumed to prevail in diasporic Muslim communities (Rondelez et al., 2018). In this case, culture is associated with a scheme of interpretation of the taboo and the psychosomatisation of mental health problems. Finally, there is also a link to the educational level of Muslims from diasporic communities, as some participants

noted that diasporic Muslims are less educated and therefore less capable of expressing ‘their’ symptoms in a psychological manner (Aragona et al., 2012; Fadil et al., 2015). Lower levels of education are also associated with greater job insecurity, which is linked to additional mental health problems and psychosomatic symptoms (Fadil et al., 2015; Nella et al., 2015). Financial stress is also related to a higher incidence of psychosomatic symptoms (Åslund et al., 2014). This thus offers an additional explanation for the greater prevalence of psychosomatic symptoms amongst diasporic Muslims.

Some participants expressed the opinion that, although Western mental health practitioners perceive psychosomatic complaints as negative, such complaints are one of the scheme of interpretation through which migrants are able to express mental health complaints. Studies have also indicated that acculturation stress is associated with more mental health problems and psychosomatisation (Jibeen, 2011; Wang et al., 2016). Given that the current context involves a population of migrants, we can suggest that it is also an explanation for the higher prevalence of psychosomatic complaints. This is especially the case, given that studies have also demonstrated that perceived discrimination is associated with higher levels of psychosomatic symptoms (Wang et al., 2016).

From the viewpoint of this trope, Muslims of diasporic communities are often believed to fit within the biomedical model when they feel psychological complaints through their body. In this context, the biomedical model could be regarded as a more rational scheme of interpretation than the psychosomatisation scheme. According to most of the mental healthcare professionals we interviewed, this explains why diasporic Muslims are more eager to go to general hospitals or to their general practitioners than they are to approach mental healthcare services. Job insecurity and psychosomatic symptoms are also associated with more visits to healthcare services (Fritzsche et al., 2012; Nella et al., 2015). Moreover, studies have indicated that the psychotherapeutic treatment of people with psychosomatic complaints is difficult, as they often refuse referrals, are at higher risk for treatment dropout, have lower

motivation and are reluctant to participate. This is clearly expressed in the following quotation (Yasky et al., 2016).

They will not be assisted there [at the psychiatric hospital], because they cannot do anything about the physical complaints. This is the message that gets back to us. (Interview 24, psychiatric nurse, general hospital)

From this psychosomatic framework, the professionals we interviewed observed that Muslims from diasporic communities are more likely to request medication for ‘their’ complaints than are to want to talk about them (Rondelez et al., 2018). In contrast, some researchers have expressed the opinion that many diasporic migrants, are actually afraid of taking too much medication, due to ‘their’ fear of becoming dependent on medication (de Jong, 2013). The following quotation indicates how diasporic Muslims find it easier to approach ‘their’ general practitioners and ask for medication than it is to visit a psychologist.

Medication, medication. It is not so that they are coming for psychiatric help: send me to a psychologist. [...] But they often do have a psychological problem in the form of psychosomatisation. And so they want – when they are sick – a pill for their sickness [...] (Interview 15, general practitioner, private practice)

5. Conclusion

In this article we elaborated on the notion of culture and the specific frame that we identified in the comments of Flemish mental healthcare workers concerning diasporic Muslims with mental health problems: the cultural-difference frame. More specifically, we identified three tropes that constitute this frame (Rondelez et al., 2018). Our data were drawn from a qualitative interpretive study in Ghent, a city in Dutch-speaking Belgium.

First, we examined the use of culture: how it is conceptualised by theorists, when our participants refer to it and how they conceptualise it themselves. In general, theorists refer to culture in terms of norms and values, schemes of interpretation and a

way of life. More recently, it has also been conceptualised in more racialised terms. We approach 'culture' as a floating signifier. Our participants refer to culture in a variety of contexts. They associate the under-representation of diasporic Muslims with mental health problems, assuming that culture influences the symptoms (or their expression), they also pay attention to cultural gender relations. Finally, our participants conceptualised culture interchangeably as norms and values, schemes of interpretation and ways of life.

Most of our participants consider 'culture' as a substantiated object, as something with a centre. Consequently, some participants perceive 'culture' as something that has an irresistible influence on individuals. Other participants, however, acknowledge the influence that people can exercise on 'culture'. From a substantive viewpoint, certain hard traits are attributed to culture (e.g. the tendency to look after 'their' own members). These elements are regarded as innate, natural, timeless and fixed. Such substantiated notions of culture nevertheless contradict the way in which theorists talk about culture. As described earlier in this article, culture currently tends to be conceptualised as a floating signifier. This also becomes clear when considering the various contexts in which culture is used and the various meanings that are attributed to culture. The interviews revealed a tendency to neglect the social constructedness of 'culture' by approaching it in such a substantiated way.

Most of our participants also had a tendency to essentialise 'culture', linking it to ethnicity, religion or language. In this case as well, we observed that participants constructed an 'Orientalist' distinction between the more 'traditional' habits and needs of Muslim cultures and the more 'evolved' solutions of the Western world. According to these participants, this sometimes resulted in frictions (Bhambra, 2007; Hoffer, 2009). This could offer an explanation for the problems experienced in trying to reach diasporic Muslims with mental health problems. The essentialised and essentialising notion of culture is also problematic. Given its neglect of other elements, it is quite simplistic, with a discourse that is homogenous and unified. Power relations are also conceptualised as monolithic. A relational conceptualisation of culture (and disability) that goes beyond essentialist distinctions offers considerable potential, but without

neglecting legitimated differences (Ferguson, 2003). In addition, little attention is paid to the agency and power of the 'Orientalised' subjects, who can challenge the power of the professionals. The 'Orient' is often used as constitutive of the 'Occident's' identity and narrative (Bhambra, 2007).

As a final critique, some of our participants referred to 'culture' as something invariable, and as something that does not change. This is also an element of 'Orientalism' (Said, 2005; Wolffers, 2013). The 'Orientalist' mechanism consists of the opinion that the 'Orient' is ahistorical, static and uniform (Said, 2005; Turner, 1978). Many 'Orientalist' writings created an atmosphere of continuous, timeless repetitions. 'Orientalist' scientists often presume that Islam is intrinsically opposed to changes (Said, 2005; Turner, 1978), while generalising specific observations as unchangeable patterns. All of the people and civilisations of the 'Orient' were supposed to have a shared, primitive and ahistorical core, and the 'Orient' was assumed to be passive (Said, 2005). Culture is not a closed system. It can be regarded as continuously changing interpretations, notwithstanding curbing mechanisms (Wolffers, 2013).

We then considered the ways in which our participants conceptualised the frame of cultural difference. This led us to identify three tropes.

The first trope that we identified was that of pressure from the community. The mental healthcare professionals we interviewed felt that one reason why diasporic Muslims do not approach established mental healthcare services has to do with the taboo on seeking outside assistance, to pressure and to gossiping in 'their' communities. Some participants thought that diasporic Muslims are obligated by 'their' religion to solve 'their' problems within 'their' families, in sharp contrast to the Belgian situation. Another remarkable observation is that our participants largely attributed the responsibility for this situation to the diasporic communities. According to these mental healthcare professionals, most diasporic Muslims seem to believe that a Muslim counsellor would disclose 'their' secrets to others. Our participants also drew a distinction between individualistic 'Western' cultures and more collectivistic 'Oriental' cultures. We associated this trope with the notion of culture conceptualised

as norms and values. In this context, our participants often constructed a culture-notion as an unconscious dichotomy between a desired value of community and the undesired Western mental healthcare system.

A second trope that we identified is that of spiritual healing. A clash of cultures can result in miscommunication, and questions are being increasingly posed about the Western orientation of the dominant identification models of mental health problems. Most of our participants referred to a contradiction between a modern, rational ‘Western’ conceptualisation of mental health problems and a magical, religious ‘Oriental’ conceptualisation. They saw spiritual healing as challenging the dichotomous capitalistic patriarchal society (Çalışkan, 2016). The supposed lack of psychological knowledge amongst spiritual healers and the supposedly controlling and demeaning situations in which they are assumed to operate were the subject of particular criticism. In contrast, counsellors with a more positive view focused on the use of culture-sensitive models, taking the explanatory models of their clients into account (Bull, 2001). When professionals accept differences in cultures as different realities, and not as faults, they can help their clients with their problems (Apostolides & Dreyer, 2008). Yet other participants asserted that the biomedical and the religious models can exist alongside each other, although other studies have indicated that this would be harmful for spiritual healers (Sax, 2014). We associated this trope of spiritual healing with culture as way of life. Religion or magic influence the context in which individuals can act. The same is true for the biomedical frame or a combination of both.

In this article, we refer to ‘spiritual healing’, a notion that is also present in Western practices of mental healthcare (e.g. in some therapies inspired through Christianity) (Rosmarin et al., 2015). It is nevertheless important to note that our participants tended to equate spiritual healing with exorcism, which is only one aspect of spiritual healing. It could be interesting to explore how diasporic Muslims conceptualise spiritual healing, in order to identify any major differences between their visions and those of the counsellors we interviewed.

The third and final trope that we identified within the cultural-difference frame is psychosomatisation. Within our group of participants, there was a belief that diasporic Muslim communities express more psychosomatic complaints than other people with mental health problems do. According to other studies, however, such is not the case (Fritzsche et al., 2012). The reasons that our participants presented for their beliefs included lack of insight, a gender element (Piko et al., 2016), the prevalent taboo amongst diasporic communities and the lower educational level of diasporic Muslims (Rondelez et al., 2018). Other reasons that can be found in the literature on psychosomatisation include greater job insecurity (Nella et al., 2015), more financial stress (Åslund et al., 2014), unrealistic expectations of medicine, a traumatic social change, stressful life events, dissatisfaction with one's position in modern society (Fritzsche et al., 2012), acculturation stress and (perceived) discrimination (Wang et al., 2016). For some of our participants, this psychosomatisation implied that diasporic Muslims fit within the biomedical model, as they are more inclined to approach general hospitals and their general practitioners, in addition to being more inclined to request medication (Rondelez et al., accepted). We associated this situation with a concept of culture as perspectives: it is the way in which diasporic Muslims with mental health problems perceive 'their' problems.

All of these tropes apparently offer the possibility of identifying the homogeneity assumption, in which greater attention is paid to within-group similarities and between-group differences, and in which little or no attention is paid to multidimensional and dynamic interplay of the personal and social contexts within which cultural and social processes are situated. When this is the case, there is a tendency to overemphasise the group memberships of individuals instead of their uniqueness. In this case, we can refer to a process of essentialisation and the reification of ethnicity (Wong & Tsang, 2004). There is an apparent tendency to forget that European American perspectives are regarded as a dominant standard in the evaluation of 'other cultures', and that 'other cultures' are conceptualised in an ahistorical way (Wong & Tsang, 2004). It is nevertheless important to notice that essentialisation is not necessarily negative.

In a dialectical way, these three tropes also indicate the manner in which the established mental healthcare system is constructed. The problems with community indicate that our mental healthcare system is based on a highly individualised vision. The issues that our participants had with spiritual healing reflect a reluctance to accept ‘unexplainable’ phenomena, despite some level of investment in mindfulness and similar therapies. Finally, the difficulties that our participants expressed with regard to psychosomatisation refer to the wide gap between body and mind that reigns in the established mental healthcare system.

It is also important to realise that there is a difference between the reasons why European individuals living in poverty are less likely to access mental healthcare, while diasporic Turks and Moroccans do. European clients living in poverty thus have difficulty accessing mental healthcare, due to the rhetoric of activation that exists in the neoliberal healthcare system, combined with issues relating to childcare or transportation. Therapists can help to eliminate these obstacles by adopting an active form of counselling. For example, they could make appointment-reminder calls or make appointments with all of the social workers and therapists on the same day (Overholser, 2016). High levels of social deprivation are also associated with higher levels of treatment dropout (Parry & McCrone, 2016). Although this is also the case for immigrants, it is supplemented with a focus on ethnicity. Moreover, the problem of discrimination plays a greater role for diasporic Turks and Moroccans than it does for European people living in poverty. Some of the participants did not distinguish between the culture of poverty and the status of being diasporic Muslims. In contrast, other participants made such statements as, “...a middle-class Turk, I think he would fit better with a middle-class Belgian than he would with a lower-class or very poor Turk or Belgian”.

One limitation of this study, which also suggests an avenue for further research is that it does not include the perspectives of the people with mental health problems. It would be interesting to identify the visions of individuals with mental health problems and how they interact with the frames of mental healthcare professionals. Given that frames are always constructed in interaction, this might identify a foundation on which

professionals construct their own frames and tropes. In the current study, we studied them in isolation, and the results therefore do not correspond to reality. Another interesting avenue for further research would be to investigate essentialisation in greater depth, in order to determine whether mental healthcare professionals are aware of it and whether they have any mechanisms for countering it. It is unlikely that all professionals would follow this mechanism. If we could identify the counter-mechanisms they employ, we could suggest them to other professionals. A third suggestion for further study would be to include more professionals working in biomedically oriented environments, as they were under-represented in this study. These professionals were difficult to reach, as they indicated that too few members of the diasporic Muslim community were present in their institutions to make a useful contribution to the study. Their inclusion in future studies could generate additional frames and tropes.

References

- Albrecht, G.L. (2003). Disability Values, Representations and Realities. In P. Devlieger, F. Rusch & D. Pfeiffer (eds.) *Rethinking Disability: The Emergence of New Definitions, Concepts and Communities* (pp. 27-43). Antwerpen: Garant.
- Apostolides, A. & Dreyer, Y. (2008). *The Greek evil eye, African witchcraft and Western ethnocentrism*. *HTS*, 64(2), 1021-1042.
- Aragona, M., Rovetta, E., Pucci, D., Spoto, J. & Villa, A.M. (2012). *Somatization in a primary care service for immigrants*. *Ethnicity & Health*, 17(5): 1-15.
- Åslund, C., Larm, P., Starrin, B. & Nilsson, K.W. (2014). *The buffering effect of tangible social support on financial stress: influence on psychological well-being and psychosomatic symptoms in a large sample of the adult general population*. *International Journal for Equity in Health*, 13(85): 1-9.
- Barnes, C., Mercer, G. & Shakespeare, T. (1999). *Exploring Disability: A Sociological Introduction*. Cambridge: Polity Press.
- Bhabra, G.K. (2007). *Rethinking Modernity: Postcolonialism and the Sociological Imagination*. Basingstoke: Palgrave Macmillan.

- Bhui, K. & Bhugra, D. (2004). *Communication with patients from other cultures: The place of explanatory models*. *Advances in Psychiatric Treatment*, 10: 474–478.
- Brah, A. (1996). *Cartographies of diaspora. Contesting identities*. London: Routledge.
- Bull, D.L. (2001). *A Phenomenological Model of Therapeutic Exorcism for Dissociative Identity Disorder*. *Journal of Psychology and Theology*, 29(2): 131-139.
- Çalışkan, D. (2016). *The “Criminal Other” and the “Exorcism of Evil” in Fay Weldon’s The Life and Loves of a She-Devil*. *International journal of humanities and cultural studies*, 2(4): 445-464.
- De Jong, J. (2013). *Migratie en geestelijke gezondheidszorg*. In I. Wolffers, A. van der Kwaak & N. van Beelen (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 231-250). Bussum: Countinho.
- Denzin, N.K. & Lincoln, Y.S. (2013). *Collecting and interpreting qualitative materials*. Los Angeles: Sage.
- Esterberg, K.G. (2002). *Qualitative Methods in Social Research*. Boston: McGraw-Hill.
- Fadil, N., El Asri, F. & Bracke, S. (2015). Belgium. In J. Cesari, (ed.). *The Oxford Handbook of European Islam*. Oxford: Oxford University Press.
- Ferguson, P.M. (2003). Winks, Blinks, Squints and Twitches: Looking for Disability and Culture Through My Son’s Left Eye. In P. Devlieger, F. Rusch, & D. Pfeiffer (Eds.) *Rethinking Disability: The Emergence of New Definitions, Concepts and Communities*. (pp. 131-147). Antwerpen: Garant.
- Fritzsche, K. Anselm, K. Fritz, M., Wirsching, M. Xudong, Z. & Schaefer, R. (2012). *Illness attribution of patients with medically unexplained physical symptoms in China*. *Transcultural Psychiatry*, 50(1): 68-91.
- Goffman, E. (1956). *The Presentation of Self in Everyday Life*. Edinburgh: University of Edinburgh Social Science Research Centre.
- Goffman, E. (1961). *Asylums. Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.

- Goffman, E. (1974). *Frames of analysis. An Essay on the Organization of Experience*. Boston: Northeastern University Press.
- Grinker, R.R. (2007). *Unstrange Minds: Remapping the World of Autism*. New York: Basic Books.
- Hall, S. (1992). Cultural Studies and its Theoretical Legacies. In: L. Grossberg, G. Nelson & P. Treichler. *Cultural Studies*. London: Routledge.
- Hall, S. (1996). *Race, the Floating Signifier. Featuring Stuart Hall*. Media Education Foundation, 61 min.
- Hoffer, C. (2009). *Psychische ziekten en problemen onder allochtone Nederlanders: beleving en hulpzoekgedrag*. Assen: Van Gorcum.
- Hofferberth, M. (2015). *Mapping the Meanings of Global Governance: A Conceptual Reconstruction of a Floating Signifier*. Millennium: Journal of International Studies, 43(2): 598-617.
- Hsieh, H. & Shannon, S.E. (2005). *Three Approaches to Qualitative Content Analysis*. Qualitative Health Research, 15: 1277-1288.
- Jibeen, T. (2011). *Moderators of Acculturative Stress in Pakistani Immigrants: The role of Personal and Social Resources*. International Journal of Intercultural Relations, 35: 523-533.
- Khalifa, N. & Hardie, T. (2005). *Possession and Jinn*. Journal of the Royal Society of Medicine, 98: 351-353.
- Kruispuntbank Sociale Zekerheid (2017). *Aantal personen van buitenlandse herkomst 2015 – Gent*. <https://gent.buurtmonitor.be/>, accessed 15 September 2017.
- Laermans, R. (1999). *Communicatie zonder mensen. Een systeemtheoretische inleiding in de sociologie*. Amsterdam: Boom.
- Lawler, S. (2014). *Identity. Sociological Perspectives. Second edition*. Cambridge: Polity Press.
- Lentin, A. (2005). *Replacing 'race', historizing 'culture' in multiculturalism*. Patterns of Prejudice, 39(4): 379-396.
- Lentin, A. & Titley, G. (2011). *The Crises of Multiculturalism. Racism in a Neoliberal Age*. London: Zed Books.

- Lewis, R. (2003). *Gendering Orientalism. Race, Femininity and Representation*. London: Routledge.
- Missinne, S. & Bracke, P. (2012). *Depressive symptoms among immigrants and ethnic minorities: A population based study in 23 European Countries*. *Social Psychiatry and Psychiatric Epidemiology*, 47: 97–109.
- Nella, D., Panagopoulou, E., Galanis, N., Montgomery, A. & Benos, A. (2015). *Consequences of Job Insecurity on the Psychological and Physical Health of Greek Civil Servants*. *BioMed Research International*: 1-8.
- Overholser, J.C. (2016). *When Words are not Enough: Psychotherapy with Clients Who are Living Below the Poverty Level*. *J. Contemp. Psychother*, 46: 89-96.
- Parry, G. & McCrone, P. (2016). *Invited commentary ... On poverty, politics and psychology*. *The British Journal of Psychiatry*, 209: 431-432.
- Piko, B.F., Varga, S. & Mellor, D. (2016). *Are adolescents with high self-esteem protected from psychosomatic symptomatology*. *European Journal of Pediatrics*, 175: 785-792.
- Ponzoni, E. (2016). *Reframing Cooperation: Challenges in Overcoming Tensions between Professional Services and Volunteer Organizations Providing Parenting Support in Immigrant Communities*. *Social Service Review* 89(1): 40-76.
- Rondelez, E., Bracke, S., Roets, G. & Bracke, P. (2016). *Racism, Migration, and Mental Health. Theoretical Reflections from Belgium*. *Subjectivity.*, 9(3): 313-332.
- Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P. (2017). *Diasporic Muslims, Mental Health, and Subjectivity: Perspectives and Experiences of Mental HealthCare Professionals in Ghent*. *DiGeSt*, 4(1): 63-84.
- Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P. (2018). *Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims*. *Social Theory & Health*. pp 1-18; doi:10.1057/s41285-018-0064-7

- Rosmarin, D.H., Forester, B.P., Shassian, D.M., Webb, C.A. & Björgvinsson, T. (2015). *Interest in Spiritually Integrated Psychotherapy Among Acute Psychiatric Patients*. *Journal of Consulting and Clinical Psychology*, 83(6): 1149-1153.
- Said, E. W. (2005). *Oriëntalisten*. Amsterdam: Mets & Schilt.
- Sax, W. (2014). *Ritual healing and mental health in India*. *Transcultural Psychiatry*, 51(6): 829-849.
- Turner, B.S. (1978). *Marx and the End of Orientalism*. London: George Allen & Unwin.
- Turner, B.S. (2011). *Religion and Modern Society. Citizenship Secularisation and the State*. Cambridge: Cambridge University Press.
- Van den Muijsenbergh, M., Wolffers, I., van den Oever, H. & Tjitra, J. (2013). Insluiting en uitsluiting van migranten in de gezondheidszorg. In I. Wolffers, A. van der Kwaak & N. van Beelen (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 107-118). Bussum: Countinho.
- Wang, C.D.C., Scalise, D.A., Barajas-Munoz, A., Julio, K. & Gomez, A. (2016). *Attachment, Acculturation, and Psychosomatic Complaints Among Hispanic American University Students*. *Journal of College Counseling*, 19: 45-60.
- Wolffers, I. (2013). Van nadruk op verschillen naar begrip voor ethnische diversiteit. In I. Wolffers, A. van der Kwaak & N. van Beelen (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 59-73). Bussum: Countinho.
- Wong, Y-L. R. & Tsang, A.K.T. (2004). *When Asian Immigrant Women Speak: From Mental Health to Strategies of Being*. *American Journal of Orthopsychiatry*, 74(4): 456-466.
- Yasky, J., King, R. & O'Brien, T. (2016). *Resistance, early engagement and outcome in psychoanalytic psychotherapy of patients with psychosomatic disorders*. *Counselling and Psychotherapy Research*, 16(4): 266-276.

Chapter 6⁴²

How to make sense of cultural difference in mental healthcare: Analysing the biographies of diasporic Muslim women with mental health problems

Vandekinderen, C., Rondelez, E., Roets, G., Bracke, S., & Bracke, P.

In progress

Abstract

Although scientific research increasingly shows evidence of a higher prevalence of mental health problems amongst diasporic Muslims, this minority group is underrepresented in Western mental healthcare services. The majority of these research perspectives identify cultural difference as a prominent frame to explain this tricky issue of underrepresentation. However, this entails the risk of building on an essentialist and pejorative notion of culture. Therefore we adopt an affirmative and productive notion of cultural difference, that allows us to uncover the complex and heterogeneous modes of action and strategies of meaning making of diasporic Muslim women with mental health problems as rooted in a specific historical, social, political, and cultural context.

⁴² American English

How to make sense of cultural difference in mental healthcare: Analysing the biographies of diasporic Muslim women with mental health problems

1. Introduction

During the last decades, an increasing body of research demonstrates a higher prevalence of mental health problems among diasporic Muslims compared to the native population in many West-European countries (Bromand et al., 2012; de Wit et al., 2008; Fassaert et al., 2009; Levecque et al., 2007; Missine & Bracke, 2012). At the same time, the existing body of scholarship reports problems regarding a remarkable underrepresentation of migrants in mental health services, due to, for example, non-compliance or dropout from treatment (Bäärnhielm & Ekblad, 2000; Fassaert et al., 2009; Latzer, 2003). In that sense, a diversity of research studies tries to explain the underrepresentation of people with a migration background in mental health services (Rondelez et al., 2016). The majority of research perspectives that cast light on this tricky issue of underrepresentation suggest that, besides structural barriers such as a lack of financial resources, limited mobility, a restricted ability to take time away from work, and a lack of linguistically accessible services (Kirmayer et al., 2011), especially cultural factors affect the help seeking process. These research approaches and findings suggest, for example, the naming of external causes for mental health, such as believing in the evil eye; the taboo and shame on mental health problems in Muslim communities; and locating suffering in certain organs and somatization with reference to the body's reactions to emotions which facilitates the expression of somatic complaints (Bengi-Arslan et al., 2002; Latzer, 2003; Rondelez et al., submitted; Smits et al., 2005; Stein, 2000; Vardar et al., 2012).

Although the recognition of cultural differences and the descriptions of cultural characteristics and practices might be useful for mental healthcare practitioners and researchers, several researchers have argued that interpretations of mental health

problems are predominantly framed and located in static and deterministic cultural assumptions (Smye, 2004). Even after the shift from bio-medical to recovery-oriented mental health services, in which the strengths and life worlds of people with mental health problems should be embraced rather than focusing on weaknesses of patients (see Deegan, 2003; Tew, 2011; Vandekinderen et al., 2012; 2014), cultural stereotypes and simplistic views of particular diasporic Muslims as outsiders, as different, and as ‘other’ are reinforced (Said, 2005). In that vein, it is argued that a problematic dichotomy is often produced and reproduced (Bäärnhielm & Ekblad, 2000; Latzer, 2003). Indeed, current research studies concerning mental health problems of migrants normatively express that migrants who have “not integrated the Western concept of ‘autonomy of the self’ as part of their personality (Latzer, 2003: 85)” have culture, whereas Europeans have psyche/reason (Rieser, 2000 in Vardar et al., 2012). As such, superior values are attributed to the West. However, the production of this dichotomy has been challenged as a form of ‘Othering’ (Said, 2005), that “erases the complex multiplicities of heterogeneous identities and experiences in favor of essentialized accounts (Smye, 2004: 78)”. Here, cultural essentialism entails the view that human beings “have essential properties (Stone, 2005: 6)”, referring to deterministic and fixed biological, psychological, and social characteristics that may lead to hierarchical social power dynamics within and between societies (Grosz, 1994; Uchendu et al, 2017).

In this article, we therefore aim to transcend this cultural determinism and essentialism (Wong & Tsang, 2004) by reframing the subject with mental health problems as “embodied, embedded, anchored, multiple, affective, interrelational and fundamentally social (Roets et al., 2008: 110)”. This means that we cannot deny cultural difference, but are enabled to interpret it in a productive and affirmative rather than deterministic and essentialist sense (Braidotti, 2013). Our contribution is based on research insights emerging from a qualitative research project that aims to gain an in-depth understanding of the underrepresentation of diasporic Muslims in Western mental healthcare. We therefore examine the discourses and practices concerning mental health problems of people with a migrant background who belong, more in particular, to the Muslim community in Ghent, a city in Belgium. In the research study,

biographical research with women of Turkish and Maghrebi descent who experience mental health problems has been conducted to unravel the strategies of these women in giving meaning to, and dealing with, their mental health problems. As such, we aim to identify the underlying assumptions of cultural difference and relationships of power that are at stake in their everyday lives in fine detail, and to examine the subjectivity of these women as evolving in the “complex network of meanings enmeshed within historical, social, economic, and political processes (Smye, 2004: 77)”.

In what follows, we first explain how we rely on an intersectional theoretical perspective to make sense of cultural difference in the lives of diasporic Muslims who seem to suffer from mental health problems. Second, we situate the research methodology of our research study. Third, we present our research findings according to four analytical threads to disentangle the agentic strategies that our respondents develop in dealing with their mental health issues. Finally, we reframe the problem of underrepresentation that might reflect the idea that diasporic Muslims should be enabled to integrate themselves in the existing social order. Yet our research shows that they are already involved in integrating themselves in our societies while opening up a cultural hybridity. The challenge for mental healthcare services is then to make sense of cultural difference by recognizing modes of agency and subjectivity that might differ from liberal and secular values.

2. An intersectional theoretical perspective

Our research project draws on three related and interdisciplinary fields of study: critical disability studies (Goodley, 2011), postcolonial studies (Bhabha, 1994; Fanon, 1952/1967; Said, 2005), and feminist studies (Braidotti, 2006a; 2011; 2014; Butler, 1990; Mahmood, 2005), where the question of subjectivity is central with reference to who or what counts as a subject (Butler, 2009; Schnabel, 2014). These fields of study engage with and challenge the norms and presuppositions about human beings that undergird our current ways of understanding and relating to ourselves (Rose, 1999), and demand that we reconsider the assumptions, discourses and taken-for-granted

ideologies that underpin practices and policies of exclusion and normalization pursuing the production of a certain type of body and a certain type of soul (Rose, 1999).

According to Braidotti (2013: 13), the particular ways in which human beings are approached and understand themselves nowadays goes back to humanism, which she describes as “a doctrine that combines the biological, discursive and moral expansion of human capabilities into an idea of teleological ordained, rational progress”. Humanism frames our understanding of the ideal Subject as white, male, heterosexual, urbanized, able-bodied, middle-class, adult and speaking a standard language (Braidotti, 2014; Davies, 1997), with normality as the zero-degree of difference (Braidotti, 2014). As such, the notion of ‘cultural difference’ obtained a pejorative meaning, rather than a productive/affirmative connotation, which resulted in passing off entire categories of human beings, who fail to exhibit these supposedly universal characteristics, as devalued ‘others’ (Braidotti, 2013; Fanon, 1952/1967; Grosz, 1994; Price & Shildrick, 1998).

Critical scholars have argued that these human subjects are even considered as others-than-humans, whose belonging is negotiable at best, and whose existence is structured along the axes of devalorized difference (Braidotti, 2014). In line with the intersection of our fields of study of critical disability studies, postcolonial studies, and feminist and gender studies, they are the medicalized ‘others’: people with disabilities and mental health problems; the racialized ‘others’: natives, post-colonials and non-Europeans; the sexualized ‘others’: women and LBGT’s; including the unique intersection of these subjects that are considered as structurally ‘other’. Being medicalized, racialized or/and sexualized are “patterns of pejoration of the human subjects that tend to be coded negatively both morally and emotionally: they express decreasing degrees of being-human (Braidotti, 2014: n. p.)”. Moreover, it has been argued that this happens in a world ordered according to “the obligation to be normal (Davis, 1995: 29)”.

In that vein, it can be argued that humanism enwrapped human beings within ways of thinking, judging and acting upon themselves as rational, self-authorizing,

transcendental subjects (Mahmood, 2005). In this realm, humanist discourses and sciences fabricated subjects capable of bearing the burdens of liberty and of engaging with a biographical project of self-realization, through the exercise of new political, moral, organization and personal forms of regulation (Rose, 1999: xvi). The norm is here being positioned as the technology that is concerned not with restricting bodies, but with re-producing them (Campbell, 2010) as governable subjects (Campbell, 2010; Rose, 1999), or in the context of current Western mental health services, with recovering them (Vandekinderen et al., 2012). Since the mid 1980s, research, policy, and practice concerning Western mental health services have concentrated on recovery, which is considered as a promising and strengths-based framework that justifies the deinstitutionalization of residential services over the last few decades and enables the increasing emphasis on developing community-based services in different Western welfare states (Bartlett & Wright, 1999; Beresford & Croft, 2004; Borg & Kristiansen, 2004; Davidson & Campbell, 2007; Postle & Beresford, 2007; Rushton, 1990; Wilson & Daly, 2007). This development has been associated with the emergence of new ideas about citizenship, focusing on the right of people with mental health problems to live on equal terms in mainstream society and promoting social inclusion in the community (Beresford, 2010). The recovery discourse explains recovery in terms of a journey of hope, consisting of a lifelong, individual process in which the individual takes back control, gets on with his/her life and (re)integrates into the social world (Borg & Kristiansen, 2008; Deegan, 1996; Jacobson & Greenley, 2001). In a nutshell, recovery is grafted onto empowering mental health service users to stimulate their personal growth, responsibility, and autonomy (Ralph, 2000). As such, the recovery paradigm is often cultivating a project of self-development and self-improvement for people with mental health problems (Jordan, 2004), “activating a vital, entrepreneurial and enterprising spirit among (their) subjects (Binkley, 2011: 92)”.

3. Agency

According to the central research insights in our respective fields of study, minority subjects are positioned – in terms of (dis)ability, religion/ethnicity and gender – in an intersection that radically challenges the humanistic ideal of the rational, unitary, male, white human subject as the measure of all things (Braidotti, 2013). In relation to our central research focus, Mahmood (2005) illustrates extensively that feminist scholarship performed the significant task of portraying Arab and Muslim women as active agents living rich and complex lives. These studies (e.g. Abu-Lughod, 1986) restored the absent voice of women to previous analyses of Middle Eastern societies that, for decades, have portrayed Muslim women as passive, submissive, and powerless beings determined by structures of male authority.

However, Mahmood (2005: 8) explores how these feminist scholars invoke a notion of human agency that locates agency in the political and moral autonomy of the subject, and understands agency as “the capacity to realize one’s own interests against the weight of custom, tradition, transcendental will, or other obstacles”. Reflecting on her own earlier work, amongst others, Abu-Lughod (1990: 43) mentions that there is perhaps “a tendency to *romanticize resistance*, to read all forms of resistance as signs of ineffectiveness of systems of power and of the resilience and creativity of the human spirit in its refusal to be dominated”. In her later work, Abu-Lughod (1990) argues that various local and everyday resistances might reflect the complex interworkings of a range of specific strategies and differential forms of power. In that vein, Mahmood (2005: 9) ascertains that “this reasoning still does not challenge the use of the term resistance to describe a whole range of human actions, including those which may be socially, ethically, or politically indifferent to the goal of opposing hegemonic norms”. This teleology tends to think of agency “mainly through the residual categories of resistance to or dislocation of dominant norms (McNay, 2000: 4)” and holds the risk of producing essentialistic counteraffirmations of identity (Braidotti, 2011).

Nonetheless, Mahmood (2005) explains that the desire for freedom from norms cannot be framed as an essential desire that motivates all beings at all times, but is

rather profoundly mediated by cultural and historical conditions. In that sense, the liberal discourse of freedom, individual autonomy and true will that constitute human nature and agency have become integral to our humanist intellectual traditions (Mahmood, 2005). This normative convention – which does not make it inherently negative, just highly regulatory – functions by transposing this specific mode of being an agentic human into a generalized standard (Braidotti, 2013), which also becomes naturalized in a large scope of the scholarship on disability, ethnicity/religion, and gender (Mahmood, 2005; Bracke, 2008). As McNay (2000: 2) points out, the massive attention to the “possibilities for resistance, subversion and the emancipatory remodeling of identity” in the three fields of study are predominantly rooted in a negative and dialectic understanding of subject formation and a divisive and antagonistic notion of (cultural) difference (Braidotti, 2011). As such, the normative political subject of poststructuralist theory often remains a liberatory one, locating agency within those operations that resist the dominating modes of power (Mahmood, 2005).

In our research, we aim to go beyond a solely negative and deterministic understanding of subject formation (Braidotti, 2013; Mc Nay, 2000) by taking a more materialist route. This feminist materialist perspective produces “a different scheme of emancipation and a non-dialectical politics of human liberation (Braidotti, 2013: 35)”. Inspired by the theoretical work of Braidotti (2006a), we aim at transposing the subject out of the dialectical identity politics into a non-unitary vision of selves as inter-related forces. Braidotti (2013: 26) introduces “a more complex and relational subject framed by embedment, sexuality, affectivity, empathy and desire as core qualities”. This challenges us to detach the notion of agency from the goals of progressive politics and the natural status accorded to the desire for liberal freedom (Mahmood, 2005), which might after all conceal the risk of ‘othering’ the diasporic Muslim women with mental health problems again. As also Mohanty (1988: 65) stated, not seldom “the discursively consensual homogeneity of a group is mistaken for the historically specific material reality of a subject”. Hence, we want to overcome the production of diasporic Muslims with mental health problems as a composite singular monolithic

subject prior to the historical and political analysis in question as it colonizes the material and historical heterogeneities of their lives (Mohanty, 1988). According to this perspective, “agency needs not to be critical in the negative sense of oppositional and aimed solely at the production of counter-subjectivities (Braidotti, 2013: 35)”, but as embodied capacities and means of subject formation (Mahmood, 2005).

We therefore draw on a productive and affirmative notion of cultural difference which allows for the creation of new images of multiple subjectivity and agency as a desire to “open up new possibilities and forms of human self-affirmation (Altini, 2010: 231)”. As Mohanty (1988) claims, these subjects are not only the victims of dominant regimes, but they challenge and subvert the process at various junctures, by responding to (cultural) difference “in a less defensive and even, at times, a more creative fashion (McNay, 2000: 3)”. In our biographical research with diasporic Muslim women with mental health problems, we attempt to grasp the modes of action and strategies of meaning making of real-life women as rooted in a specific historical, social, political, and cultural context.

4. Methodology

Our research methodology aims at capturing the experiences and meanings of cultural difference and mental health problems as a potentially productive and affirmative force (Braidotti, 2006a; 2006b; 2013).

4.1. Research context

Our research study is implemented in the City of Ghent, which is the capital of the province of East-Flanders in Belgium. In Ghent, a considerable part of the migrant population of Muslim majority countries are of Turkish and Maghreb origins, connected to a story of migration to Belgium between 1964 and 1974 as labor migrants for low-skilled jobs in the coalmine and steel and textile industries after the signing of the bilateral labor migration agreements in 1964 (with Morocco and Turkey) and 1967 (with Tunisia and Algeria) (Verhaeghe et al., 2012). Therefore, most of the current Turkish and Maghreb ethnic minorities in Ghent are already second or third generation

migrants, who often experience weak socio-economic integration and not seldom live in structurally precarious situations (Fadil et al., 2015; Kaya & Kentel, 2007; Martens et al., 2005).

Seen the underrepresentation of diasporic Muslim women with mental health problems in established mental healthcare, we decided to address a wide range of organizations in Ghent to recruit women for our research. We contacted by phone and email the following instances: city services, community health centres, mental health services, group practices, private practices of general practitioners, psychiatrists or psychologists, general hospitals and psychiatric hospitals. However, the search for participants ran not as smooth as we hoped beforehand, and based on the hints of professionals working in the above mentioned practices and organizations, we gradually broadened our scope of organizations, as we decided also to approach organizations with a less specific focus on mental health: welfare organizations, street work, a toy library, Centers for Pupil's Counseling, community work, women's refugee centers, ... We got the opportunity to introduce our research topic to diasporic Muslim women on a breakfast organized by the Federation of Moroccan Associations and in the toy library, and although we caught some expressions of interest, the big rush of participants held off. In the end, we succeeded to recruit 12 women of Turkish or Maghrebi descent with mental health problems across the different organizations.

4.2. Strategies of data-collection

We adopted an interpretative, and more in particular, biographical research approach in which knowledge is considered as situated, contextualized, gendered, and grounded in human activity (Chamberlayne et al., 2000; Denzin & Lincoln, 2003; Goodley et al., 2004). We aimed to reflectively interpret slices and glimpses of the dynamics of subject formation to identify agentic strategies and processes of meaning making in women's everyday lives, being contextualized in their respective social, political, and cultural contexts. Biographical research indeed evolves as field in which the interrelation between biography and society is interrogated, in an attempt to understand and situate individual life experiences within their historical, social, cultural and

political context (Roberts, 2002; Schiettecat et al., 2017). Essential to our biographical research design was the belief that the perspective and lived experiences of the diasporic Muslim women with mental health problems can provide valuable sources of knowledge (Booth & Booth, 1996). Therefore, these women participated as central informants in our research study.

However, as described above, it was a difficult process to find participants. First and foremost, the departure point of our research was the underrepresentation of diasporic Muslim women in mental health services. Logically, it's not obvious to reach these women by way of these professional channels. Further, we mentioned the term 'mental health problems' in our research explanation, and although we explicitly denote its social, cultural, historical and political character, some of the women might not connect to this terminology and refer to their experiences in another language. Additionally, a professional informed us about the fact that one woman refused to participate because she didn't recognize herself in the description 'Turkish woman' that we used, but identified herself as a purely Belgian woman. In some cases, professionals were a bit reluctant to allow us to contact women living in turbulent home situations in which they concealed their problems from their husband, since calling them was a very fragile venture which had to happen between strict hours.

Eventually, we conducted 12 semi-structured interviews (Bogdan & Biklen, 1998) which were all audio-taped and fully transcribed. The interviews took between one hour and three and a half hours and took place at a location chosen by the participant. That implies that the interviews were conducted at the home of the participant, at a bar in the city of Ghent, or in the hospital where the women were treated. All participants signed an informed consent form, clearly stating that they could end their participation at any time in the research process and that the anonymous character of the research was guaranteed. During the interviews, we tried to map the migration background of the women and how they experience and give meaning to their mental health problems in their daily life. We also explored the discourses and practices within the Muslim community concerning mental health problems and

Western mental healthcare and the processes of meaning making and agentic strategies that these women develop in dealing with their mental health problems.

4.3. Strategies of data-analysis

The data were analysed in an exploratory and interpretative way by means of a qualitative content analysis (Wester, 1987), defined as “any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings (Patton, 2002: 453)”. In the analysis, the theoretical and empirical perspectives “were very actively fused (Goodley et al., 2004: 64)”. The data were analysed by engaging in a directed approach to content analysis (Hsieh & Shannon, 2005), in order to provide thick and rich descriptions of the subjectivities created in particular settings, as the meaning and sense of agency cannot be fixed in advance, but must emerge through an analysis of specific modes of being in certain historical, political, cultural, and social realities (Mahmood, 2005). As such, we used empirically-based feedback loops, “moving back and forth” between the women’s biographies and theory, modifying original theoretical statements to fit into the biographical experiences and using pieces of the biographies relevant to the emergent theoretical concepts (Emerson, 2004). We reflectively analysed the everyday experiences of diasporic Muslim women with mental health problems, and specifically with a Turkish or Maghrebi background, guided by our attempt to identify strategies of meaning making and agency. Cultural difference and subject formation functioned as sensitising concepts (Patton, 2002).

5. Findings

We illustrate the central findings of our explorative research structured around four analytical nodes: (1) the embodied and embedded nature of mental health problems, (2) family and community life, (3) education and employment, and (4) religion. Although we make a distinction between four nodes in our analysis, the modes of action and strategies of meaning making of our interlocutors are inherently interrelated on the overlap of the domains of difference of disability, race/religion, and gender.

5.1. The embodied and embedded nature of mental health problems

The interviews with diasporic Muslim women with mental health problems often contain fragments of complex pasts and presents, characterized by a multifaceted amalgam of social problems (Gabel, 1999). Their mental health problems are entangled in problems and situations such as poor education or work conditions, poverty and financial difficulties, relations marked by physical and emotional violence, and complex family relations or loneliness. When the women tried to identify traces of the origin of their mental health problems, they all connected to past events that are embedded in social relationships and the way they have dealt with it. They refer to a complex web of social relations that compose the realities of their mental health problems. Let's turn to the example of Durya, a young woman with a Moroccan background who was born in the Netherlands but lives in Ghent for several years. She is studying socio-cultural work, and keeps intensive contact with the Federation for Moroccan Associations, where she is confronted with many women with a Moroccan background who have mental health problems. Based on the stories of the women she met there, she predominantly frames mental health problems as entangled with social and relational situations:

We receive a lot of questions of women who are depressed, because they're out of their relationship with their husbands, or because raising their children remains challenging. The women I've talked to see how their depression has been put in motion by the hands of others. At the time, I meet someone who is being harassed by her mother in law. She says that her mother in law has made her mentally ill. She says: "I have no rest in my life. If she disappears from my life, then I'm different, not like I am right now." And often the family of the man plays a role (...), just as problems in the marriage that are not acceptable in society.
(Durya)

The story of Zaineb also covers a very complex situation. Zaineb was born in Belgium, in a Turkish migrant family, and lives in Ghent with her two sons. She was referred to a psychiatric hospital by her general practitioner, as she saw creepy faces through the

window that no one else could see. During her hospitalization, it became clear that many other problems were at play. Zaineb had incurred financial debts due to her divorce. Her ex-husband did not pay any alimantation for their children. Her individual worker from the psychiatric hospital who still follows up her situation now she is treated on an ambulant basis, joined the interview, and tried to explain how they intervened in the situation:

We had to support her with her debts, the education of the children, the housing, ... things where Zaineb was not very good at and that we had to take over a bit. I still remember their house looked beautiful from the outside but on the inside it was a debris. (...) The youngest [son] wanted to play football, which was financially very challenging for this family. So I called Olympia Gent and we discussed alternatives. Normally Zaineb had to pay the registration fee of 75 euro at once in the month of August. But we obtained that it could be paid in three times. (...). Zaineb just was not able to manage all these things all by herself, it was just not an option. I was her right hand and arm. (...) Also her children frequently came over to the hospital, and I then repaired their bicycle. (individual worker)

Reflecting on the intervention, which she evaluated as very helpful, Zaineb refers to how her individual worker supported her to become stronger in dealing with the broad range of (social) problems, rather than narrowly focusing on the ‘clinical nature’ of her mental health problems. In the same vein, Izgi, a 26 years old woman with a Turkish background, highlights how the difficult social constellations and hard (financial) living conditions in which she grew up as a young woman intertwined with her mental health problems:

We lived together with our grandparents and that complicated things at home. My dad had a hard time choosing between his parents and his own family, which led to many conflicts. (...) And my aunt also lived in our home. So we slept in a very small room. (...) I studied “youth and disability” until the fifth year of secondary school, but I was forced to quit because of financial problems at home. I had to work, take care of the family and provide financial support. I worked for two years planting

flowers. That was a hard job, standing straight for eight hours. I didn't have a diploma, so I couldn't be picky. I didn't have much choice, and just started where I could. During those two years I continued doing the different undeclared jobs which I started during secondary school. I handed off every cent I earned to my parents. Then I went to adult education to finish my training but it failed due to psychological problems. I wanted to go on, but my body just shut down. (...) All those years I carried a lot on my shoulders. My body just wouldn't go any step further. That is how I've become ill. I just couldn't carry on. At that point, I put a halt to everything, my internship, my training, ... Simultaneously I was engaged with my boyfriend and this also didn't end well. All those things together. (Izgi)

In the above excerpt, Izgi situates her mental health problems in relation to the complex material and social context in which she grew up. Moreover, she describes her mental health problems in terms of how at a certain moment, her body stopped functioning. This is in line with the accounts of many of the diasporic Muslim women with mental health problems we interviewed. They often refer to bodily dysfunctions to describe their problems. As Sinem – a 28 years old woman of Turkish descent who had recently divorced and is mother of two young children – expresses:

I couldn't sleep. I couldn't sit down. I couldn't eat. I went outside but nowhere felt right. Just nowhere. I cried all the time. Suddenly I couldn't cry anymore. I was always alone. (...) I think I went to the emergency unit of the hospital ten or twenty times. I couldn't breathe. (Sinem)

Also Gülcin, a divorced woman of Turkish descent of 31 years old whose parents migrated to Belgium, frames her mental health problems in this sense:

I also consult a neuropsychiatrist. He prescribes antidepressiva. I fainted a lot but that was because my body has reached its limits. My body just couldn't cope anymore with all the sorrow and I fainted regularly. At first the neuropsychiatrist thought it was a kind of epilepsy, but after some research he came to a different conclusion: it was just emotional. (Gülcin)

The literature about mental health problems among migrant and ethnic minority communities addresses these bodily manifestations mainly in terms of ‘somatic symptoms’ which are framed as a cultural expression of mental health problems (Bäärnhielm & Mösko, 2012; Boneham et al., 1997; Buytaert et al., 2009; Inhorn & Serour, 2011; Karasz, 2005; Lawrence et al., 2006; Marwaha & Livingston, 2002; Schnittker, 2003; Vardar et al., 2012). However, this cultural approach is rooted in a Western mind-body dualism, while the contributions of our interlocutors reflect how mind and body are intrinsically related (Dolphijn & van der Tuin, 2012).

5.2. Family and community life

The taboo within their community concerning mental health problems was brought up as a central issue during the interviews. Eslem – the daughter of a Turkish mineworker – was hospitalized on the psychiatric ward of a general hospital for sleeping problems. However, she refused to participate in outdoor activities, e.g. going to the market, badminton sessions, ...

Everyone in this neighborhood knows that “the lunatics” stay here. And if they note you joining the group for outdoor activities, under supervision of a therapist, it becomes incontestable, and you are lost. I have a family, and I don’t want other people to blame my sons: “your mother is nuts”.
(Eslem)

Also Nadir, a 36 years old woman living in Ghent, whose grandparents has migrated to Belgium, said that she took great care that people would not know that she was visiting a psychiatric institution:

I went there on a day to day basis and every day I spotted the environment before entering the hospital, to assure that nobody saw me. I don’t want to be labeled as “crazy”. Because in the end, it’s considered as the nuthouse. Whenever I saw somebody, I took a detour until that person was gone. Once I met an acquaintance and then I said I was there to interpret. (Nadir)

She camouflaged her months-long hospitalization in a psychiatric institution even for her closest family - being her youngest brother and father - developing subtle strategies which enabled her to consult professional help while dealing with the taboo within the community:

My youngest brother worked at night. So, he would get up in the evening. My therapy session ended at 4:30 pm. So after my therapy I went home – it's only a 20 minute walk – and I waited until my brother left and returned to the hospital. I could stay outside until 9 pm. I did it like this almost every day. I always carried a cellphone with me, in case my dad called. Sometimes he needed an interpreter. When he called, I told him I was with somebody and couldn't talk, but that I would return his call. That wasn't a lie. I was attending a group therapy. Then I told him to make an appointment at 5 pm and I joined him. (...) I choose a hospital at a central location close to the city, so I was nearby when they needed me. But living like this is so exhausting. It is like leading a double life for months. I also had to take care of the laundry. Some days I went home with big bags full of laundry. But because of my problems I also had a shop addiction: every time I felt bad, I went shopping. So, I pretended that those big bags were filled with new clothes instead of laundry. (Nadir)

Durya explained how in Maghrebi culture weakness and the devoir to be strong is a gendered issue. She experienced how women above all must stand strong, which entails that women in many cases conceal their troubles:

The woman has to be the strong one, because when she gives up, she is perceived as weak. Within the community women are expected to be strong. (...) Women are really good at hiding their problems. I mean, like exceptionally good. That's something I have seen and learned throughout time. I still know women who are so cheerful while I know all their problems. They do not show it to anyone. And nobody sees that there are problems. (Durya)

However, most of the women we interviewed searched professional help. Some of them preferred to visit a therapist with the same ethnic background, assuming that the therapist's affinity with the culture could facilitate a good understanding of their situation. Others consulted psychologists and psychiatrists of Belgian origin, and they were confronted with a cultural gap at play, for example, when professionals advised unmarried young women living with their parents to take some distance from their family and community, as Gülcin explains:

I went to a psychiatrist in Ghent, but she didn't understand me. I had briefly explained the situation and she was like: "go away from home, go live on your own and take some distance from your community". (Gülcin)

Also Izgi experienced this:

My psychiatrist said: "Can't you go live on your own?" That is something that is impossible within our community. A girl that still lives at home, who isn't married and then moves out to live alone. That's when social pressure kicks in. What will people say about me? You get it? It's not just about me, but they will refer to me as "the daughter from". I don't want that. If I was the only one to bear the consequences, I wouldn't care that much. It's just that other people will look at my parents and judge our situation at home. As a matter of fact, the solution is indeed leaving home, but that's just not possible. (Izgi)

This illustrates how some of the women were confronted with mental health workers hinging on an (often subtle) discourse of individual autonomy. Mental health services endorsing the recovery paradigm make strong that they approach persons with mental health problems as "subjects capable of claiming their rights and making decisions for their lives based on their free and informed consent as well as being active members of society (Pieters et al., 2017)". This self-directing approach relies on a rather restricted notion of individual agency which – when put forward as a universal drive and benchmark to evaluate degrees of citizenship – risks to discredit the ways in which our interlocutors operate and develop alternative and subtle agentic strategies in

dealing with their mental health problems in often complex and delicate social, political and cultural contexts. However, their natural network and community holds the potential of offering important resources of support when people experience problems. Izgi and Gülcin – two young women of Turkish descent – refer to the solidarity within their community:

We take care of sick people in the family out of respect. That is solidarity. If someone gets ill, we automatically take care of him or her. (Izgi)

We help each other in our community. That's obvious. I also do this. We take care of each other. (Gülcin)

Meyra, a married Turkish woman, who migrated to Belgium at the age of 12 together with her mother and stepfather, illustrates the interdependency within the community on the basis of some concrete examples:

You can't leave the community because you need them. If we die, we want to be buried in accordance with our religious rituals. At that moment, we also need the community. And our parents don't know the language. They worked throughout their life and never had the time to follow a language training. So, they need the younger people of their community. (Meyra)

Also Nadia, a 41 years-old woman and daughter of Tunisian migrants, received (material) help from the community after her divorce:

I didn't know her. It was a Turkish woman who also wore a headscarf. I bought some furniture from her via a second hand forum. She had the same problem as me. She had a lot of new stuff and said: "For you I will make a special price." I also received a lot of stuff for free. (...) And I got some help from a converted Muslim, she provided food. That's something I really felt, you are not on your own. (...) If you don't have family, you really need the community, people who support you, also in psychological ways. (Nadia)

As such, throughout many narratives in our analysis, we discovered how the Muslim community at various points holds the potential of care, support, and resources for the women with mental health problems.

Moreover, the narratives of the women mirror how a narrow and essentialist notion of cultural identity seems highly inadequate to gain an in-depth insight in their multiple and complex schemes of interpretation and their strategies of dealing with mental health problems. The accounts of the diasporic Muslim women with mental health problems strikingly illustrate that the Muslim community in Ghent is not a monolithic cultural category. This community consist of various ethnicities and ethnicity is intersected with other categories such as generation, SES, living in a city or on the countryside, education level,... Tirra was 15 years old when she migrated with her family – five years after her father already left to work in the textile factory – from Morocco to Belgium at the beginning of the 1980s. At the age of 53, she has had two divorces. Her first husband hit her regularly, pushed her down the stairs and tried to kill her by setting her on fire. Her second husband was an illegal Egyptian, who married her for the sake of his regularization:

The neighbor is a Moroccan. His wife committed suicide. She was 40 and probably had some issues with her husband. Her family would like that I marry him because they know me well and because they know that I am an honest woman. But I don't want to get married anymore. Also, he is Moroccan but he is from the other side of Morocco. I come from a more modern city. We are open and modern. They come from the mountains. The women there are often very closed. You never know that he wants me to stay at home and do not want me to work. That he wants me to stay inside. In that region the women are often veiled. I don't wear a headscarf. I've just had a new haircut. (Tirra)

Tirra differentiates between modern and more traditional parts of Morocco, and as such reveals that an essentialist notion of culture disregards the multiple heterogeneities within a community, as also strikingly illustrated by Zaineb:

I come from the capital. Most of the other come from Emirdag. That clashes. Ankara is very beautiful. Emirdag is a rather dirty village. My mom and dad were modern so I was raised like that. In those villages women need to wear a headscarf. And for example they can't greet other men. I'm raised differently. (Zaineb)

In the same vein, Izgi, although emphasizing her Turkish roots, refers to education as a decisive factor in her young life, providing her with a certain kind of freedom:

I was raised with a lot of freedom. I've had the luck that my mother studied and has a more open-minded view and more insight in things. Not everybody has that. There are mothers who did not study and just got a cleaning job. They did not engage with alternative views so they give less freedom and hold on to certain restrictive rules, because they don't know otherwise. That is the difference: ignorance. (...) I have the luxury – I call that a luxury – that I have such a strong, educated family. (Izgi)

While the women cited above convincingly affirmed their Turkish or Moroccan roots, at the same time, they differentiate and distinguish themselves from other women with the same origin. In doing so, they often refer to notions as 'modern', 'freedom', 'less traditional', relying on a liberal discourse. As such, they strikingly enough confirm a dominant but problematic dichotomy between modernity and tradition, in which Muslim subjects are generally situated at the hierarchical inferior side.

Izgi draws a rather blunt – and in a way essentialist – distinction between Turkish and Belgian culture concerning the focus on the individual or the community. However, when she makes reference to her own situation, she profoundly states that she blends both:

In your culture, the individual is very important. Being independent. Taking care of yourself. That is the big difference with our culture. We know that we can rely on the community and that we take care of each other. That just goes automatically. That kind of solidarity is part of our culture. Your community is more closed off in terms of problems or family. But beware, I grew up within Turkish culture but I also picked up

some things from Belgian culture: to stand up for yourself, to set boundaries and act upon it. (Izgi)

We unravel a similar dynamic in the reasoning of Meyra who – in line with Durya – stresses the burden of responsibility that women – in contrast to men – need to bear within her community, and how this might cause mental health problems. And although she counts herself explicitly to the community, she explains how she transformed this common practice in her personal situation:

Men can go outside more easily. Women have the children and the household to take care of. Thinking about themselves for one moment is out of the question. And this also renders problems. The women from our community carry a lot of responsibilities. I did the same and it has made me more ill. I told my husband: “I’m having a hard time and I quit my job. You are going to help me with the household. If you don’t want to help, things will stay as they are. Because I will not get up to clean the house.” In this regard, I am a very happy woman. He took on his part of the household. He told me: “You work, I work, so it’s normal we do this together.” He also bought a dishwasher to make life more comfortable. But I do hear other stories from many of my friends. Their husbands say: “You are the woman, it’s your responsibility.” But men should show respect to their wives. (Meyra)

Durya sketches the generational difference and associated tension – frequently referred to by the women we interviewed – in perceptions and norms with regard to divorce within the Moroccan community. Moreover, she reveals how cultural ideas and practices are entangled with historical, social, economic and political processes, by referring to the opportunities on the labor market for women created by the economic wealth of a state:

The society in which we are growing up has an influence. We are more verbal, we are stronger, we have our demands towards a man: there has to be a match, he has to be sweet, ... When I look at our mothers, they just wanted someone who took care of them and they obeyed. That is a

totally different life. (...). I am also divorced. The women of my generation, who had problems at home or had enough from their partners, were relieved to divorce. It didn't work out and I don't have to go on with this. Ok, on to the next one. This second generation has a different attitude: there are other fish in the sea. We are perceived as being too westernized. We also live in a very prosperous country that does not abandon divorced women. This is a contrast with Morocco. There, it is the man who takes care of you. If you get divorced there and have to live with your children, it's hopeless. That's a one-way ticket to the gutter and there aren't any jobs. (Durya)

5.3. Education and employment

Hafsa is the daughter of an Algerian migrant who came to Belgium as a guest worker. Her father killed her mother during a stay in Algeria, where they were finalizing the distribution of the goods as a result of their divorce. At the age of 18, Hafsa stranded in a women's refuge center for domestic violence committed by her brothers and sister, and she cut off contact with her family for three years. During an entire period, her work was very important to keep her life on track:

Having a job was a necessity for me. Making money. Having control over my budget so that problems wouldn't increase. To experience self-satisfaction. That I can contribute to society and other people. (Hafsa)

Many of the women referred to work as an important strategy to deal with their mental health problems, as it was the case for Nadir:

I always worked very hard so that I could repress certain things. I didn't want to cave in. That was the easy way for me, focusing on the job. (Nadir)

Izgi explains how her mother subtly hoodwinked her parents-in-law, responding to their primary concern, in particular bringing in money, to create the necessary space that enabled her to continue higher education. Education and work were her productive ways of escape to cope with the difficult private situation in which she was entwined and which challenged her mental health:

My parents came from Turkey. Once they arrived in Belgium, the state actually required of them to go to school and learn the language. In return, they received financial incentives. My mother told her parents in law that going to college was compulsory (“otherwise, I don’t receive any money”), while as a matter of fact that wasn’t the case. Money was very important for the parents in law, so it was a convincing argument, allowing my mother to go studying at college. (...) My grandma denigrated my mother. She remained silent and could not stand up for herself. But she did go to college while having three children. That was her freedom. Her job and her studies. (Izgi)

Work also seems to be an important strategy in increasing well-being. Tirra explains how her job as a logistic assistant in a hospital entails satisfying social encounters with both patients and colleagues which contribute to her mental health:

I feel better when I’m at work. Because I have a lot of contact with the patients. They love to see me coming because I do a lot for them. I just feel better being close to my patients. When I don’t really have anything to do I can just go to one of my patients and have a small chat, becoming acquainted with each other. And then we just start talking. That just feels good. I like being busy, and having my colleagues around me. (Tirra)

However, at the same time the narratives of different women contain references to arduous educational trajectories, not seldom hampered by language problems. Most of the women we interviewed are low-skilled, entailing limited opportunities on the labor market and less challenging, poorly paid jobs, often resulting in financial problems, also due to the fact that in many cases, they are divorced and single mothers.

Meyra was raised by her mother in a small Turkish village, where they had to survive under harsh material living conditions after her father died. Meyra experienced difficult times, as she was bullied due to their financial problems. Her mother remarried and they travelled to Belgium, where Meyra experienced a bumpy school course with more bullying, partly due to language problems:

Actually, I needed a good language training which I didn't have, causing difficulties at school. It also influenced my communication with people. I had classmates who verbally abused me and teachers who bullied me. They told me: "You have to go to professional secondary education or special secondary education." Just because I didn't know the language and had troubles with syntax. That's how I started to reflect about my situation. I started crying. I didn't feel good anymore. (Meyra)

She delivered a big effort to keep up her language by following evening courses, reading Dutch books, watching Dutch television programs, listening to the Dutch radio and making Dutch friends. As such, she succeeded finishing her training "office clerk". However, her headscarf prevented her from finding a job as an office clerk. Moreover, she had to wait a year before she received benefits, while she had to pay rent and electricity on her own. Forced by financial reasons, she accepted a job as cleaner:

So, then I started to work at a hospital as a cleaning lady. I worked there for about four years. It's there where my problems started. I had a job that I really didn't like but I felt obliged to the job. I didn't have any other job. (...) Eventually I resigned. I could not go any further. I could not sleep. I was stressed out and angry and whenever someone said something that annoyed me, I exploded.

Meyra was refused a position as office clerk because of the fact that she was visibly wearing a religious symbol. The material reality in which she had to survive compelled her to start as a cleaning lady in a hospital, where her older colleagues passed on the dirty tasks to her. Meyra considers this physically hard and little challenging or uplifting job in a poorly amicable environment, as the last straw that has tackled her. In this vein, she strikingly points out that mental health problems are not an individual matter, but are embedded in social and material environments.

5.4. Religion

All of the women express themselves as being religious, that is, being Muslim, which was in eight of the twelve cases visually clear on the basis of wearing a headscarf.

Others explained their ritual of washing five times a day. Their narratives expose how Islam plays a vital role in assigning meaning – and in some cases even meaningfulness – to mental suffering. Asking Gülcin what makes her feel better at certain moments, she answers:

To believe in Allah, to know, that everything stems from Allah. I know that he protects everyone. When bad things happen to me, it doesn't mean that he doesn't love me, but that he wants to protect me from other things. We also believe in life after death. We are put to a test in this world to decide if we go to paradise or to hell. (Gülcin)

Naïma, a Moroccan woman who migrated to Belgium at the age of 24 accompanied by her sister and brother, explains the origins of her mental health problems in terms of the presence of the devil in her body:

When psychological problems arise, it's the devil. You do know he exists, don't you? I am a hundred percent sure. The devil is in your body. He is in your head and ideas. Someone who doesn't really know the devil, starts believing that those ideas stem from themselves. But that is not true. They are not ours, but from the devil. (Naïma)

According to Naïma the devil lodged himself in her body, from where he could determine her thinking. In her explanation, Naïma places her body in a social, historical, and economic reality, by clarifying that the devil saw his chance to penetrate in the period after her migration, when her body and its thoughts were weakened by loneliness and financial troubles:

The devil awaits the moment. Before I was married, I lived on my own. And when you live on your own, you start thinking: I need to pay the rent, I am afraid that I won't find a job, ... You start thinking. And you will fall. The devil knows that. When you are weak, he can come inside. And he stayed in my head for three years. He made me afraid of other people. I lost every faith. I did not sleep. He made my head so tired. He often spoke in my head. He makes people psychologically sick. (Naïma)

Trusting on her religion and through consulting God – noteworthy she sees salvation in different religions, since “they all rely upon one and the same God” – Naïma figured out a strategy to banish the devil. She used a physical/material medium to introduce Quranic verses into her body:

Religion is very important in this case. It could be Christianity, or the Islam, or, ... That is all the same, it entails the same God. And you have to count on him. God has made me strong. God has helped me. He said to me: “You have to search in the Quran, for what frightens the devil.” You know what I did? For three months, I put my earbuds in and listened to a cassette with Quranic verses when I went to sleep. Every day. And I felt that the devil was cornered. He became afraid. I felt it. He really got afraid. And I felt that he left through my ears. And he never returned. Now he can't come in anymore because I am stronger and he knows that I have the Quran. And that is what people have to know. You won't remain sick forever. (Naïma)

For some of the women we spoke, religious practices and persons seemed to be part of the strategies they develop in their recovery process, as explained by Izgi:

In our community, there is a strong belief that the imam is of great importance to heal. I do go to the imam. Because of the weight on my shoulders and the lack of strength. I go to the psychologist. I do everything to move forward. It meant a lot to me. But still, for that inner peace I want to go the imam. We read meditations from the Quran. And then you feel genuinely lighter. (Izgi)

At the moment of the interview, Hafsa is hospitalized in a psychiatric institution for panic attacks. Before her admission into the hospital, she experimented with religiously inspired rituals, hoping to reduce the attacks:

In 2012, when I visited my father in Algeria, I went to a doctor in the village who uses Quranic verses to heal you. It is accompanied by a certain ritual, to discover whether there are evil spirits. He uses a glass of water and he explains that the prayer will have an effect on that water

and then you have to drink it. But it didn't work, I kept on having panic attacks. (Hafsa)

I am in favor of homeopathy. My mother was experienced in these Maghrebi practices. You burn herbs on charcoal. You have to know very well which kind and amount of herbs. The smoke can clear the air from unrest, sadness or aggression. Specific herbs can drive away evil spirits or Jins as we call them. It can also purify people, when you get in the smoke cloud. I have done this with the help of the second wife of my father. (Hafsa)

Hafsa also mentions the habit of wearing a blue-eyed amulet, which contains magical powers that protect you from the evil eye and the jealousy of other people. At certain moments, religion and spirituality seem to flow into each other. In the excerpt below, praying is framed as a form of meditation. Moreover, the quote shows how some of the women mix and combine different approaches and methods (covering religious prayers, spiritual mediation and yoga, you tube movies, psychotherapy) to deal with their mental health problems and as such produce their personal hybrid strategy which they frame as a coherent story:

Prayer can enlighten you, similar to yoga. Prayer is like meditation. You can let go of things. The Quran also describes how you can relinquish troubles. And the imam tells stories about what people have experienced. On YouTube you can find the story of a man who is poor, but nevertheless does much effort for his child. Such stories do me a power of good. Then butterflies start to tickle in my belly. A feeling like: ah, I'm happy. In fact, it's the same with the imam but he relies on different methods. (...) And also, my psychotherapist says: "If you have troublesome people in your life, just throw them away." That is also in the Quran. If you have troublesome people in your life, try to extract them from your life in a respectful, polite, and friendly manner. I also follow yoga and meditation. (Meyra)

Several of the women extensively flesh out the distinction between religion and culture, taking a critical stance towards their culture, without dissociating themselves

from it. They criticize the inferior social position of women, unraveling the incongruities between the cultural interpretation and the Quran:

I'm not fond of my culture. I prefer my faith, that is one straight line. I experience that there are too many taboos in my culture. In my faith it would be appreciated that you seek help. While in our culture, seeking help is still very taboo. Because, people look at each other and are very sensitive to each other's perceptions. And yeah, I am a divorced woman. So, I am inferior to women that are married. While my faith states that, if it really doesn't work, it is better to divorce. The Quran contains a full chapter on this topic. And it also has a chapter on the rights of women. While, when I look at the culture, men have more rights than women. And when I look back to my faith, it's just not true. Women have equal rights at the least. When I look back at the culture the man is the head of the family, but when I look at my faith, the mother is three times more important than the father. The Quran states: "Three times your mother and then your father." So, you see, culture and faith do not match. (Durya)

Secularity is one of the pillars of Western Humanism, as such, an instinctive form of aversion to religion is historically an integral aspect of secular-liberal emancipatory politics of which feminism has been an integral (if critical) part (Bracke, 2008; Braidotti, 2013; Mahmood, 2005). As pointed out by Mahmood (2005: 1), "the vexing relationship between feminism and religion is perhaps most manifest in discussions of Islam", since the Muslim feminine subject occupies an uncomfortable place in feminist scholarship as she might carry on "practices and ideals embedded with a tradition that has historically accorded women a subordinate status".

However, the accounts of the women illustrate how belief systems are perhaps not incompatible with critical thought and practices of citizenship. A post-secular approach, based on firm anti-humanist grounds, "makes manifest the previously unacceptable notion that agency and political subjectivity, can actually be conveyed through and supported by religious practices (Braidotti, 2013: 35)", as Gülcin explains:

My greatest sorrow was to be a divorced woman. Because you are perceived as less in our culture. I felt that with my own mother. It's at that point I started to lose my self-confidence. (...) I love to read, so I bought many books to read during the summer holidays. As a matter of fact, I did need to buy one more book to receive the discount. (laughing). So I bought a book by a Turkish psychiatrist whose therapy is inspired by Islam. Every session was shaped by the Quran. During summer holidays, I was in the birth village of my parents, where there is nothing doing round, you can't even go outside to have a drink. And there I read all my books. This book was the only one that remained. So I was like: ok, I'll give it a try. Actually, it was therapeutic for me. It was like that book was written just for me. And he kept on giving examples from the Quran. In that book, I read that a divorced woman comes first, because the prophet was also married with a divorced woman. And then I had the insight, if people were truly Islamic, they would protect me more. And show more care and support towards a divorced woman. Because when they truly follow the Islam, then divorced women come on the first place. So I was like: actually they are stupid. And that's how I got by. (Gülcin).

6. Conclusion

Our research draws on the finding that, although scientific research increasingly shows evidence of a higher prevalence of mental health problems amongst diasporic Muslims, this minority group is underrepresented in Western mental healthcare services. Scientific studies exploring the issue of mental health problems amongst diasporic Muslims have extensively documented the importance of cultural factors. As such, cultural difference is identified as a prominent frame to explain this underrepresentation of diasporic Muslims mental health problems in Western mental health services. It is argued, for example, that beliefs, norms and moral values which are linked to Muslim culture facilitate the body's reactions to emotions, which explains the expression of somatic complaints (Begin-Arslan et al., 2002). Another research argument focuses on the underrepresentation in mental healthcare as the consequence

of a collectivistic community life in Muslim communities, that are characterized by patterns of taboo and shame (Rondelez et al., submitted).

These findings mainly reveal a friction between the cultural norms and values of diasporic Muslims and those of Western mental healthcare, which is currently predominantly rooted in a recovery paradigm which – although heretical with the dominant biomedical model based on a strong mind-body dualism (Engel, 1977; Wade & Halligan, 2004) – still resonates clinical and medical overtones. The recovery paradigm attaches great importance to, for example, the values of individual responsibility and self-determination, resilience and self-empowerment (Vandekinderen et al., 2012). In Western mental health services being crafted on the recovery paradigm, mental health is perceived as the dynamic ability to adapt and self-manage one's own well-being and the ability to address the physical, emotional and social challenges of life (Huber et al., 2011; Thornicroft et al., 2011). Recovery is defined as a person-driven process, in which “individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience” (SAMHSA, 2012). In that vein, significant and valuable efforts of mental healthcare initiatives can be observed, in their attempts to develop a culture-sensitive approach to meet specific needs of ethnic minorities. Certain organizations for example recruit people with another ethnic background to fulfil the job of cultural worker. However, these initiatives often exist in the margins of regular mental healthcare and as such, the dominant and exclusive structures, rationales and premises of Western mental healthcare remain largely unquestioned. In that context, the cultural difference of diasporic Muslims is often framed as a matter of inferior cultural value in contrast with the humanist rationales and values of Western mental healthcare practices, that are ascribed a universal and even superior character. Even culture-sensitive mental healthcare therefore entails the risk of building on an essentialist and pejorative notion of culture, which leads to a dismissing of the heterogeneities within ethnic minority groups and to a devaluation of the culture of diasporic Muslims.

In this contribution, we therefore wanted to recapture an affirmative and productive notion of cultural difference, that allows us to embrace differences and heterogeneities within and across cultures (Braidotti, 2011). Our aim was to uncover the complex and heterogeneous ways in which diasporic Muslim women with mental health problems, “who most often fall out of the realms of those considered as ‘emancipated subjects’ (Bracke, 2008: 52)”, deal with their mental health problems. In doing so, we adopted a notion of agency that is delinked from a teleology of progressive politics (Mahmood, 2005). We conceptualized agency in the variety of ways in which norms are lived and inhabited, aspired to, reached for and consummated, and as such, (re)locate agency in a tradition of thought about habitus (Mahmood, 2005; Bracke, 2008). As Bracke (2008: 63-64) points out, “this point of departure allows for different (non-liberal, non-secular) understandings of the capacity to act and shape the world, and notably understandings of autonomy, of subjectivities shaped within a tradition and by the dynamics of that tradition, including their capacities to transform a tradition”.

Tracing the ‘origin’ of their mental health problems, our interlocutors refer to complex family situations, financial challenges, high expectations towards women taking responsibility for both family life and work, difficult educational and employment trajectories, ... In doing so, they frame their mental health problems as embodied, embedded, and inherently social and in-process rather than natural, objective, purely biological and deterministic (Hughes, 2007; Roets & Braidotti, 2012). As such, they challenge the body-mind dualism which has historically functioned as a reductive shortcut in social theory (Braidotti, 2006a). Moreover, their narratives expose how cultural difference is intertwined with other axes of difference, and how subjects are formed ‘in-between’ or in the intersection of the ‘parts’ of difference (Bhabha, 1994). Therefore, women belonging to the Muslim community in Ghent cannot be understood as a monolithic cultural category; our research shows that the Muslim community, but equally well our society, entails many heterogeneities.

Some of our respondents positioned themselves according to the axes of modernity and tradition, inscribing themselves in an emancipation process according

to modern conceptions of humanity (Asad, 1996) and explicitly distinguishing themselves for example from women who wear a headscarf. Strikingly, the women who resonate with this modernity discourse and as such reproduce a dominant dichotomous script (Bracke, 2011), often sketched a personal history marked by betrayal by their relatives and as such, took distance of their family and/or community, also when they develop strategies to deal with their mental health problems (e.g. hospitalization in a psychiatric institution). Within this context, these women may benefit from identifying themselves with modernity, while imputing traditional – and according to the liberal discourse inferior – norms and values to community, as it installs a bearable constellation in which they position themselves as emancipated. Moreover, many of the women stress the emancipatory potential of education, that offers them the horizon of a future perspective, and identify employment as a productive way to position and integrate themselves within society. However, a reality check in some cases bares difficult educational and employment trajectories, which in some cases enable their mental health problems. Moreover, some respondents mention a challenging family-work balance, solved in some cases by redistributing household tasks with their husband (or buying a dish washer). As such, they implicitly hint to the emancipation of their generation.

Some women stress how they benefit from the solidarity of the Muslim community, not seldom in contrast and framed as superior to individuality which according to them characterizes Western society. As such, for many of our respondents, the Muslim community is a vital resource of (material) care and support when they experience mental health problems. Nevertheless, our analysis reveals how many women at the same time criticize the subordinate position of women within their community. In this vein, some of the women appeal to their religion, which has systematically been connected to women's oppression (Bracke, 2008), exactly to denounce the inferior position of (divorced) women in Muslim community. By establishing a link between religious texts, generally read in terms of patriarchal domination, and women's emancipation, they install a shift in meaning, aiming to re-articulate and reposition the female subject in the Muslim community. Almost all

respondents identify Islam religion as an important resource to give meaning to and deal with their mental health problems. For example, one woman resolutely turns to religion to scare away the devil, and to deal with her family-work expectations, explaining that God figured out a very balanced plan in favor of women: men have to go work outside, while women can stay at home and take care of their household and children. Additionally, she poses the performative question: ‘Or do you think Western women are so much better off, being overstressed by the combination work and children?’, shedding another light on emancipation. However, many of the women we interviewed creatively combine different strategies stemming from different traditions, namely religious prayers, meditation and yoga, You Tube movies, psychotherapy, medication,... and as such produce their personal hybrid strategy. Interestingly, they draw clear parallels between their religious prayers and more broadly spread spiritual practices in Western society such as yoga and meditation. In doing so, they translate their religious practices in terms that resonate within the secular society in which they live.

The diverse accounts of the women illustrate above all that cultural difference cannot solely be read as the reflection of pre-given ethnic or cultural traits set in the fixed tablet of tradition (Bhabha, 1994), but it opens up “the possibility of a cultural hybridity that entertains difference without an assumed or imposed hierarchy” (Bhabha, 1994: 4). In that sense, cultural difference entails a rather complex and on-going negotiation, through which “multiple forms of belonging and complex allegiances” are produced (Glissant, 1990 in Braidotti, 2011: 80). As such, our research findings learn us how to reframe the underrepresentation of diasporic Muslims in mental healthcare. The idea that they are not making use of Western mental healthcare services might implicitly hint to the underlying assumption that they need to integrate themselves in the existing social order, yet our research shows that they are involved in integrating and emancipating themselves in our societies in creative and hybrid ways. The challenge for mental healthcare services is then to make sense of cultural difference by recognizing modes of agency and subjectivity that might differ from

liberal and secular values and to interpret cultural difference as a potentially affirmative force.

References

- Abu-Lughod, L. (1986). *Veiled sentiments: Honor and poetry in a Bedouin society*. California: University of California press.
- Abu-Lughod, L. (1990). *The romance of resistance: Tracing transformations of power through Bedouin women*. *American Ethnologist*, 17(1): 41-55.
- Altini, C. (2010). *Potentia as potestas: An interpretation of modern politics between Thomas Hobbes and Carl Schmitt*. *Philosophy & Social Criticism*, 36(2): 231-252.
- Asad, T. (1996). Comments on conversion. In P. van der Veer (Ed.), *Conversions to modernities: The globalization of Christianity* (pp. 263-274). London: Routledge.
- Bäärnhielm, S., & Ekblad, S. (2000). *Turkish migrant women encountering health care in Stockholm: A qualitative study of somatization and illness meaning*. *Culture, Medicine and Psychiatry*, 24(4): 431-452.
- Bäärnhielm, S., & Mösko, M. (2012). *Cross-cultural training in mental health care: Challenges and experiences from Sweden and Germany*. *Eur Psychiatry*, 27(1): 51-56.
- Bartlett, P. & Wright, D. (1999). *Outside the walls of the asylum: The history of care in the community 1750-2000*. London: The Athlone Press.
- Bengi-Arslan, L., Verhulst, F.C. & Crijnen, A.A. (2002). *Prevalence and determinants of minor psychiatric disorder in Turkish immigrants living in The Netherlands*. *Soc. Psychiatry Psychiatr Epidemiol*, 37(3): 118-124.
- Beresford, P. & Croft, S. (2004). *Service users and practitioners reunited: The key component for social work reform*. *British Journal of Social Work*, 34(1): 53-68.
- Beresford, P. (2010). *Re-examining relationships between experience, knowledge, ideas and research: A key role for recipients of state welfare and their movements*. *Social Work & Society*, 8(1), 6-21.
- Bhabha, H.K. (1994). *The location of culture*. London and New York: Routledge.

- Binkley, S. (2011). *Psychological life as enterprise: Social practice and the government of neo-liberal interiority*. *History of the Human Sciences*, 24(3): 83-102.
- Bogdan, R.C. & Biklen, B.K. (1998). *Qualitative research for education: An introduction to theories and methods*. 4th ed. New York: Pearson Education group.
- Boneham, M.A., Williams, K.E., Copeland, J.R.M., McKibbin, P., Wilson, K., Scott, A., & Saunders, P.A. (1997). *Elderly people from ethnic minorities in Liverpool: Mental illness, unmet need and barriers to service use*. *Health and Social Care in the Community*, 5(3): 173-180.
- Booth, T., & Booth, W. (1996). *Sounds of silence: Narrative research with inarticulate subjects*. *Disability & Society*, 11(1): 55-69.
- Borg, M., & Kristiansen, K. (2004). *Recovery-oriented professionals: Helping relations in mental health services*. *Journal of Mental Health*, 13(5): 493-505.
- Borg, M., & Kristiansen, K. (2008). *Working on the edge: The meaning of work for people recovering from severe mental distress in Norway*. *Disability & Society*, 23(5): 511-523.
- Bracke, S. (2008). *Conjugating the modern/religious, conceptualizing female religious agency: Contours of a 'post-secular' conjuncture*. *Theory, Culture & Society*, 25(6): 51-67.
- Bracke, S. (2011). *Subjects of debate: Secular and sexual exceptionalism, and Muslim women in the Netherlands*. *Feminist Review*, 98: 28-46.
- Braidotti, R. (2006a). *Transpositions: On nomadic ethics*. Cambridge: Polity Press.
- Braidotti, R. (2006b). *Posthuman, all too human: Towards a new process ontology*. *Theory, culture & Society*, 23(7-8): 197-208.
- Braidotti, R. (2011). *Nomadic subjects: Embodiment and sexual difference in contemporary feminist theory*. New York/Chichester, West Sussex: Columbia University Press.
- Braidotti, R. (2013). *The posthuman*. Cambridge: Polity Press.

- Braidotti, R. (2014). *Metamorphic others and nomadic subjects*. Text written for the exhibition by Oliver Laric at ar/ge kunst Galerie Museum, 28.11.2014 – 24.01.2015. Available at : <http://www.argekunst.it/wp-content/uploads/2014/11/Metamorphic-Others-and-Nomadic-Subjects1.pdf>
- Bromand, Z., Temur-Erman, S., Yesil, R., Heredia Montesinos, A., Aichberger, Mc., Kleiber, D., Schouler-Ocak, M., et al. (2012). *Mental health of Turkish women in Germany: Resilience and risk factors*. *European Psychiatry*, 27(2): 17-21.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.
- Butler, J. (2009). *Performativity, precarity and sexual politics*. Lecture given at Universidad Complutense de Madrid, June 8, 2009.
- Buytaert, E., Vandedrinck, E., & Lemmens, G.M.D. (2009). *Psychiatrische stoornissen bij migranten: Feiten en hypothesen*. *Tijdschrift voor Geneeskunde*, 65(18): 1-8.
- Campbell, T.W.H. (2010). *Governing educational difference: Towards a genealogy of dyslexia*. (unpublished doctoral dissertation). University of Leeds, Leeds.
- Chamberlayne, P., Bornat, J., & Wengraf, T. (2000). Introduction: The biographical turn. In P. Chamberlayne, J. Bornat, & T. Wengraf (Eds.), *The turn to biographical methods in social science: Comparative issues and examples* (pp. 53-70). Londen: Routledge.
- Davidson, G., & Campbell, J. (2007). *An examination of the use of coercion by assertive outreach and community mental health teams in Northern Ireland*. *British Journal of Social Work*, 37(3): 537-555.
- Davies, B. (1997). *Constructing and deconstructing masculinities through critical literacy*. *Gender and Education*, 9: 9-30.
- Davis, L. (1995). *Enforcing normalcy: Disability, deafness and the body*. London: Verso.
- Deegan, G. (2003). *Discovering recovery*. *Psychiatric Rehabilitation Journal*, 26(4): 368-376.

- Deegan, P. (1996). *Recovery and the conspiracy of hope*. Downloaded from <http://www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope>.
- Denzin, N.K., & Lincoln, Y.S. (2003). *The landscape of qualitative research: Theories and issues*. London: Sage Publications.
- de Wit, M.A., Tuinebreijer, W.C., Dekker, J., Beekman, A.J., Gorissen, W.H., Schrier, A.C., Penninx, B.W., et al. (2008). *Depressive and anxiety disorders in different ethnic groups: A population based study among native Dutch, and Turkish, Moroccan and Surinamese migrants in Amsterdam*. *Soc. Psychiatry Psychiatr Epidemiol*, 43(11): 905-912.
- Dolphijn, R., & Van der Tuin, I. (2012). *New materialism: Interviews and cartographies*. University of Michigan Library: Open Humanities Press.
- Emerson, R. (2004). Working with key incidents. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman (Eds.), *Qualitative research practice* (pp. 457-472). London: Sage.
- Engel, G.L. (1977). *The need for a new medical model: A challenge for biomedicine*. *Science, New series*, 196(4286): 129-136.
- Fadil, N., Asri, F.E., & Bracke, S. (2015). Islam in Belgium: Mapping an emerging interdisciplinary field of study. In J. Cesari (Ed.), *The Oxford handbook for European Islam* (pp. 222-261). Oxford: Oxford University Press.
- Fanon, F. (1952/1967). *Black skin, white masks*. US: Grove Press Inc.
- Fassaert T., de Wit, M.A., Tuinebreijer, W.C., Verhoeff, A.P., Beekman, A.T., & Dekker, J. (2009). *Perceived need for mental health care among non-western labour migrants*. *Soc Psychiatry Psychiatr Epidemiol*, 44(3), 208-216.
- Gabel, S. (1999). Depressed and disabled: Some discursive problems with mental illness. In M. Corker, & S. French (Eds.), *Disability discourse* (pp. 38-46). Buckingham, Philadelphia: Open University Press.
- Goodley, D., Lawthom, R., Clough, P., & Moore, M. (2004). *Researching life stories: Method, theory and analyses in a biographical age*. London/New York: RoutledgeFalmer.

- Goodley, D. (2011). *Disability studies: An interdisciplinary introduction*. London: Sage Publications.
- Grosz, E. (1994). *Volatile bodies: Toward a corporeal feminism*. Bloomington, IN: Indiana University Press.
- Hsieh, H.F., & Shannon, S.E. (2005). *Three approaches to qualitative content analysis*. *Qualitative Health Research*, 15(9): 1277–1288.
- Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., Leonard, B., Lorig, K., et al. (2011). *How should we define health?* *BMJ (Clinical Research Ed.)*, 343(9666).
- Hughes, B. (2007). *Being disabled: Towards a critical social ontology for disability studies*. *Disability & Society*, 22 (7): 673-684.
- Inhorn, M.C., & Serour, G.I. (2011). *Islam, medicine, and Arab-Muslim refugee health in America after 9/11*. *The Lancet*, 378(9794): 935-943.
- Jacobson, N., & Greenley, D. (2001). *What is recovery? A conceptual model and explication*. *Psychiatric Services*, 52(4), 482-485.
- Jordan, B. (2004). *Emancipatory social work? Opportunity or oxymoron*. *British Journal of Social Work*, 34(1): 5-19.
- Karasz, A. (2005). *Cultural differences in conceptual models of depression*. *Social Science & Medicine*, 60(7): 1625-1635.
- Kaya, A., & Kentel, F. (2007). *Belgische Turken: Een brug of een breuk tussen Turkije en de Europese Unie?* Brussels: Koning Boudewijn Stichting.
- Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., et al. (2011). *Common mental health problems in immigrants and refugees: General approach in primary care*. *CMAJ*, 183(12): 959-967.
- Latzer, Y. (2003). *Traditional versus Western perceptions of mental illness: Women of Moroccan origin treated in an Israeli mental health center*. *Journal of social work practice*, 17(1): 77- 94.
- Lawrence, V., Banerjee, S., Bhugra, D., Sangha, K., Turner, S., & Murray, J. (2006). *Coping with depression in later life: A qualitative study of help-seeking in three ethnic groups*. *Psychological Medicine*, 36(10): 1375-1383.

- Levecque, K., Lodewyckx, I., & Vranken, J. (2007). *Depression and generalised anxiety in the general population in Belgium: A comparison between native and immigrant groups*. *Journal of Affective Disorders*, 97(1-3): 229-239.
- Mahmood, S. (2005). *Politics of piety: The Islamic revival and the feminist subject*. Princeton, NJ: Princeton University Press.
- Martens, A., Ouali, N., Van de maele, M., Vertommen, S., Dryon, P., & Verhoeven, H. (2005). *Etnische discriminatie op de arbeidsmarkt in het Brussels Hoofdstedelijk Gewest: Onderzoek in het kader van het Sociaal Pact voor de werkgelegenheid van de Brusselaars*. Brussels: BGDA.
- Marwaha, S., & Livingston, G. (2002). *Stigma, racism or choice: Why do depressed ethnic elders avoid psychiatrists?* *Journal of Affective Disorders*, 72(3): 257-265.
- McNay, L. (2000). *Gender and agency: Reconfiguring the subject in feminist and social theory*. Cambridge: Polity Press.
- Missine, S., & Bracke, P. (2012). *Depressive symptoms among immigrants and ethnic minorities: A population based study in 23 European countries*. *Soc Psychiatry Psychiatr Epidemiol*, 47(1): 97-109.
- Mohanty, C.T; (1988). *Under Western eyes: Feminist scholarship and colonial discourses*. *Feminist Review*, 30(autumn): 61-88.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. California: Sage Publications, Thousand Oaks.
- Pieters, G., Ruud, T., van Weeghel, J., Bähler, B., Shields-Zeeman, L., & Keet, R. (2017). *Recovery for all in the community: Learning from each other: Consensus paper on fundamental principles and key elements of community-based mental health care*. Downloaded from <https://assets-sites.trimbos.nl/docs/5bdc3fde-00c3-4383-978f-1dcb94f4d858.pdf>
- Postle, K., & Beresford, P. (2007). *Capacity building and the reconception of political participation: A role for social care workers?* *British Journal of Social Work*, 37(1): 143-158.
- Price, J., & Shildrick, M. (1998). *Vital signs*. Edinburgh: Edinburgh University Press.
- Ralph, R.O. (2000). *Recovery*. *Psychiatric Rehabilitation Skills*, 4(3): 480-517.

- Roberts, B. (2002). *Biographical research*. Buckingham and Philadelphia: Open University Press.
- Roets, G., Reinaart, R., & Van Hove, G. (2008). *Living between borderlands: Discovering a sense of nomadic subjectivity throughout Rosa's life story*. *Journal of Gender Studies*, 17(2): 99-115.
- Roets, G., & R. Braidotti. (2012). Theorizing the unity of bodies and minds: Nomadology and subjectivity in disability studies. In D. Goodley, B. Hughes, & L. Davis (Eds.), *Disability and social theory: New developments and directions* (pp. 161-176). London: Palgrave Macmillan.
- Rondelez, E., Bracke, S., Roets, G., & Bracke, P. (2016). *Racism, migration and mental health: Theoretical reflections from Belgium*. *Subjectivity*, 9(3): 313-332.
- Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C., & Bracke, P. (submitted). "But that is a cultural given.": *Diasporic Muslims, mental healthcare professionals and the cultural-difference frame*. *Ethnography*.
- Rose, N. (1999). *Governing the soul: The shaping of the private self*. London: Free Association Books.
- Rushton, A. (1990). *Literature review: Community based versus hospital-based care for acutely mentally ill people*. *British Journal of Social Work*, 20(4): 373-383.
- Said, E.W. (2005). *Orientalisten*. Amsterdam: Mets & Schilt.
- SAMHSA's working definition of recovery. Downloaded from <http://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated>.
- Schiettecat, T., Roets, G., & Vandenbroeck, M. (2017). *Capturing life histories about movements into and out of poverty: A road with pits and bumps*. *Qualitative Social Work*, published online.
- Schnabel, L. (2014). *The question of subjectivity in three emerging feminist science studies frameworks: Feminist postcolonial science studies, new feminist materialism, and queer ecologies*. *Women's Studies International Forum*, 44: 10-16.
- Schnittker, J. (2003). *Misgivings of medicine? African Americans' skepticism of psychiatric medication*. *Journal of Health and Social Behavior*, 44(4): 506-524.

- Smits, C.H., de Vries W.M., & Beekman A.T. (2005). *The CIDI as an instrument for diagnosing depression in older Turkish and Moroccan labour migrants: An exploration study into equivalence*. *Int J Geriatr Psychiatry*, 20(5): 436-445.
- Smye, V. (2004). *The nature of the tensions and disjunctures between aboriginal understandings of and responses to mental health and illness and the current mental health system*. (unpublished doctoral dissertation). The University of British Columbia, Vancouver.
- Stein, D. (2000). *Views on mental illness in Morocco: Western medicine meets the traditional symbolic*. *CMAJ*, 163(11): 1468-1470.
- Stone, A. (2005). *Towards a genealogical feminism: A reading of Judith Butler's political thought*. *Contemporary Political Theory*, 4(1): 4-24.
- Tew, J. (2011). *Social approaches to mental distress*. Basingstoke: Palgrave Macmillan.
- Thornicroft, G., Szukler, G., Mueser, K., & Drake, R. (2011). Organizing the range of community mental health services. In G., Thornicroft, G. Szukler, K.T. Mueser, & R.E. Drake (Eds.), *Oxford textbook of community mental health* (pp. 107-117). Oxford: Oxford University Press.
- Uchendu, U., Roets, G., & Vandebroek, M. (2017). *Mapping constructs of gender in research on Igbo women in Nigeria: Embracing a Southern feminist theoretical perspective*. *Gender and Education*, published online.
- Vandekinderen, C., Roets, G., Roose, R., & Van Hove, G. (2012). *Re-discovering recovery: Re-conceptualizing underlying assumptions of citizenship and interrelated notions of care and support*. *The Scientific World Journal*. doi. 10.1100/2012/496579
- Vandekinderen, C., Roets, G., & Van Hove, G. (2014). *Untangling the non-recyclable citizen: A critical reconceptualization of responsibility in recovery*. *Qualitative Health Research*, 24(10): 1418-1430.
- Vardar, A., Kluge, U., & Penka, S. (2012). *How to express mental health problems: Turkish immigrants in Berlin compared to native Germans in Berlin and Turks in Istanbul*. *European Psychiatry*, 27(2): 50-55.

- Verhaeghe, P.-P., Van der Bracht, K., & Van de Putte, B. (2012). *Migrant zkt toekomst: Gent op een keerpunt tussen oude en nieuwe migratie*. Antwerpen: Garant.
- Wade, D.T., & Halligan, P.W. (2004). *Do biomedical models of illness make for good healthcare systems?* *BMJ*, 329(7479): 1398-1401.
- Wester, F. (1987). *Strategies for qualitative research*. Muiderberg: Coutinho.
- Wilson, G., & Daly, M. (2007). *Shaping the future of mental health policy and legislation in Northern Ireland: The impact of service user and professional social work discourses*. *British Journal of Social Work*, 37(3): 423-439.
- Wong, Y.R., & Tsang, A.K.T. (2004). *When Asian immigrant women speak: From mental health to strategies of being*. *American Journal of Orthopsychiatry*, 74(4): 456-466.

General conclusion and discussion⁴³

1. Introduction

At the start of this doctoral research project, I immersed myself in the literature and learned that diasporic Muslims are under-represented in the established mental healthcare systems of the West. At the same time, I learned that they are particularly at risk for mental health problems. In the literature, this conundrum has been approached and conceptualised from a variety of perspectives. To my view, however, the existing body of knowledge lacked an in-depth and dynamic understanding of the interactions between mental healthcare professionals and potential clients, in this case diasporic Muslims with mental health problems. With this doctoral research project, I have addressed this lack of knowledge about the under-representation of this group by focusing on processes of subjectification in the interactions between mental healthcare professionals and diasporic Muslims with mental health problems from an intersectional perspective.

At the end of this doctoral research project, I would first like to direct attention to the four concepts that guided this work: subjectification, agency, frames and culture/racialisation. Subjectification can be defined as the process that forms the subject. In my work, however, it was also important to attribute agency to the subjects, in this case diasporic Muslim women. In my initial impression, diasporic Muslims (and particularly those with mental health problems) were constructed as subjects throughout their trajectories in mental healthcare. I further acknowledged that migration processes also inform the ways in which participants are subjectified. The field of (mental) healthcare is characterised by certain norms and rules that reflect social patterns of stratification and influence processes of subjectification.

⁴³ British English

In the first article, I proceeded from the work of Michel Foucault and his seminal account of how subjects come into being. The second article considers views on subjectification by Nikolas Rose (who was influenced by Foucault) and Edward Said. As their notion of subjects and subjectification did not allow me to find enough variety in the discourses of mental healthcare professionals, I turned to the theories of Erving Goffman and Judith Butler in the third article. In the fourth article, I supplemented these theoretical streams with the ideas of Stuart Hall. Finally, in the fifth article, my co-author and I worked with feminist theories based on Foucault's work, including the work of Saba Mahmood and Rosi Braidotti. Throughout this doctoral research project, I have applied these theories to the special case that I address in order to resolve weaknesses with the strengths of other theories.

The second part of this concluding chapter is devoted to the methodology used in this doctoral research project, with particular attention to what I did, as well as to the strengths and weaknesses of the methods used? In the third section, I summarise the findings of this project. Finally, I present a number of suggestions for further research, as well as the implications of this study for policy, practice and research.

2. Theory

2.1. Subjectification

As mentioned in the introduction, the under-representation of diasporic Muslims in established mental healthcare services has been studied from a variety of perspectives. Less attention has been paid to the perspective of subjectification, particularly when conceptualised as the process through which subjects are constituted in the field and institutions of mental healthcare (Foucault, 2006; Mahmood, 2012; Rose, 1998; 1999). In this vein, I considered it important to address the role of power – not only in terms of repression and domination, but also as a productive force in the construction of discourses of professionals and diasporic Muslims and the subjects that they are (Blackman et al., 2008; Braidotti, 2002; Mahmood, 2012; Rose, 1998; 1999). To this end, I reframe the under-representation of diasporic Muslims in mental healthcare

services in terms of subjectivity and the failure to be ‘good’ subjects of Western biomedical regimes (Rondelez et al., 2016).

This productive aspect is also reflected in a focus on resistance. It is through the interaction between the influence of mental healthcare and the reaction of diasporic Muslims to processes including individualisation, recovery and ‘Orientalism’ that diasporic Muslims with mental health problems are created. Mental healthcare professionals can also be regarded as being subjected to the mental healthcare system, and they also can display resistance against it. For example, my observation that many professionals adhere to a culture-sensitive framework might be perceived in this light. At the same time, many of these professionals tend to hyper-culturalise the situation. This is consistent with the contemporary neo-liberal ideas that have shaped the current mental healthcare system. As indicated by this pattern, subjectification operates as one individual is subjected to someone or something else, as well as when individuals are subjected to their own identities (Foucault, 1975; 1982).

The power of neoliberal mental (and other) healthcare is exerted by many different institutions, including the state apparatus and public institutions, as well as welfare societies, families and the field of medicine (Foucault, 1975; 1982). Many of these institutions were representatives in the snowball sample. In almost every type of organisation, I observed professionals who expressed the opinion that ‘good subjects’ (which diasporic Muslims have yet to become) are constructed through a continuous gaze, judgement and dominant frames. The mental healthcare professionals have thus drawn a distinction between the ‘normal’ native Flemish people with problems who accept the recovery narrative and the ‘abnormal’ diasporic Muslims.

For example, consider the frame of recovery, which is particularly prevalent in current practice. According to this frame, individuals must be responsible for their own recovery. In particular, the frame of recovery is accompanied by techniques that enhance subjectivity. As argued by Rose, the biomedical system shapes humans as subjects, who are suitable for the neoliberal system: productive, independent and healthy (Rose, 1999). One notable implication in the context of the participants is that

they should be encouraged to seek employment or abandon the religious frame (Rose, 1998; 1999).

According to Foucault (1975; 1982), subjectification occurs through practices of division. The constructed difference between ‘the normal’ and ‘the pathological’ plays an important role in how West-European societies have constructed subject positions that have since become regarded as unitary and universal (Roets & Braidotti, 2012). I have observed this in the mechanisms of ‘othering’ that are at play within the frames of mental healthcare professionals. Some professionals construct diasporic Muslims with mental health problems as the ultimate ‘other’, who does not fit within the neoliberal subject notion. (Foucault, 1975; 1982; Roets & Braidotti, 2012). This is evident throughout the body of research characterised by a dominant ‘Orientalist’ logic of cultural differences (Foucault, 1975; 1982; Said, 2005). Most of the professionals with whom we spoke perceived themselves as representing modern, rational ‘Western subjects’, in contrast to the traditional, religious ‘Oriental’ diasporic Muslim. From this perspective, diasporic Muslims are assumed to be incapable of adapting to Western neoliberal society. I also observed that the conceptualization of their ‘problems’ as mental health problems is a dividing practice, not constructed through science. The divide is subsequently packaged in scientific discourse (Foucault, 1975). In contrast, diasporic Muslim women are more likely to associate mental health problems with social circumstances.

Inspired by Foucault, gender theories conceptualise subjectification as a dialectical process of freedom and constraint, with implicit passivity on the part of the subject. In my research, this is also what characterises the vision of mental healthcare professionals on diasporic Muslims, who are regarded as passively undergoing the influences of their community (e.g. spiritual healing). According to some feminist authors (e.g. Mahmood and Braidotti), however, it is also important to pay attention to identity as a lived set of embodied potentialities, instead of focusing on externally imposed constraining norms.

Despite the relevance and sharp analytical distinctions of Foucault’s account of subjectification, it lacks sociological foundations. For this reason, I complemented my

thinking about subjectivity in mental healthcare with the more sociological grounded theory of Nikolas Rose. In particular, Rose's approach to power and the subject were quite useful to my investigation of how particular subjects (i.e. diasporic Muslim communities in Belgium) are regarded as being at odds with the 'good subject' of established mental healthcare. In this context, the 'good subject' is apparently shaped in a manner that impedes the accessibility of established mental healthcare services to diasporic Muslims and complicates their paths through this system.

While Foucault and Rose provide solid foundations for analysing subjectification, the work of Said is essential for addressing the systematic 'Orientalism' that has shaped these processes of subjectification. Examples include the notion that 'non-Western societies' or individuals are naturally more traditional and non-scientific and that the 'Occidental' explanatory model should overrule and regulate the 'Oriental' explanatory models (Rondelez et al., 2016). Another critique that I have formulated on the work of Rose and Foucault is that, although they do attend to the work of the subjects themselves, they devote much less attention to how subjects react: how they might resist or display an entire set of possible responses to and engagement with the processes of subjectification through which they are formed

2.2. Agency

In the context of subjectification, theories of agency focus primarily on action as resistance to or dislocation of dominant norms. According to the professionals we interviewed, diasporic Muslims should demonstrate resistance against the dominant norms in their communities. Otherwise, these norms would continue to pose an impediment to mental healthcare. In concluding the empirical work, I sought a more precise and varied account of agency with which to explain the various motivations and ways of struggle, appropriation and transformation that people use to consider cultural meanings and resources. Such logics can generate understanding of the more creative elements of actions and agency. They can also give rise to new ideas of autonomy and reflexivity. For this reason, I turned to Mahmood and Braidotti in order

to examine how diasporic Muslim women with mental health problems actually look and react.

The work of Saba Mahmood directs a more pronounced and profound focus to the agency of the subject (Rondelez et al., 2016). She conceptualises agency as a capacity for action enabled and created by historically specific relations of subordination instead of in opposition to those relations of subordination (Mahmood, 2001; 2012). The diasporic Muslim women we interviewed in the past doctoral research project referred to such reasoning when expressing the opinion that the community – which can sometimes be oppressive – could help them to overcome their mental health problems.

An excessive focus on agency is likely to result in a voluntaristic view. The liberal subject model, in which the subjects act without any connection to a social context, can be situated within this perspective. These subjects are actually the neoliberal, autonomous individuals who are considered ‘good subjects’. In this perspective, the religious subject is merely a blind follower (Mahmood, 2012; Macmillan, 2011). This was also the perspective of most of the mental healthcare professionals participating in our research: diasporic Muslims are not capable of interpreting their problems in the proper terms, and they do not approach established mental healthcare services because of the roles that religion and community play in their lives. Drawing on the work of Mahmood, I have added nuance to this presentation: religious subjects are subjects who devote themselves to the religious experience. According to Mahmood, this devotion is not passive, instead requiring training and techniques of the ‘self’, including a struggle against one’s own ego (Mahmood, 2001; 2012). Within the context of my research, it is possible to identify a liberal notion of agency in the frames of many professionals, along with a supposed non-liberal context, in which diasporic Muslim women are situated. That having been said, some of the diasporic Muslim women with whom we spoke asserted that they did not need established mental healthcare services, as they were able to find the support they needed within their own communities or religion. According to the professionals I interviewed, such reasoning is symptomatic of oppression.

We argue the importance of considering the agency of subjects and the fact that identities and subjectivities are always in process, being affected by perceptions, resources and contexts (Braidotti, 2013). For this reason, the final study of this project focuses on the agentic strategies and strategies of meaning-making, which are always in relation and interaction with other, in addition to a focus on multiple subjectivities (Braidotti, 2013). In this regard, the study was aimed at describing the experience of cultural (and other) differences as potentially productive, positive powers, in addition to describing subjects in their embedded and embodied forms and materiality (Braidotti, 2006; Roets et al., 2008). The study also considers internal differences within subjects and categories (Braidotti, 2013; Vandekinderen et al., in progress).

2.3. Frames

In addition to the concepts of subjectification and agency, I investigated the notion of frames, given my interest in patterns and structures within the discourses of mental healthcare professionals concerning the under-representation of diasporic Muslims in established mental healthcare services.

Drawing on Goffman's seminal work on frames, and inspired by a post-structuralist approach, I defined frames as cognitive and affective relational aspects of meaning that are constructed in consideration of complex social contexts and that provide instructions for knowing, analysing and acting events during social interactions through codes that are often unexpressed and implicit codes (Goffman, 1956; 1974). The three frames I discerned in the narratives of the mental healthcare professions are mental structures, as they have no concrete presence in mental healthcare institutions, although they do have real consequences. They also have an affective dimension. As demonstrated in my research, mental healthcare professionals tend to be more positive or negative towards diasporic Muslims in accordance with the frames that they use. In my study, I also addressed the setting in which the frames were formulated: post-modern Western mental healthcare. Instead of simply putting Goffman's frames into practice, I reformulated them. This revealed clearer evidence

that mental healthcare professionals could also have good intentions. The frames also guided the answers of the participants, albeit unconsciously.

In Goffman's theory, subjects often passively undergo the operation of the frames. His work appears to be based on a relatively monolithic and totalitarian notion of power, in which subjects are constrained by the frames of the organisations that govern them and in which dominant groups intentionally use their power to undermine the potential agency of the dominated subjects. This theoretical outlook is difficult to reconcile with our final empirical findings. A different theoretical approach is needed, including with regard to the prevalent recovery frame, with its emphasis on agency and the need to regulate one's own life. Moreover, Goffman's notion of the subject is built on a troubling essentialist foundation, as it conceptualises the subject as a rational 'self' that is formed by stable social arrangements. His subject notion is thus devoid of bodily, social and historical context.

I addressed these problems by taking a more post-structuralist approach to power and subject formation (Goffman, 1961). The work of Judith Butler (2009) on frames proved useful in this regard, as it relies on a more dynamic notion of power, attends to the paradox of agency and does rest on an ontology of the rational subject. According to Butler, frames are never watertight: "[s]omething exceeds the frame that troubles our sense of reality (Butler, 2009: 9)". A theoretical approach acknowledging the dynamic and contingent nature of social reality is better suited to account for changes in the frames of biomedicine and resocialisation/recovery. In Butler's theoretical outlook, norms are regarded as vulnerable. In other words, regulatory schemes are revisable in terms of history and context (Rondelez et al., 2018). In my results this became clear in the shift from the dominance of the biomedical frame to the frame of recovery, although both are still present.

2.4. Culture and racialisation

A final theoretical concept that was needed in this research project was that of culture and racialisation. I observed that the professional participants regularly referred to the differences between secular Christian and Islamic cultures (i.e. between the 'Occident'

and the ‘Orient’). This observation led me to Edward Said’s theory of ‘Orientalism’ – a systematic, historical, European discipline that produced the ‘Orient’.

Said focuses on the ways in which ‘otherness’ is constructed – the ‘self’ is constructed as well (Said, 2005) – as negative and as the counterpart of the ‘Western subject’. One important aspect for my case is that, through geopolitical reshuffling, the ‘Orient’ has increasingly come to coincide with Islam, thus explaining the increasing importance of the oppositional framing of the ‘West’ and ‘Islam’. These developments have been accompanied by the construction of differences between ‘us’ (Western professionals) and ‘them’ (diasporic Muslims with mental health problems), with superior characteristics attributed to the ‘West’ and inferior characteristics attributed to ‘Islam’. These distinctions are essentialised, transforming the ‘Oriental other’ into a bad subject for ‘Western, biomedical, neo-liberal’ mental healthcare system. For example, the results of the current study indicate that Muslims are regarded as unknowing or as presenting only ‘non-sense’ (Said, 2005; Sayyid, 2003). This implies that dominant ‘Western’ perspectives fail to recognise the cultural or situated character of their own world, instead considering it universal (Gailly et al., 1988). This view is reflected in the statements of most of the professionals I interviewed, who neither questioned their own views on diasporic Muslims with mental health problems nor recognised their own tendency to present diasporic Muslims as a negative version of their own images of the ‘self’. At the same time, the interviews revealed a tendency to hyper-culturalise the ‘other’. In this case as well, these results suggest that mental healthcare professionals approach culture in a homogeneous manner, regarding people as being completely determined by their culture. This perspective also appeals to a relatively essentialist conceptualisation of culture on the part of the professional participants in this study.

Based on the findings of the current study, the deconstructive theoretical impulse that runs throughout Said’s work goes only so far when analysing the narratives of the Muslims with mental health problems with whom we spoke. This is because it fails to account for the way in which Islam is also a religious tradition that guides and instructs diasporic Muslims about the correct behaviour (Bracke, unpublished). Said’s work

allows a critical deconstruction of the binary and categorical dialectic between ontologically differing categories, although it does not allow any imagination (or re-imagination) of a non-deterministic or non-dualistic conceptualisation of diasporic Muslims (Braidotti, 2013; Butler, 2004; Foucault, 1978; Vandekinderen & Roets, 2016). In addition, the incorporation of Said's theory into practice in the context of this study led to Stuart Hall's thinking about race and racialisation as a floating signifier.

In Hall's work, race and culture are treated as discursive floating signifiers (i.e. as empty signifiers that function as badges or tokens), thus highlighting the importance of tracing how and when various elements of race are invoked (Hall, 1992; 1996b; 1996c). In present-day Europe, culture and religion have been adopted as new ways in which to talk about race and the auspices under which processes of racialisation take place. Racialisation is a process that constructs race and social relations based on meanings that are assigned to differences (Hall, 1996a; 1996b). In my empirical findings, I discerned three critical tropes (psychosomatisation, spiritual healing and pressure from the community), which were indeed presented in terms of culture and religion, around which such processes of racialisation occurred in the narratives of the mental healthcare professionals who participated in this study.

I still missed an element in the critical thinking of Said and Hall with regard to questions of culture: a more systematic treatment of intersections with other axes of power relations, class and gender. In the existing literature, race and culture are too often conceptualised on their own. For this reason, I also turned to the work of Rosi Braidotti, noted in the final chapter. Throughout this doctoral research project, I have tried to pay attention to this issue and to adopt an intersectional perspective, although further research taking this into account is still needed.

3. Methodology

This theoretical discussion is based in part on qualitative research that mapped out existing frames used by mental healthcare providers in Ghent (Belgium). This research was combined with biographical research amongst diasporic Muslim women who were

seeking mental healthcare services. Given the lack of in-depth research on the under-representation of diasporic Muslims in established mental healthcare services in Belgium, we conducted qualitative, semi-structured interviews to explore the personal meanings that both parties assigned to their experiences in their contacts within the context of mental healthcare. The interviews were semi-structured, in order to allow the participants sufficient space to articulate their own insights. In the context of this research project, it was not possible to observe the actual interactions, in order to obtain an even more dynamic understanding of the situation. This would have been possible with an ethnographic study.

For the sake of reflexivity, it is important to acknowledge that the methods that a researcher employs can function in and of themselves as mechanisms of inclusion/exclusion or perpetuate prevailing 'us'/'them' distinctions. For example, when considering my results, I must reflect on whether the selection of frames might not have been prompted by prevailing 'us'/'them' distinctions, such that I ignored other frames. This might have been the case with the cultural-difference frame, which coincides with a particular dominant 'us'/'them' narrative. I have addressed this possibility by looking carefully at the stories of diasporic Muslims and tracing whether, how and where an 'us'/'them' narrative emerges. To overcome this problem, I also appealed to other theoretical frameworks, including Hall, Mahmood and Braidotti.

For the initial empirical component, I conducted 31 qualitative interpretative interviews with a wide range of professionals from various organisations in the city of Ghent. I started by contacting local actors who were affiliated with umbrella organisations, after which I delved more deeply into the field of mental healthcare organisations. Following a snowball-sampling strategy (Esterberg, 2002), all of the participants were asked if they knew other interesting contacts for my study. In the end, the participants consisted of social-cultural workers, psychologists, psychiatrists and general practitioners in such settings as umbrella organisations in the mental healthcare sector, city services, community mental health centres, mental healthcare services, psychologist practices and welfare organisations. The results focused more on ambulant professionals, as their roles have been enhanced by the prevailing

tendency towards de-institutionalisation. Mental healthcare professionals are important, as the presence of a supporting role and relationship of trust plays an important role in the healing process of individuals with mental health problems.

The organisations and individuals selected for this study might have been disproportionately likely to be culturally sensitive than to subscribe to a biomedical orientation. Although the selection of participants was broad, the response amongst biomedically oriented sources was low, as few professionals have experience working with diasporic Muslims with mental health problems. Biomedical professionals were ultimately under-represented in the sample, as many responded to the request to participate by pointing out that they did not have enough Muslims in their institutions to be of interest for the study. Such experiences are most lacking amongst professionals in the established mental healthcare services, which have a largely biomedical orientation. This suggests that diasporic Muslims are most under-represented at the institutional, biomedical end of the mental healthcare spectrum. It also draws attention to the restrictive nature of my selection and implies that biomedical views were under-represented in my analysis. It would therefore be interesting to conduct additional research involving professionals at the biomedical end of the spectrum, exploring whether it would alter the current findings (e.g. by identifying additional frames or revealing less hyper-culturalisation).

At the same time, community care centres and system therapists were over-represented. This could explain the focus in our results on culturally sensitive ways of treating patients and the dominance of the family in the interviews conducted. This result is also an effect of the snowball sampling that was employed. I decided to use the snowball-method, as many people and services had initially refused to participate in the study. This was due in part to the privacy that the professionals granted to people with mental health problems. It was also because many noted that their patients/clients did not include any Muslims with mental health problems, and I was specifically looking for mental healthcare professionals who had experience with diasporic Muslims. Such mental healthcare professionals could thus be regarded as a hidden population.

For the reasons stated above, snowball sampling proved to be a good method for the purposes of this study (Billiet & Waege, 2006; Esterberg, 2002). This sampling method is nevertheless accompanied by several disadvantages. In particular, with snowball sampling, there is a risk that all of the participants will be taken from the same pool, thereby resulting in too much similarity between participants. This might have prevented me from obtaining as much variation in perspectives as I had wanted. To address this risk, I started the snowballs in a variety of social locations. Some of these points of entry yielded more participants than others did: psychiatrists, psychologists and general practitioners in private practice were better represented in the sample than were professionals from large established institutions. Overall, 25 participants had a more culturally sensitive perspective, and 6 had a more biomedical perspective.

The second empirical component of this doctoral research project involved analysing the other side of the situation: the stories of the diasporic Muslim clients themselves. For this study, we conducted biographical research with 12 diasporic Muslims who were settled in Belgium and who were seeking mental healthcare services. We found out that seeking help from mental healthcare professionals was only one of several strategies on which they relied

We shifted our initial search for diasporic Muslims of Turkish and Moroccan background to those of Turkish and Maghrebi background. This was done in order to ensure a sufficient number of participants from this hidden population. As already mentioned, Turkish and Moroccan Muslims are amongst the largest groups of diasporic migrants in Belgium. As such, our findings might have been different if we had collected data from diasporic Muslims from other groups (e.g. the influence of their communities might have been less pronounced). We also shifted our attention from men and women to focus solely on women. This was because the researchers who collected the data were women. Based on the information obtained from the mental health professionals, we learned that men might have difficulty discussing this sensitive topic with a woman. We are nevertheless aware that our data and findings would have been different had we included men amongst our participants.

In the chapters based on the study amongst the professionals, I often concluded that additional research was needed from the viewpoint of the diasporic Muslims themselves. Their stories often remain unheard or are easily assessed as inaccurate or irrelevant. This became clear in the frame of psychosomatisation and the ‘Orientalist’ tendencies. This led to the observation that their experiences are assumed to be biased by their position, while the professionals claim to know best. We attempted to address this by conducting interviews with diasporic Muslims. Although these interviews yielded a wealth of interesting findings, it might also have been interesting to follow the paths of diasporic communities through the established mental healthcare system, as well as their explorations of the other places and practices that people with mental health issues pursue.

The process of reaching a sufficient number of participants and conducting the interviews was long and difficult. I am also aware of possible biases in this respect. With regard to mental healthcare professionals, I might have reached only participants with relatively positive views on the topic, as I observed they all saw the need for further research in this area. Professionals who do not believe that diasporic Muslims might be treated differently within the mental healthcare system might have been more reluctant to participate in this study. The information obtained from the diasporic Muslims is likely to be subject to selection bias. Those who recognise the existence of mental health problems are obviously more likely to participate. Our research design made it difficult or impossible to reach diasporic Muslims who had not found their way to established mental healthcare services. This might have been easier within a more ethnographical study with fieldwork and participant observation, which offers more tools for gaining trust.

Our position as members of an ethnic majority had both positive and negative consequences for our research. One positive element is the fact that diasporic Muslim research participants were often more inclined to disclose opinions or narratives that they felt were taboo within their communities. Negative consequences included the fact that people were not as open about certain topics in order not to offend us (e.g. they might have been much more positive about established mental healthcare). The

women might have feared that we would report on their situations, and that this would have negative repercussions on their lives or families (e.g. their children might be taken away). A second negative consequence has to do with the possibility that our own way of thinking was also relatively essentialist, and that we were also subject to the mechanisms of ‘othering’ (which have been discussed theoretically and described empirically throughout this dissertation) by treating people as different based on their ethnicity. We have attempted to address this possibility by discussing our research in detail with each other (Traustadóttir & Kristiansen, 2004).

4. Ethical considerations

I am aware that knowledge is not objective. If it were, it would be severed from the subject positions from within which it was produced. I subscribe to more critical epistemological schools of thought that attend carefully to the subject positions of the researcher (Haraway, 1988). Along these lines, researchers themselves become the data-gathering instrument, and facts are not merely collected, but constructed in dialogue with the participants (Davies, 2008; Eriksen, 2010; Frank, 2000; Kloos, 2002). In this context, we considered it important not to predefine what might be included under ‘mental health problems’, but instead to allow the participants define it for themselves. Especially in our conversations with diasporic Muslims, we allowed the respondents to guide us through their world of mental health. Our participants thus had a relatively direct influence on the research. By opting for a biographical research method, we also tried to diminish the power of the researcher as author and authority, and to consider our participants as active interpreters constructing reality through speech and interaction (Frank, 2000). The influence that the women we interviewed had on the research became clear when we observed their resistance against the notion of Turkish or Moroccan, opting instead to identify themselves as Muslim. This also suggested that the informants were rarely passive, seldom accepting positions in which they perceived themselves as victims (Frank, 2000).

I was also confronted with the fact that writing stories down involves isolating these stories from the narrative flux of storytelling in real life. This influenced the end

result (Davies, 2008; Eriksen, 2010; Frank, 2013). It is also important to consider how a story is used at the various moments in which it is told, as people hear it differently through its repetition at such moments (Frank, 2013). The research methodology employed in this study allowed us to hear the stories only once, thus resulting in a particular version of these stories. Our data would have been enriched if we had been able to hear the stories multiple times. This would have been possible with an ethnographic research method.

Another ethical consideration associated with this study concerns the issue of who is responsible for what is done with the collected knowledge. Is the researcher responsible? Can the knowledge be used against the research participants? The researcher obviously has the responsibility to anonymise the data as much as possible. I have done this to prevent the information from being used against my participants (e.g. that the diasporic Muslim women would be stigmatised by their community or that professionals would encounter problems in their workplaces because of what they told me) (Eriksen, 2010; Frank, 2000; Kloos, 2002; Traustadóttir & Kristiansen, 2004).

A more positive ethical point is the fact that our research could also be used to ameliorate the situations of both parties (Kloos, 2002). The diasporic Muslims with mental health problems could receive more adequate help, and the professionals might be able to reach a group that is currently missing within the established mental healthcare system.

5. Results

This doctoral research project was intended to contribute to existing scholarship by posing and solving two research questions. I pursued this first by

mapping, analysing, and theorising existing frames of mental healthcare used with regard to diasporic Muslims of Turkish and Moroccan background by a wide spectrum of mental healthcare providers and professionals

to answer the following question: *'Which frames do mental healthcare professionals use when they are approaching diasporic Muslims with mental health problems?'*

The results I obtained revealed three frames: the frame of biomedicine, the frame of recovery and the frame of cultural difference. In my observation, the biomedical frame expresses itself in the belief that diasporic Muslims are more likely to express psychosomatisation, as they are often unaware of their problems in relation to the mind, instead tending to translate their mental health problems as problems of the body. This view was common amongst most of the professionals participating in this study.

The second frame that I observed is the frame of recovery. Following Rose's (1999) analytical grid, I identified an ethical and a technical aspect of subjectification within this frame. The ethical aspect of subjectification refers to the idea that diasporic Muslims with mental health problems should be (or develop into) free, independent, autonomous citizens and clients. The technical aspect of subjectification, which refers to what subjects must do themselves, is influenced by the neo-liberal logic. Their task is to cure themselves, which Rose refers to as the 'therapeutic imperative'. The notion of the 'therapeutic imperative' contains evidence of a 'psy-logic' and a neo-liberal logic. I also observed that both theorists and some professionals tend to neglect social and cultural influences. The final frame I identified, and which I added to Goffman's (1956; 1961; 1974) observations, does take this into account.

I conceptualised this third frame as one of cultural difference. The epistemological aspect of the frame refers to the question 'how can we know the subject?' I observed that most of the culturally sensitive participants believe that this could be accomplished through such means as listening to the clients themselves. This frame provides evidence of the cultural logic or the logic of cultural difference, often with its underlying 'Orientalism'. This model is contrasted with the 'Western' consultation model or the biomedical recovery model, with their neoliberal and biomedical logic. I also observed that the culturally sensitive participants tended towards hyper-culturalisation.

Within the cultural-difference frame, I observed three tropes. First, I identified pressure from the community, which refers to ‘culture’ in terms of ‘values and norms’. This refers to the ontological element of subjectification – the view on the nature of being of the subjects – by often overruling their individuality. The second trope is that of spiritual healing, or ‘culture’ as a way of life. In this context, the ontological element of subjectification is expressed in the fact that diasporic Muslims are regarded as unknowing subjects. The ‘Oriental’ and biomedical visions held by most of the mental healthcare professionals is in opposition to the perspectives of the diasporic Muslims and the functioning of spiritual healing. The third trope was that of psychosomatisation, which operates according to a concept of ‘culture’ as interpretation. The ontological element of subjectification could be identified in this case as well, given that the professionals who participated also regarded diasporic Muslims as unknowing subjects and opposed the ‘Orientalist’ biomedical view of diasporic Muslim perspectives on spiritual healing.

The second manner in which we sought to contribute to existing scholarship was by

conducting biographical research with Muslims of migration background who were seeking mental healthcare services. We did this by examining how they experienced Western mental healthcare discourses and services, and the discourses and practices that are used within the Muslim community. These efforts were also intended to theorise the strategies that they develop in seeking mental healthcare services.

Doing this we want to formulate an answer on the next question: ‘*How does the diasporic Muslim community cope with mental health problems, and can this explain the under-representation of diasporic Muslims in established mental healthcare services?*’

Based on our results, we concluded that cultural difference is neither deterministic nor essentialist, and that it should not be conceptualised as such. Instead, it should be conceptualised as going beyond the ‘self’/‘other’ distinction. In this vein, cultural

difference can be conceptualised as affirmative instead of pejorative. In other words, ‘otherness’ should be offered from the confines of a negative mirror image of the ‘self’ and considered in light of its positive and productive qualities. This approach could result in an effective hybridisation of culture. An essentialist conceptualisation of cultural identity does not do justice to the complex schemes of interpretation and ways of handling mental health problems that were revealed by the diasporic Muslim women with whom we spoke.

This study was based on the observation that diasporic Muslims are under-represented within established mental healthcare services, which are currently largely influenced by a recovery frame. I would nevertheless advise professionals not to assume that diasporic Muslim women must be lead to established mental healthcare service. They would do be better to consider what the women actually say and do. Mental health professionals should thus continuously question their own frames, thereby being aware of them. Given that the diasporic Muslim women with whom we spoke were situated between two cultures, it is important to consider the internal diversity existing within the community. Additional reflexivity would also result in the insight that the ‘problematic’ under-representation is the wrong question to ask.

To re-conceptualise the problematic aspect of the under-representation of diasporic Muslims in the established mental healthcare services, we attempted to go beyond a relatively negative or deterministic understanding of the formation of the subject by moving the subject out of the dialectic and into a non-unitary vision of ‘selves’ (considered as inter-related forces), releasing the solely humanist liberal conceptualisation of agency. It is not necessary for agency to maintain only a critical oppositional focus on the construction of counter-subjectivities. It would be better to consider it as an embodied means of subject formation (Bracke, 2008; Braidotti, 2013; Mahmood, 2012; Vandekinderen et al., in progress).

By paying attention to the agency of women, we observed that women practice a hybridisation of culture. This was expressed in their relationships within their families and communities, in their education and work trajectories, and in how they referred to religion.

The results show that, when referring to their mental health problems, our interlocutors were often entangled with a variety of other problems. In addition, when they tried to look at the origin of their problems, they all connected it to past events embedded in social relationships, as well as to the ways in which they have dealt with or embodied these problems. In contrast to the dominant frame of recovery, which focuses on the individual, we observed that the diasporic women with whom we spoke work with alternative agentic strategies to cope with their problems in contexts that are often complex. Their natural networks/communities provide a wide array of important resources and support in case of problems (Vandekinderen et al., in progress).

Another observation was that the women we interviewed referred to their work and education both as a source of mental health problems and as a resource or positive strategy for coping with mental health problems. The possibility of working or studying could offer a way out of difficult private situations that often result in mental health problems. In addition, employment could also contribute to mental well-being. On the other hand, many difficulties connected to educational trajectories or low-skilled jobs could also lead to more mental health problems (Vandekinderen et al., in progress).

A final result is that Islam also plays a role in how the women assign meaning to mental health problems. For example, one woman explained her problems in terms of possession by the devil. She also placed her body within a socio-historical and economic context. In addition to religious explanations of mental health problems, some women used Islam (as a religious tradition) as a strategy for recovering from mental health problems. The women did not always clearly separate religion from spirituality, however, and some women referred to hybrid forms. In contrast, most of them did draw clear distinctions between religion and culture, using religion to formulate a critical reflection of their culture. Such expressions of religion are thus not necessarily in contradiction to agency and political subjectivity.

Thus far, I have discussed the general frames that mental health professionals and diasporic Muslims use when talking about mental health. In what follows, I discuss

the content of these frames, which is situated underneath the frames and which I have used to construct the overarching themes/frames. First, I present what the professionals told me about the possible problems on the side of mental healthcare. Second, I consider what the same professionals said about what they believe are possible problems on the side of diasporic Muslims. Finally, I present the beliefs that diasporic Muslims expressed with regard to what the problems are.

5.1. The content of the frames

5.1.1. Professionals: Problems on the side of mental healthcare

The professionals made references to structural and cultural barriers that are responsible for the under-representation of diasporic Muslims in established mental healthcare services. Examples of structural barriers included high costs and the fact that psychological help is not reimbursed (Memon et al., 2016). I also observed that some participants did not believe that this was a problem and that most of the ethnic minorities in Belgium are able to afford mental healthcare. According to most studies, however, diasporic Muslims often do not have sufficient financial resources to contact mental health services (Buytaert et al., 2009; Lindert et al., 2008; Vardar et al., 2012). They also tend to have a lower rate of salaried employment and often a higher incidence of mental health problems, disregarding major intra-ethnic differences (Fossion et al., 2002; 2004; Kleinman, 1988; Lay et al., 2006; Lindert et al., 2008; Marwaha & Livingston, 2002). Another structural barrier to which the professionals referred is the lack of affordable ambulatory care.

There also would be too little onrush to residential mental healthcare. Most of the professionals participating in this study expressed the belief that there is a need to make residential mental healthcare more easily accessible (e.g. by eliminating the long waiting lists).

In addition to financial and structural elements, the professionals also invoked reasons that could be conceptualised as cultural aspects. For example, they discussed the need for ethnic matching or care that is not provided within a therapeutic setting.

On the one hand, this might be a way to cope with the community taboo on mental health problems. At the same time, diasporic Muslims with mental health problems are often aware of the ‘Whiteness’ of the subjectification process within mental health institutions, which is likely to reinforce a White, Euro-centric model of mental healthcare that does not consider ethnicity (Memon et al., 2016). This might explain why diasporic Muslims are likely to prefer mental health professionals of similar ethnic backgrounds, as reported in some studies (Hutchinson & Gilvarry, 1998; Memon et al., 2016). Some authors have indeed demonstrated that therapeutic relationships benefit from racial, ethnic or cultural similarity. It has been argued that lack of resemblance within a therapeutic relationship might trigger a presumed lack of understanding (Bhui & Bhugra, 2004). According to other studies, however, a shared ethnic background between counsellors and clients could create specific problems, including the client’s concern that the counsellor will pass personal information on to the shared ethnic community (Tsang et al., 2011). In any case, there is evidence that differences other than ethnic or religious background are at play within therapeutic relationships (see e.g. Blackman, 2001; Groen, 2009). The results of this study are situated somewhere in between: some participants referred to the positive aspects of ethnic similarity, while others referred to the fact that Dutch-speaking diasporic Muslims were more likely to prefer Belgian professionals.

In the interviews, the professional participants also referred to differences in culture as problematic with regard to reaching diasporic Muslims. Other studies have shown that cultural factors play an important role in diagnosis, treatment and care (Kleinman & Benson, 2006). Studies have demonstrated that healthcare settings often do not provide enough time or resources for mental healthcare professionals and people with mental (or other) health problems to cope with the complexities originating from differences in ethnic origin (Chang et al., 2016). Other studies have also focused on the need to consider the culture of the professionals involved, which might sometimes be characterised by White, middle-class frameworks (Heinz & Kluge, 2012; Inhorn & Serour, 2011; Kluge et al., 2012; Rechel et al., 2013; Vardar et al., 2012). The biomedical culture is considered important in the transmission of

stigma, the incorporation and maintenance of institutional racial bias and the construction of health differences across minorities (Kleinman & Benson, 2006). For this reason, some of the professionals I interviewed did not consider particular cultural and religious sensitivities. For example, they did not recognise that classification systems for mental health problems (e.g. the International Classification of Diseases [ICD] and the Diagnostic and Statistical Manual of Mental Disorders [DSM]) are actually ‘Western’ cultural classification systems (Summerfield, 2008). As indicated by the results of the current study, although some professionals try to take cultural aspects into account, they often go too far and engage in hyper-culturalisation. In both cases, the subjectification process constructs an image of individuals with mental health problems that is often not compatible with the situations of diasporic migrants. According to some scholars, this is likely to leave diasporic Muslims feeling that professionals do not understand them (Ang, 2007; Memon et al., 2016) and having more negative perceptions of the healthcare system (Abas, 1996; Diaz-Perez et al., 2004; Fossion et al., 2002; Lawrence et al., 2006; Marwaha & Livingston, 2002; Vardar et al., 2012). Other researchers have identified problems with the notion of cultural competence. In many cases, particularly in the field of medicine, culture is treated as being synonymous with ethnicity, nationality or language (Vardar et al., 2012). I observed this in my research as well. In line with the aforementioned research, I also observed that most of the professionals drew a distinction between ‘modern’ and ‘traditional’ medicine, placing diasporic Muslims on the side of traditional health beliefs (Vardar et al., 2012). This is consistent with the frame of psychosomatisation and spiritual healing.

One solution to this problem that has been proposed in the literature involves making accessible interpreting services available and training healthcare workers to use them (Inhorn & Serour, 2011; Rechel et al., 2013). Another impediment that the professionals participating in this study mentioned with regard to Western mental healthcare, however, is a lack of sufficient interpreters, which they said is likely to make counselling impossible. In some cases, this problem is solved by using a family member or another professional who speaks the person with mental health problems’

native language. Such situations are far from ideal. One alternative would be to work with a professional interpreter who also has knowledge of the mental health professional's own language and culture (van der Kwaak & Wolffers, 2013). Other problems associated with language barriers include more time per clinical visit, less frequent clinical visits, less understanding of the professional's words, more lab tests, more emergency visits, fewer contacts with specialists, less follow-up and more negative perceptions of mental healthcare (Lindert et al., 2008; Memon et al., 2016; van der Kwaak & Wolffers, 2013). Professionals tend to perceive people who are unable to speak the majority language very well as morally failing, stupid or less reactive. Professionals are likely to be less motivated to expend additional effort to understand them, and individuals with mental health problems are likely to be less capable of breaching the stereotypes (van den Muijsenbergh et al., 2013). Although the professionals participating in the study did not express these attitudes, some of the interviews did reveal traces of them. For example, several professionals referred to the supposed attitudes of other organisations. Many scholars have suggested that mental healthcare professionals could increase their knowledge by working with intercultural mediators and increasing their collaboration with the communities they serve (Ang, 2007). One potential problem with these solutions is that there might be too few interactions between the different communities to realise them. A proposed solution is to work with the diasporic communities themselves to overcome the mistrust and ensure cultural sensitivity (Boneham et al., 1997).

5.1.2. Professionals: Problems on the side of diasporic communities

The mental healthcare professionals participating in this study situated several problems on the side of the diasporic Muslims. One problem had to do with their culture or pressure from their communities, as well as with the idea that they are loyal to their families and communities. Second, a taboo on mental healthcare and mental health problems is assumed to be at play within diasporic communities, and the professionals expected that this would impede individuals from seeking help. Other studies have referred to a common professional belief that there is stigma on mental

health problems in the Muslim community. Such stigma is assumed to dissuade diasporic Muslims from seeking help, lest anyone find out about their problems (Boneham et al., 1997; Fossion et al., 2002; 2004; Memon et al., 2016). The professionals I interviewed also believed that the threat of community stigma could lead to a greater preference for private coping strategies (e.g. prayer and other religious practices). According to some of the professionals, this could explain why some diasporic migrants might regard traditional healers and religious leaders as a better source of help than Western psychiatric care (Lawrence et al., 2006). The existing body of knowledge nevertheless contains no consensus concerning whether traditional frameworks are less stigmatising than the psychiatric framing of mental problems is (Karasz, 2005).

Finally, the professionals participating in this study referred to the language problems of diasporic Muslims, many of whom do not have a sufficient command of Dutch in order to receive therapy. Language is an important aspect in and of mental healthcare. It can be regarded as an essential element in the diagnostic and therapeutic process (Ang, 2007; Memon et al., 2016; van der Kwaak & Wolffers, 2013). Studies have indicated that diasporic migrants often do not have the opportunity to their healthcare providers in the languages most comfortable to them (Diaz-Perez et al., 2004; Memon et al., 2016).

In contrast to the possible problems that the professionals we interviewed noted on the own side of mental healthcare services in Belgium, they referred only to cultural elements when speaking about possible impediments on the side of diasporic Muslims with mental health problems. Many healthcare professionals lack knowledge about diasporic migrant cultures (Ang, 2007; Buytaert et al., 2009; Lindert et al., 2008), and they tend to blame the mental health problems of diasporic migrants largely on their culture (Ang, 2007).

5.1.3. Diasporic Muslim women

In the interviews, diasporic Muslim women identified several barriers that they have experienced. First, some of them struggled with the dualistic mind-body perspective

that is prevalent in the established mental healthcare system, accompanied by the tendency to conceptualise somatic symptoms as cultural expressions of mental health problems. In contrast to this view, the Turkish and Maghrebi noted that they regard the mind and body as being intrinsically related and as ontologically differing attributes of a single reality.

Second, most of the women we interviewed referred to the importance of cultural sensitivity within the context of mental healthcare. For some, this constituted a reason to visit professionals of the same ethnic background, in the hope that it would facilitate an understanding of their situations. In some cases, those who had consulted professionals of Belgian background, had been confronted with the influences of a cultural gap, reflecting difficulties with the dominant framework of individual autonomy (Vandekinderen et al., in progress).

A third observation made by the women we interviewed had to do with taboos within their communities and the belief that women have a particular need to be strong. For some, this constituted a reason to conceal any problems they might have. Nevertheless, all of them had sought help for their problems (Vandekinderen et al., in progress).

The results of the second empirical study suggest that the question of why diasporic Muslims are under-represented in established mental healthcare services might be the wrong question to ask. It should be reframed. The conviction that diasporic Muslims with mental health problems do not approach established mental healthcare services might indirectly indicate the presence of an underlying expectation that diasporic Muslims should integrate themselves into the established social order. According to the results of this doctoral research project, however, diasporic Muslims are involved in creative and hybrid forms of integration and emancipation within Belgian society. One challenge for the established mental healthcare system is to consider cultural differences by recognising modes of agency and subjectivity that might vary from the prevailing liberal and secular principles, in addition to regarding such cultural differences as a potentially affirmative force (Vandekinderen et al., in progress).

6. Further research

The research process never ends. At the end of this dissertation, therefore, I would like to suggest several recommendation for further research.

By conducting this research as I did, I was able to contribute insight into the relations of power between the two parties in the context of mental healthcare. The selected research method nevertheless restricts this contribution to the micro level. The study of the meso and macro levels is also necessary. This could be accomplished through such means as conducting a network analysis of health and social welfare organisations in Ghent and tracing diasporic Muslims with mental health problems and mental health professionals having experience with diasporic Muslims, given the lack of such professionals in established mental healthcare services. It would be interesting to learn whether the discussion I observed is also present throughout the established mental healthcare system and, if so, which form it takes. Network analysis might also be helpful for taking into consideration the fact that the participants are not isolated units. This is true of organizations as well. The working of an organisation cannot be understood solely in terms of its own institutional structure, as it is composed of different groups. Instead, it is necessary to examine a myriad of cross-cutting interpersonal and interorganisational ties. Network analysis addresses the characteristics of relationships, rather than those of actors. It is an excellent way to research power, particularly for relational conceptualisations of power and influence, as in the work of Foucault and his followers. For example, it might be interesting to investigate whether and how professionals and organisations refer to each other and which organisations receive diasporic Muslims with mental health problems from whom.

Another idea would be to examine whether culturally sensitive and biomedically oriented organisations constitute relatively closed networks. Such insight could explain why there are fewer diasporic Muslims in established mental healthcare systems. It could also be applicable to networks of diasporic Muslims themselves, possibly explaining why some diasporic Muslims with mental health problems find

their way to professional mental healthcare services, while others do not. It might also be interesting to examine their personal networks as an indication of their relationships to the community and their access to specific services. Such a study could investigate the goal, the magnitude, the structure and the dynamics of an existing network. A network analysis could also focus on the importance of individual social relationships and broader structural positionings in individual lives, as well as in the development of institutions (Davies, 2008).

It could also be interesting to elaborate the side of the diasporic Muslims with mental health problems in greater depth. For example, our initial exploration suggests that Muslim women who hybridise culture possess a substantial amount of agency. This finding is based on the stories of only 12 women, all of whom were seeking mental healthcare assistance. Arriving at an accurate overview will require including additional perspectives (e.g. those of individuals who do not find their way to established mental healthcare services) and other types of individuals (e.g. men). According to the mental health professionals I interviewed, the actions and reactions of men differ from those of women, and it is important to determine whether the reasons that professionals give for their levels of under-representation or treatment dropout are similar to those of diasporic Muslims who do not come. The inclusion of other contexts (e.g. street work, emergency services, justice) is also important, as the under-representation of diasporic Muslims in established mental healthcare services could also be due to their over-representation in those settings. The aforementioned contexts also encounter diasporic Muslims with mental health problems – perhaps even to a greater extent –and their inclusion could diversify the results. This is an important consideration, as my observations suggest that it is necessary to avoid homogenising and/or essentialising diasporic communities.

In addition to such diversification, it is also necessary to conduct research on and amongst other diasporic groups (e.g. in another city). This could be interesting, as my results suggest the need to avoid homogenising the diasporic community. The Muslim women we interviewed did draw distinctions between Muslims from different regions in Turkey. Avoiding homogenisation will require research that considers differences

according to place of residence. This could affect the relative ease with which various groups access established mental healthcare services, thus adding another dimension to my findings. It will also be necessary to replicate this study amongst diasporic communities from other regions. For example, diasporic migrants from Eastern Europe are becoming more prominent in Ghent. The fact that these communities migrated more recently than the Moroccan and Turkish communities did could mean that they are less familiar with the mental healthcare system. Their different origin could also generate different perspectives on mental health (and mental healthcare). On the other hand, because they are from Europe, their perspectives might be more comparable to those of native Belgians, despite their status as diasporic Muslim migrants.

As clearly indicated by our interviews with diasporic Muslim women, religion plays an important role. These women preferred religion over culture as a strategy. Even acknowledging the influence of the community, I observed that the professionals I interviewed were primarily interested in Islam as a religion, even though they equated it with culture and ethnicity. I therefore recommend research on this religious context and the influence of imams and/or spiritual healing, without ‘Orientalising’ or ignoring the existence of spiritual healing practices in ‘Western’ culture. Such insight could be a valuable supplement to our findings with regard to the second research question: How does the diasporic Muslim community cope with mental health problems, and can this explain the under-representation of diasporic Muslims in established mental healthcare services?

7. Implications for policy, practice and research

7.1. Implications for policy and practice

The observation that the frames used by mental healthcare professionals and by diasporic Muslim women affect the accessibility of diasporic Muslims to mental healthcare services has important implications for policy and practice. The following recommendations are based on our results. One important general conclusion is that it is important to be aware of the ‘Orientalist’ frames used by the professionals who

participated in our study. It would be beneficial for diasporic Muslims if all parties (society, the mental healthcare system and diasporic Muslims) were to avoid ‘us’/‘them’ discourses and practices of ‘othering’, as this gives people a sense that they are regarded as different from the norm and not welcome in mainstream society. Rather than drawing attention to the ethnic background or religion of the individuals they serve, mental healthcare professionals should create a sphere in which every person is regarded as equal, and in which diversity is positively valued. Diasporic Muslims with mental health problems should thus feel welcome in mental healthcare services, such that they could perceive these services as an acceptable additional option, alongside their other own ways of coping with mental health problems. In addition, of the finding that culturally sensitive participants tend to over-culturalise and ascribe more influence or importance to culture than it really has also suggests that it is important to avoid essentialising or overemphasising cultural differences. Ethnic groups are neither internally homogeneous nor essentially different from other groups.

7.1.1. Waiting lists

In this and the following paragraph, I focus on an important barrier observed by the professionals who participated in this study. Flanders as a whole also has problems with the accessibility of mental healthcare (e.g. long waiting lists, expensive therapists and high barriers), with the result that people with mental health problems often do not get the help they need (Coppens & Van Audenhove, 2016). The long waiting lists constitute an important element in fighting mental health problems, given that one third of the general population experience mental health problems. Nevertheless, some mental healthcare centres should impose a halt on their registrations, as the waiting time for new clients is already too long. For the diasporic Muslims who participated in this study, there are apparently even fewer counsellors, thus further exacerbating problems associated with long waiting lists. The problems are intensified even further by the unavailability of affordable care. This situation can lead individuals with mental health problems to refuse mental healthcare services, even if they are available.

The pressure on the mental healthcare system could be reduced by increasing the support that the system receives. It would also help to increase support for general practitioners, as they are the first point of contact for many people with mental health problems. Of all people with mental health problems who are seeking help, 70% start by approaching their general practitioners. Many general practitioners experience high work pressure and do not have the proper training to address these problems.

7.1.2. The central role of the general practitioner in the community

Given the barriers to entry in the mental healthcare system, general practitioners are increasingly playing a key role in the detection, relief and treatment of mental health problems, as well as in encouraging their patients to seek specialised help as needed. Primary healthcare professionals should be trained to recognise the higher incidence of psychiatric problems amongst diasporic migrants. General practitioners could also play a role in organising preventive measures by providing information and education within diasporic migrant families or communities about the possible role played by social and familial processes. This role is necessary, as demonstrated by the results of this study. General practitioners should be supported in such efforts through intensive cooperation with other disciplines (e.g. social workers and psychologists working in primary care). As identified in this study, this could also be beneficial in arriving at a total approach to the problem. This first step that is needed is an integrated, multidisciplinary approach within an accessible primary care setting (Buytaert et al., 2009).

Supporting primary healthcare workers could result in the earlier detection of possible problems, which could subsequently result in less difficult all-encompassing problems. For 40 years, community health centres that are located in the neighbourhood have been ideally situated to perform this role. With a fixed payment system, patients who are enrolled in the centre do not need to pay for consultations or medical visits at home. This is covered by health insurance. This arrangement is in contrast to 'classical' healthcare, in which caregivers are paid for performance. In this way, community health centres serve a pivotal role in making healthcare services

accessible to vulnerable groups. Working-class areas in major cities, where many diasporic Muslims live, are particularly likely to have a shortage of primary healthcare professionals. The Belgian Secretary of Health recently decided to impose a moratorium on the establishment of new community health centres, thereby realising savings in the amount of €7 million. This decision is likely to have detrimental consequences, given the social goals of the community health centres, particularly with regard to the provision of accessible, high-quality and efficient healthcare services, which result in many innovative projects (Van Duppen, 2017). The Belgian system of community health centres has received international recognition as a good practice. The fixed payment system costs no more than does performance-based payment, and it is much more accessible. It eliminates financial barriers, as patients are no longer required to pay the non-refundable part of their medical expenses, in addition to being likely to exhibit better prescription behaviour (especially with regard to antibiotics), to receive medication at inexpensive rate and to have fewer referrals to specialists, thereby reducing the costs of second-line medical care. (Van Duppen, 2017; De Maeseneir et al., s.d.)

Primary healthcare professionals have recently begun to receive support from primary psychologists, who provide advice and short-term help. In one to four consultations, the primary psychologist outlines the problem and works together with the client to determine how to address it. Primary psychologists provide advice, information and tips that can help individuals with mental health problems act independently by developing their strengths and self-reliance. If additional support is needed, primary psychologists refer clients with more severe mental health problems to other professionals. Because of the limited number of sessions, primary psychologists are able to restrict the waiting time to one or two weeks. This allows them to reach a broad range of people with mental health problems, in addition to detecting mental health problems at an early stage. Primary psychologists are also responsible for broadening the cooperation between other mental (and other) healthcare professionals. They are therefore able to refer individuals with mental health problems to the right place in the network. This makes it possible to realise

multi-stage healthcare (i.e. healthcare that starts with the least intensive intervention and progressing to more specialised care only if needed). In addition, primary psychologists are responsible for training general practitioners and other primary healthcare workers to help people with minor mental health problems.

Experience has shown that the supply of primary psychologists is not sufficient to meet the large demand of individuals with mental health problems. In many cases, therefore, priority is assigned to people in poverty or/and diasporic groups. One positive aspect of primary psychologists has to do with the fact that individuals with mental health problems perceive them as truly accessible, such that they are willing to approach them in an early stage of their problems. The accessibility emerges from the neutral and accessible space in which the consultations take place, as well as from the low price, quick availability and the fact no long-term engagement is needed, along with the favourable cooperation with general practitioners.

In conclusion, primary psychologists reinforce the primary healthcare system, bringing mental healthcare closer to people and intervening sooner, thus possibly easing the pressure on secondary healthcare (Coppens & Van Audenhove, 2016; Stad Gent, s.d.; VVGG, s.d.).

7.1.3. Sensibilisation and prevention

Diasporic Muslims handle their mental health problems in their own way, as observed in our second study. According to our results, however, they also do this because they experience barriers to the established mental healthcare system (e.g. taboos prevailing within their communities). Investments in sensibilisation and prevention could facilitate the step towards established mental healthcare services. For example, sensibilisation campaigns (e.g. *Te Gek*) could be improved by ‘showing’ the faces of some diasporic Muslims as well, instead of only native Belgian people.

One solution for reducing the under-representation of diasporic Muslims could be to increase contact with mental healthcare and welfare organisations. In addition, increasing contact with people with mental health problems could also address the stigma existing within diasporic Muslim communities. This is an underlying

motivation for the current mental healthcare reform, in which the further expansion of community care is crucial. Increased contact between the community and people with mental health problems could provide an opportunity to reduce stigma and facilitate the reintegration of people with mental health problems into the community. Such efforts would focus on the strengths of the community and work to counteract the difficulties posed by the same diasporic community.

Another suggestion would be to invest in adjusting the expectations that diasporic migrants have of mental healthcare services. This could be accomplished by general practitioners, who form the first step towards mental healthcare and who are very accessible. It could also be accomplished by adopting alternative methods of intake in the mental healthcare system. General practitioners and mental health institutions could be advised to provide diasporic clients with clear information about what mental healthcare could mean for them (e.g. how it works and what it entails, in addition to its goal and the duration of treatment). It would also be important to refer to the possibility of using an interpreter who does not know the diasporic Muslim with mental health problems, who are reliable and who have taken an oath of secrecy.

Mental healthcare professionals should also be sensibilised to the necessity of taking their own frames into account. They should reflect on how their own professional backgrounds and expectations inform such notions as treatment compliance. There is a risk that the incompatibility of the frames used by mental healthcare professionals and those used by diasporic Muslims could result in diasporic Muslims being regarded as not fitting within the organisational and cultural system of mental healthcare, in addition to identifying them as difficult or bad. The results of this study demonstrate that this risk is real. The desired reflection could be promoted by organising contact with diasporic Muslims with mental health problems or by integrating experts in this area into multidisciplinary teams. Insight into varying perceptions of mental health problems and their solution could help to increase reflection concerning the professionals' own frames. In addition, the observation that care providers are influenced by the general tendency in society to 'Orientalise'

diasporic Muslims illustrates the necessity of maintaining a focus on these perceptions within the general population.

7.2. Implications for culturally sensitive professionals

Culturally sensitive professionals deserve particular attention, as they are situated in the middle of the confrontation between the two parties. Culturally sensitive methods and caregivers are necessary to prevent treatment dropout amongst diasporic clients. It is therefore crucial to develop such methods. The results of this study reveal a need to increase the cultural competence of mental healthcare professionals. Some Members of diasporic communities tend to seek professionals who are empathic and who have knowledge of (or are receptive to) ‘other’ cultures. At the same time, many professionals feel that they lack such knowledge or attitudes. It is therefore important for mental healthcare institutions to invest in education or intercultural contexts in which professionals can learn from experience.

As mentioned above in the context of community health centres, it could be helpful to have culturally sensitive professionals work in interdisciplinary teams and in interdisciplinary ways to work on the mental-health and socio-economic problems of people with mental health problems. The inclusion of diasporic mental healthcare professionals could be helpful as well.

Finally, the results of this study suggest that the under-representation of diasporic Muslims in established mental healthcare services could be reduced by the adoption of more outreach-based forms of treatment and approach. Culturally sensitive care providers could be assigned to go into communities and actively seek out this population. This might also be a way to address the stigma and distrust that are prevalent in diasporic communities.

7.3. Implications for research

Given the limited body of knowledge on the under-representation of diasporic Muslims in established mental healthcare services (in Belgium), this doctoral research project constitutes a good first step. Additional research is still needed. As indicated

by the results of this study, although qualitative research can generate interesting data, access to the populations remains difficult. This underscores my opinion that qualitative research may add value to the study of this conundrum, as it allows the researcher to gain deep insight into how frames are shaped in the interactions between mental healthcare professionals and diasporic Muslims and how people experience them.

As described in the general introduction, there are several different ways of studying the under-representation of diasporic Muslims in established mental healthcare services. I situated my study within a qualitative research stream that considers discourses, paradigms and frames held by one of the parties involved. Compared to the other streams of research, however, this one is somewhat underdeveloped. As indicated by the results of this study, however, such orientations can produce interesting results that can enhance the other research streams. I would therefore encourage other researchers to subscribe to this research stream.

As indicated by the results of this study, it is important to consider ‘Orientalist’ tendencies within the frames used by mental health professionals, even if the professionals present themselves as culturally sensitive. Researchers should be aware that the theories that they employ can lead to blind spots, as was the case in our shift from Rose and Said to Goffman and Butler. Although mental healthcare professionals also have good intentions, these intentions might be obscured by particular theories. Theoretical triangulation could be an interesting solution to this problem. This also became clear in the various theories on subjectivity that I have used to formulate my own combined notion.

Based more on our second study amongst diasporic Muslim women, I would also recommend that researchers take sufficient time to build rapport with the participants. As mentioned before, it is a difficult process to reach a large enough number of participants. Further studies might therefore benefit from including larger numbers of participants. There appears to be a taboo within the community, and participants do not always recognise themselves in the description formulated by the researchers. This also illustrates the complexity existing within diasporic communities. I therefore

recommend that researchers work in the most intersectional manner possible, as well as with an open view. One never knows where research will lead.

References

- Abas, M. (1996). *Depression and Anxiety Among Older Caribbean People in the UK: Screening, Unmet Need and the Provision of Appropriate Services*. *International Journal of Geriatric Psychiatry*, 11: 377-382.
- Ang, W. (2007). *Werken met allochtonen: culturele sensitiviteit in de klinische praktijk*. *Tijdschrift voor Geneeskunde*, 63(12): 556-560.
- Bhui, K. & Bhugra, D. (2004). *Communication with Patients from Other Cultures: The Place of Explanatory Models*. *Advances in Psychiatric Treatment*, 10: 474-478.
- Billiet, J. and Waege, H. (2006). *Een samenleving onderzocht. Methoden van sociaal-wetenschappelijk onderzoek*. Antwerpen: De Boeck.
- Blackman, L. (2001). *Hearing Voices. Embodiment and Experience*. London: Free Association Books.
- Blackman, L., Cromby, J., Hook, D., Papadoulos, D. & Walkerdine, V. (2008). *Editorial: Creating Subjectivities*. *Subjectivity*, 22: 1-27.
- Boneham, M.A., Williams, K.E., Copeland, J.R.M., McKibbin, P., Wilson, K., Scott, A. & Saunders, P.A. (1997). *Elderly people from ethnic minorities in Liverpool: mental illness, unmet need and barriers to service use*. *Health and Social Care in the Community*, 5(3): 173-180.
- Bracke, S. (unpublished). *Foucault and Religion: Towards an Exploration of Secular Governmentality*.
- Braidotti, R. (2002). *Metamorphoses. Towards a materialist theory of becoming*. Cambridge: Polity Press.
- Braidotti, R. (2006). *Transpositions: On Nomadic Ethics*. Cambridge: Polity Press.
- Braidotti, R. (2013). *The Posthuman*. Cambridge: Polity Press.
- Butler, J. (2004). *Undoing Gender*. London: Routledge.
- Butler, J. (2009). *Frames of War. When is Life Grievable?* Brooklyn: Verso.

- Buytaert, E., Vandedrinck, E. & Lemmens, G. M. D. (2009). *Psychiatrische stoornissen bij migranten: feiten en hypothesen*. Tijdschrift voor Geneeskunde, 65: 1-8.
- Chang, J. Dubbin, L. & Shim, J. (2016). *Negotiating substance use stigma: the role of cultural health capital in provider-patient interactions*. *Sociology of Health & Illness*, 38(1): 90-108.
- Coppens, E. & Van Audenhove, C. (2016). *Eerstelijnspsycholoog is succes: Lage drempel, toegankelijk en flexibel*. Consulted on 10/02/2018: <https://sociaal.net/analyse-xl/eerstelijnspsycholoog-is-succes/>.
- Davies, C.A. (2008). *Reflexive Ethnography. A Guide to Researching Selves and Others*. London: Routledge.
- De Maeseineir, K., Drielsma, P., Jamart, H. & Suetens, M. (s.d.). *Kabinet De Block blokkeert toegang tot de gezondheidszorg voor kwetsbare patiënten*. Consulted on 10/02/2018: <http://www.wgcbotermarkt.be/site2/?q=node/203>.
- Diaz-Perez, M., Farley, T. & Martin Cabanis, C. (2004). *A Program to Improve Access to Health Care Among Mexican Immigrants in Rural Colorado*. *The Journal of Rural Health*, 20(3): 258-264.
- Eriksen, T.H. (2010). *Small Places, Large Issues. An Introduction to Social and Cultural Anthropology*. New York: Pluto Press.
- Esterberg, K.G. (2002). *Qualitative Methods in Social Research*. Boston: McGraw-Hill.
- Fossion, P., Ledoux, Y., Valente, F., Servais, L., Staner, L., Pelc, I. & Minner, P. (2002). *Psychiatric disorders and social characteristics among second-generation Moroccan migrants in Belgium: An age- and gender-controlled study conducted in a psychiatric emergency department*. *European Psychiatry*, 17: 443-450.
- Fossion, P., Servais, L. Rejas, M.-C., Ledoux, Y., Pelc, I. & Minner, P. (2004). *Psychosis, migration and social environment: an age-and-gender controlled study*. *European Psychiatry*, 19: 338-343.

- Foucault, M. (1975). *Geschiedenis van de waanzin in de zeventiende en achttiende eeuw*. Meppel: Boom.
- Foucault, M. (1978). *The History of Sexuality*. New York: Vintage Books.
- Foucault, M. (1982). *The Subject and Power*. *Critical Inquiry*, 8(4): 777-795.
- Foucault, M. (2006). *History of Madness*. London: Routledge.
- Frank, A.W. (2013). *The Wounded Storyteller: Body, Illness & Ethics*. (2nd edition). The University of Chicago Press: Chicago.
- Frank, G. (2000). *Venus on Wheels. Two Decades of Dialogue on Disability, Biography, and Being Female in America*. Berkeley: University of California Press.
- Gailly, A., et al. (1988). *Psychische klachten bij Turken en hun benadering*. Brussel: Cultuur en Migratie v.z.w.
- Goffman, E. (1956). *The Presentation of Self in Everyday Life*. Edinburgh: University of Edinburgh Social Science Research Centre.
- Goffman, E. (1961). *Asylums. Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.
- Goffman, E. (1974). *Frames of analysis. An Essay on the Organization of Experience*. Boston: Northeastern University Press.
- Groen, S. (2009). *Recognizing Cultural Identity in Mental Health Care: Rethinking the Cultural Formulation of a Somali Patient*. *Transcult Psychiatry*, 46: 451-62.
- Hall, S. (1992). Cultural Studies and its Theoretical Legacies. In: L. Grossberg, G. Nelson & P. Treichler. *Cultural Studies*. London: Routledge.
- Hall, S. (1996a). Introduction: who needs 'Identity'? In S. Hall & P. du Gay, *Questions of Cultural Identity* (pp. 1-17). Thousand Oaks: Sage Publications.
- Hall, S. (1996b). *Race, the Floating Signifier*. Featuring Stuart Hall. Media Education Foundation, 61 min.
- Hall, S. (1996c). Wat is het 'zwarte' in zwarte populaire cultuur? In G. Wekker & R. Braidotti, (Eds.) *Praten in het donker: multiculturalisme en anti-racisme in feministisch perspectief*. (pp. 149-164). Kok Agora: Kampen.

- Haraway, D. (1988). *Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspectives*. *Feminist Studies*, 14(3): 575-599.
- Heinz, A. & Kluge, U. (2012). *Editorial. Mental Health in Different Groups of Migrants and Ethnic Minority Within Europe and Beyond: Regional and Cross-national Challenges and Approaches in Research, Practice and Training*. *European Psychiatry*, 27: 1-3.
- Hutchinson, G. & Gilvarry, C. (1998). *Ethnicity and dissatisfaction with mental health services*. *British Journal of Psychiatry*, 172: 95-96.
- Inhorn, M. C. & Serour, G. I. (2011). *Islam, Medicine, and Arab-Muslim Refugee Health in America After 9/11*. *The Lancet*, 378: 935-943.
- Karasz, A. (2005). *Cultural differences in conceptual models of depression*. *Social Science & Medicine*, 60: 1625-1635.
- Kleinman, A. (1988). *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: The Free Press.
- Kleinman, A. & Benson, P. (2006). *Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It*. *PLoS Medicine*, 3(10): 1673-1676.
- Kloos, P. (2002). *Culturele antropologie. Een inleiding*. Assen: Koninklijke Van Gorcum.
- Kluge, U., Bogic, M., Deville, W., Greacen, T., Dauvrin, M., Dias, S., Gaddini, A., Koitzsch Jensen, N., Ioannidi-Kapolou, E., Mertaniemi, R., Pucipinos, I., Riera, R., Sandhu, S., Saravry, A., Soares, J.J.F, Stankunas, M., Straßmayr, C., Weibel, M., Heinz, A. & Priebe, S. (2012). *Health Services and the Treatment of Immigrants: Data on Service Use, Interpreting Services and Immigrant Staff Members in Services Across Europe*. *European Psychiatry*, 27: 56-62.
- Lawrence, V., Banerjee, S., Bhugra, D., Sangha, K., Turner, S. & Murray, J. (2006). *Coping with depression in later life: a qualitative study of help-seeking in three ethnic groups*. *Psychological Medicine*, 36: 1375-1383.
- Lay, B., Laubner, C., Nordt, C. & Rössler, W. (2006). *Patterns of inpatient care for immigrants in Switzerland: A case control study*. *Social Psychiatry and Psychiatric Epidemiology*, 41: 199-207.

- Lindert, J., Schouler-Ocak, M., Heinz, A. & Priebe, S. (2008). *Mental health, health care utilisation of migrants in Europe*. *European Psychiatry*, 23:14-20.
- Macmillan, A. (2011). *Michel Foucault's Techniques of the Self and the Christian Politics of Obedience*. *Theory, Culture & Society*, 28(4): 3-25.
- Mahmood, S. (2001). *Feminist Theory, Embodiment, and the Docile Agent: Some Reflections on the Egyptian Islamic Revival*. *Cultural Anthropology*, 16(2): 202-236.
- Mahmood, S. (2012). *Politics of Piety. The Islamic Revival and the Feminist Subject*. Princeton: Princeton University Press.
- Marwaha, S. & Livingston, G. (2002). *Stigma, racism or choice. Why do depressed ethnic elders avoid psychiatrists?* *Journal of Affective Disorders*, 72: 257-265.
- Memon, A., Taylor, K., Mohebbati, L.M., Sundin, J., Cooper, M., Scanlon, T. & Visser, R. (2016). *Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England*. *BMJ Open* 6: doi 10.1136/bmjopen-2016-012337.
- Rechel, B., Mladovsky, P., Ingleby, D., MacKenbach, J.P. & McKee, M. (2013). *Health in Europe 5: Migration and Health in an Increasingly Diverse Europe*. *The Lancet*, 381: 1235-1245.
- Roets, G., Reinaart, R., & Van Hove, G. (2008). *Living between borderlands: Discovering a sense of nomadic subjectivity throughout Rosa's life story*. *Journal of Gender Studies*, 17(2): 99-115.
- Roets, G. & Braidotti, R (2012). *Nomadology and Subjectivity: Deleuze, Guattari and Critical Disability Studies* (pp. 161-178) Goodley, D., Hughes, B. & Davis, L. (eds.) *Disability and Social Theory. New Developments and Directions*. Basingstoke: Palgrave Macmillan.
- Rondelez, E., Bracke, S., Roets, G. & Bracke, P. (2016). *Racism, Migration, and Mental Health. Theoretical Reflections from Belgium*. *Subjectivity*, 9(3): 313-332.

- Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P. (2018). *Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims*. *Social Theory & Health*.
- Rose, N. (1998). *Inventing Ourselves. Psychology, Power, and Personhood*. Cambridge: Cambridge University Press.
- Rose, N. (1999). *Governing the Soul. The Shaping of the Private Self*. London: Free Association Books.
- Said, E.W. (2005). *Orientalism*. Amsterdam: Mets & Schilt.
- Sayyid, B.S. (2003). *A Fundamental Fear. Eurocentrism and the Emergence of Islamism*. London: Zed Books Ltd.
- Stad Gent (s.d.). *Eerstelijnspsychologen*. Consulted on 10/02/2018: <http://www.geestelijkgezondvlaanderen.be/eerstelijnspsychologen>
- Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *The British Medical Journal*, 336: 992-994.
- Traustadóttir, R. & Kristiansen, K. (2004). Introducing gender and disability. In: K. Kristiansen & R. Traustadóttir (eds.) *Gender and Disability Research in the Nordic Countries*. Lund: Studentlitteratur.
- Tsang, A. K. T., Bogo, M. & Lee, E. (2011). *Engagement in Cross-Cultural Clinical Practice: Narrative Analysis of First Sessions*. *Clinical Social Work Journal*, 39: 79-90.
- Vandekinderen, C. & Roets, G. (2016). *The Posthuman always rings twice: Theorizing the differences of impairment in the lives of people with "mental health problems"*. *Disability & Society*, 31(1): 33-46.
- Vandekinderen, C., Rondelez, E., Roets, G., Bracke, S. & Bracke, P. (in progress). *How to make sense of cultural difference in mental health care: Analysing the biographies of diasporic Muslim women with mental health problems*.
- Van den Muijsenbergh, M., Wolffers, I., van den Oever, H. & Tjitra, J. (2013). Insluiting en uitsluiting van migranten in de gezondheidszorg. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 107-118). Bussum: Coutinho.

- Van der Kwaak, A. & Wolffers, I. (2013). Interculturele communicatie in de zorg. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 87-106). Bussum: Countinho.
- Van Duppen, D. (2017). *'Minister De Block laat audit wijkgezondheidscentra uitvoeren door lobbyisten voor privatisering gezondheidszorg'*. Consulted on 10/02/2018: <http://www.knack.be/nieuws/belgie/minister-de-block-laait-audit-wijkgezondheidscentra-uitvoeren-door-lobbyisten-voor-privatisering-gezondheidszorg/article-opinion-877883.html>.
- VVGG (s.d.). *Feiten & cijfers*. Consulted on 10/02/2018: <http://www.geestelijkgezondvlaanderen.be/feiten-cijfers>
- Vardar, A., Kluge, U. & Penka, S. (2012). *How to Express Mental Health Problems: Turkish Immigrants in Berlin Compared to Native Germans in Berlin and Turks in Istanbul*. *European Psychiatry*, 27: 50-55.

Appendices

1. Appendix A: Information mental healthcare professionals

No	Date	Profession	Institution	Gender	Ethnicity	Years of experience with diasporic Muslims	Works exclusive with diasporic Muslims
1	05/11/2014	Social cultural worker	Community health centre	F	Belgian	39	No
2	18/11/2014	Social cultural worker	Umbrella organisation	M	Belgian	0	No
3	21/11/2014	Social cultural worker	Umbrella organisation	M	Belgian	22	No
4	25/11/2014	Psychologist	Community health centre	F	Belgian	5	No
5	11/12/2014	Psychologist	City service	F	Belgian	38	No
6	17/12/2014	Social cultural worker	Welfare organisation	F	Belgian	0	No
7	14/01/2015	Psychologist	Community health centre	F	Belgian	4	No
8	14/01/2015	Social cultural worker	Community health centre	F	Belgian	39	No
9	21/01/2015	Social cultural worker	City service	F	Turkish	10	Yes
10	02/02/2015	Social cultural worker	Welfare organisation	F	Belgian	9	Yes
11	17/02/2015	General practitioner	Community health centre	F	Belgian	8	No
12	25/03/2015	Psychologist	Mental health services	F	Moroccan	8	Yes
13	24/02/2015	Psychologist	Private practice	F	Turkish	8	No
14	17/03/2015	Psychologist	Private practice	F	Turkish	9	Yes
15	21/03/2015	General practitioner	Private practice	F	Belgian	30	No
16	27/03/2015	Psychiatrist	General hospital + private practice	M	Belgian	30	No
17	02/04/2015	Psychologist	Group practice	F	Belgian	1	No
18	15/04/2015	Psychologist	Group practice	M	Belgian	20	No

19	21/04/2015	Psychologist	Private practice	F	Turkish	7	Yes
20	17/06/2015	General practitioner	Private practice	M	Turkish	17	No
21	17/06/2015	General practitioner	Group practice	F	Belgian	2	No
22	25/06/2015	General practitioner	Group practice	F	Belgian	25	No
23	26/06/2015	Psychologist	Welfare organisation	M	Moroccan	15	Yes
24	26/06/2015	Psychiatric nurse	General hospital	F	Belgian	11	No
25	28/06/2015	Psychologist	Private practice	F	Belgian	22	No
26	29/06/2015	Psychiatrist	Private practice	F	Belgian	26	No
27	30/06/2015	Psychiatrist	General hospital	M	Belgian	16	No
28	01/07/2015	Psychologist	Group practice	M	Belgian	40	No
29	06/07/2015	Psychologist	Private practice	M	Belgian	17	No
30	13/05/2016	Social cultural worker	Psychiatric hospital	F	Belgian	19	No
31	17/08/2016	Social cultural worker	Psychiatric hospital	F	Belgian	2	No

2. Appendice B: Information diasporic Muslims

Name	Age	Migration background	Organisation
Durya	30-40	Morocco – 2 nd generation	Federation of Moroccan Associations
Zaineb	45-55	Turkey– 2 nd generation	psychiatric hospital
Izgi	20	Turkey – 2 nd generation	private practice of Turkish therapist
Sinem	28	Turkey – 3 rd generation	private practice of Turkish therapist
Gülcin	31	Turkey – 2 nd generation	private practice of Turkish therapist
Eslem	40-50	Turkey – 2 nd generation	psychiatric wing in general hospital
Nadir	36	Turkey – 3 rd generation	psychiatric hospital
Meyra	25-35	Turkey – 1 st generation	community health center
Nadia	41	Tunisia – 2 nd generation	women’s refugee center
Tirra	53	Morocco – 1 st generation	community health center
Hafsa	30-40	Algeria – 2 nd generation	psychiatric wing in general hospital
Naïma	30-40	Morocco – 1 st generation	community health center

English summary

Diasporic Muslims are largely under-represented in established mental healthcare services in Western-Europe, but they are also at particular risk for mental health problems. This issue has been identified, conceptualised and approached from a number of perspectives. Nevertheless, the existing body of knowledge has yet to provide an in-depth and dynamic understanding of what happens in the interactions between mental healthcare professionals and diasporic Muslims. This doctoral research project is aimed at exploring this under-representation and these interactions in theoretical and empirical terms.

The second chapter is entitled *“Racism, migration, and mental health. theoretical reflections from Belgium”*.

Central objective

Our central objective for the first part of this doctoral research project is to conduct an extensive critical literature review of sociological research on the topic. We have attempted to draw theoretical conclusions about this literature. By following the Foucaultian view that mental health institutions shape the subjects that pass through them, we focus on the role of subjectivity in the under-representation of diasporic Muslims in established mental healthcare services. We aimed to sharpen the critical perspectives that are needed for an intersectional approach to the problem: disability, religion, ethnicity, migration and gender. Such an approach is also necessary, as it is important to contest ‘natural’ constructions of the ‘Other’ that circulate in Western societies and uncover their processes of construction.

Theoretical contribution

We have examined discursive strategies within the sociological literature that rely on the demarcation between the ‘normal’ and the ‘a-normal’, and that frame the subject

of mental health. We identified a general tendency amongst the various critical lenses (disability, religion, ethnicity, migration and gender). All of these perspectives can be used to discern mechanisms of ‘othering’ within sociological scholarship. The modern formation of the Western subject is based on an opposition to the mentally ill, religious, non-White female ‘Other’. The mechanisms used consist of the universalisation or the elision of the mental health of minorities, essentialising ‘them’ as fundamentally different. Although this perspective has been criticised in post-colonial research, we observed an absent ‘missing revolution’ of post-colonial theory in sociological theory. We also observed that little attention has been paid to the agency of the ‘others’ within the two mechanisms. At the end of this chapter, we consider ways in which attention to agency could make it possible to unpack the initial conundrum in which diasporic Muslims have poorer mental health and are nevertheless under-represented in the established mental healthcare services, as well as to progress beyond the mechanisms of ‘othering’. We should also acknowledge that such sustained attention to agency is not enough. Considering the intellectual project of decolonising theory, the notion of agency itself should also be reconsidered.

The focus of this study is not on techniques of normalisation, as such a focus would require a more empirical study. We address this issue in the later chapters. In addition to this more theoretical part, this doctoral research project thus drew upon qualitative research to map out the frames of mental healthcare existing amongst a wide spectrum of mental healthcare providers in the city of Ghent, Belgium. We also conducted biographical research with diasporic Muslims who were seeking mental healthcare.

First, we examined the perspectives of mental healthcare professionals. To this end, we conducted 31 qualitative interpretative interviews with a wide range of professionals from different organisations. The participants, who were selected through snowball sampling, included social-cultural workers, psychologists, psychiatrists and general practitioners in umbrella organisations in the context of mental health (and mental healthcare), city services, community mental health centres, mental health services, psychologists, welfare organisations and other entities. We

focused primarily on ambulant professionals, as the trend towards deinstitutionalisation had assigned a more important role to this group. Mental healthcare professionals are important, as the presence of a supporting role and relationship of trust plays an important role in the healing process for individuals with mental health problems. The duration of the interviews ranged from 45 minutes to 2 hours. I conducted the interviews together with a Master's student, Audrey De Roeck, who participated in this doctoral research project in the context of her Master's thesis.

In the third chapter, "*Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent*", we focus on the first group of interviews, analysing them according to a framework we derived from the work of Nikolas Rose.

Central objective

This chapter focuses specifically on processes of subjectivity that occur within existing mental healthcare services. We devote particular attention to the ways in which 'a proper subject of mental healthcare' is (or is not) created. In the chapter, we consider how mental healthcare professionals approach and construct diasporic Muslims in Ghent.

Theoretical contribution

We identified four different aspects of subjectivity in Rose's work: ontological, epistemological, ethical, and technical. This also led us to expand our analytical approach. Additional attention was needed to the neo-liberal context and the 'psy-logic' that is included in it. This logic is based on the notion that individuals have personal responsibility to be free and healthy subjects. The narratives of our participants reflected yet another logic. We therefore expanded our original perspective by considering a logic of cultural difference, based on the work of Edward

Said. In *Orientalism*, Said describes the intricacies of power/knowledge through which Europe produced the 'Orient'. At the centre of this process lay the production of an ontological and epistemological essentialised distinction between the 'Orient' and the 'West'. In more recent times, the notion of the 'Orient' has increasingly come to coincide with Islam, with superior values being attributed to the West and inferior ones attributed to Islam. The epistemological structures of 'Orientalism' obscure the profoundly dialectical ways in which identities of and knowledge about 'self' and 'other' are constructed.

Empirical findings

In addition to allowing us to select and obtain insight, the work of Rose and Said made it possible to deflect crucial insights concerning underlying rationales and views of professionals in mental healthcare services. Examples include oppositional dichotomies between the 'self' and 'other' and the ways in which diasporic Muslims are perceived as unknowing subjects. Other examples include the ways in which mental healthcare professionals exercise authority over and use their expert knowledge on these subjects, as well as their approach to the culture of diasporic Muslims as homogeneous, despite their own claims to adopt a culturally sensitive approach.

Implications

Our application of the work of Rose and Said revealed a blind spot in our analysis. Although their work allows a critical deconstruction of this binary dialectic between 'self' and 'other', it does not allow us to go beyond a negative appreciation of professionals in mental healthcare in order to imagine (or re-imagine) a non-deterministic and non-dualistic framing of the formation of human subjects amongst diasporic Muslims.

In the fourth chapter, “*Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims*”, we shift our analytical attention to the frames of mental healthcare professionals, as conceptualised by Goffman.

Central objective

In the process of shifting to Goffman, we were committed to revisiting Goffman’s theory in light of several theoretical sensibilities that inform our empirical material. In particular, we focused on an adapted notion of power and the subject. Based on this notion, we tried to disentangle the various frames that mental healthcare professionals use when approaching diasporic Muslims.

Theoretical contribution

Based on Goffman’s theory and the theories about frames that he inspired, we conceptualise frames as cognitive and affective devices that are produced in consideration of the complex social context in which they are created and that provide guidelines for knowing, analysing, persuading and acting. Based on our empirical research, we identified three frames: the biomedical frame, the resocialisation frame and the cultural difference frame. The first two frames were also present in the work of Goffman. Given the changes that have occurred in these frames over time, along with the emergence of a third frame, we identify elements of theories developed by other scholars. We treat these changes as having resulted from changes in regulatory schemas, which we conceptualise as historically revisable.

Empirical findings

Mental healthcare professionals who rely on a biomedical frame presume that diasporic Muslims lack awareness of ‘their’ mental health problems, instead translating them as problems of the body. Within the resocialisation frame,

responsibility for recovering is placed on the shoulders of people with mental health problems. When situated within this frame, our participants regarded it as problematic that a recovery frame does not fit with the frame applied by diasporic Muslims. The cultural difference frame emerged as many participants noted that they considered cultural differences as a crucial barrier in their contacts with diasporic Muslim with mental health problems. Many participants thus adopt a more culturally sensitive approach in the treatment of this target group.

Implications

As clearly revealed in our analysis of the frames, knowledge about mental health is largely conceptualised by the dominant group: mental healthcare practitioners. In contrast to Goffman, however, our analysis also indicates that the notion of power is not totalitarian, but dynamic. Finally, the analysis reveals that more attention should be paid to the agency of diasporic Muslims. To our mind, this is an important evolution. It is nevertheless important to mention that the distinction between the frames is particularly analytical in character. In our empirical data, the frames occur in concert and interact with each other

Central objective

Our initial analysis revealed three frames, the third of which is not addressed in Goffman's writings. For this reason, in Chapter 5, "*But that is a cultural given': Diasporic Muslims, mental healthcare professionals and the cultural-difference frame*", we address this frame in greater detail.

Theoretical contribution

In terms of theory, we observed that a slightly adapted version of Goffman's theory of frames still exists. The emergence of a cultural difference frame within the context of mental healthcare is a remarkable finding. This frame is also linked to several

prevailing characteristics of ‘Orientalisme’. We focused more on this new frame as floating signifier, on how the floating signifier of culture is used within this frame and on the three elements/tropes that are part of the frame. Within this context, our participants also used culture as a floating signifier, making references to culture in terms of norm and values, culture as a way of life and culture in terms of schemes of interpretation, although they were not aware of this framework. These three conceptualisations of culture can also be linked to the three different tropes within the frame of cultural difference.

Empirical findings

Different professionals had different conceptualisations of culture, and they used the concept in different contexts. The contexts we identified include that of the under-representation of diasporic Muslims in established mental healthcare services, the context of differences in symptoms, the context of gender relations in Islamic culture and the fact that culture is used as a motivation. In these contexts, the mental healthcare professionals we interviewed conceptualise culture according to the theoretical conceptualisation of culture in terms of norms and values, schemes of interpretation and ways of life. According to our analysis, our participants indicated that they combine the various conceptualisations without any problem. We also formulated several critiques concerning the ways in which these professionals used the notion of ‘culture’. For example, some participants regarded ‘culture’ as a substantiated object, essentialising it as ethnicity, language or religion and treating it as an invariable entity. In addition, nearly all of our participants constructed a difference between ‘us’ and ‘them’. This frame can be disentangled into three tropes: pressure from the community, spiritual healing and psychosomatisation.

Implications

Mental healthcare practitioners should become aware of culture as a floating signifier accompanied by its various ‘signifieds’. They should realise that the notions of culture

that they use are not substantiated, invariable or essentialised ‘things’. They are ‘living’ concepts, which are also influenced by the opinions of diasporic Muslims themselves.

Finally, the results of the second part of the empirical phase of this doctoral research project, in which we interviewed diasporic Muslims, are presented in the chapter entitled “*How to make sense of cultural difference in mental healthcare: Analysing the biographies of diasporic Muslim women with mental health problems*” (Chapter 6).

This chapter consists of an analysis of the other side of the story: the stories of the diasporic Muslim clients. For this study, we conducted biographical research with 12 diasporic Muslims who were settled in Belgium and who were seeking mental health services. In this study, we focused specifically on women, in line with the gender intersection that we had described at the beginning of this project. Such a focus is interesting, given the gender element that mental health professionals attribute to psychosomatisation (amongst other reasons). We also expanded our focus on Turkish and Moroccan Muslims to Turkish and Maghrebi Muslims. We did this in order to ensure that we would find enough participants, as it was difficult to reach diasporic Muslims with mental health problems. It is also important to realise that the Muslim community is neither monolithic nor fixed. It should be approached in an intersectional manner, given that cultural difference is not merely a reflection of ethnicity or cultural traits, but a complex negotiation of cultural hybridity. The interviews took 1-3.5 hours each, and they were conducted in locations selected by the participants. Locations included the participants’ homes, a bar in the city of Ghent and the hospital where the women were receiving treatment. Caroline Vandekinderen conducted the interviews and performed the initial analysis for this part of the research.

Central objective

The purpose of this study was to focus on the agentic strategies of diasporic Muslim women when they deal with mental health problems in daily interactions. As

demonstrated in the previous chapters, attention to the agency of diasporic Muslim ‘others’ is often lacking.

Theoretical contribution

The interactions reflected assumptions about cultural difference and power relations, in addition to providing an overview of how the women’s subjectivity developed within their social, political, historical and cultural contexts. These subjects are regarded as the ultimate ‘Other’ of the rational, unitary, male, White ‘Self’ that has functioned as ‘the measure of all things’ since the advent of modernity. They were also presented as passive, submissive and powerless. Contemporary feminist scholarship has been successful in presenting Arab and Muslim women as active agents with rich, complex lives. Nevertheless, this line of scholarship continues to work with a concept of ‘agency’ that is located within the context of political and moral autonomy, while considering the possibility of pursuing one’s own interests, as opposed to customs, traditions and transcendental obstacles. This vision is subject to criticism, as these women are not only victims: they also subvert and challenge these processes at various times in ways that are less defensive and sometimes creative.

Empirical findings

Our analysis revealed four domains in which the subjects embed their stories. The overall observation is that of the hybridisation of culture as expressed in the embodied and embedded nature of mental health problems, as well as in the women’s educational and work trajectories, along with their religion. The meaning-making strategies of the women we interviewed were entangled throughout their stories. Analysis of the interviews revealed that the women regarded mental health problems as a multifaceted combination of social problems, often situating the origin of these problems in events in their networks of social relations. Our results clearly indicate that diasporic Muslim women with mental health problems consider their communities in two ways: as a

source of support, as well as the source of taboo. They thus appear to conceptualise mental health problems in general as a social phenomenon, and not as a biological, objective, deterministic or natural element. In addition, their experience of ‘somatic’ symptoms are seemingly in contradiction to the biomedical frame. The ‘Western’ conceptualisation is based on the dualism between body and mind. The conceptualisations of Turkish and Maghrebi women with mental health problems were based on an intrinsically related connection between body and mind. They were also based on their presentation as one reality of which they are only two different elements. Although they do not conceptualise mental health problems in cultural terms, they do express the desire for more cultural sensitivity in mental healthcare services.

Mental health problems also have a complex relationship with education and employment. Although experiences of discrimination and pressure within these contexts could result in mental health problems, education and employment can also be a helpful source of contact, financial freedom or resources for counteracting mental health problems or difficult private situations. Finally, the women we interviewed associated religion with mental health problems as a means of addressing them, supplementing the recovery process or ascribing meaning to them. In this way, spirituality and religion were often intertwined, although they often separate religion from culture. The women used religion to engage in critical reflection about their cultures. This finding suggests that religion is not necessarily incompatible with critical thought, and that it can also generate agency and political subjectivity.

Implications

The under-representation of diasporic Muslims with mental health problems in established mental healthcare services could benefit from the application of a more hybrid conceptualisation of their identities by mental healthcare professionals. Their identities are less monolithic than expressed in the ‘Orientalist’ ‘us’/‘them’ presentation: they are constructed by an imaginary, illusory unity of fractures. As indicated by this empirical study, however, the ‘problematic’ under-representation

could benefit from a process of re-framing by calling on mental healthcare professionals to engage in continuous questioning of their own ways of working.

Nederlandstalige samenvatting:

Identiteitsconstructies op het snijpunt van geestelijke gezondheid, religie, etniciteit en gender in België

1. Probleemstelling

Diasporische migranten⁴⁴ ervaren heel wat extra druk op hun mentale gezondheid. Ten eerste als gevolg van ervaringen tijdens het migratieproces zelf: ze vluchten vaak voor geweld of economisch erg moeilijke omstandigheden en komen in een (totaal) andere context terecht, waar ze helemaal opnieuw moeten beginnen. Ten tweede door ervaringen in die nieuwe context: ze worden vaak geconfronteerd met processen van racisme en sociale uitsluiting. Onderzoek heeft ondertussen aangetoond dat dit negatieve gevolgen heeft voor hun mentale gezondheid (Brown, 2003; Chakraborty et al., 2010; Karlsen et al., 2005). Dit resulteert bijvoorbeeld in het feit dat er bij tweede generatie migranten meer schizofrenie (Cantor-Graae & Selten, 2005; Fossion et al., 2002; 2004; Gramaglia et al., 2016; Hoffer, 2009; Livingston & Sembhi, 2003; Marwaha & Livingston, 2002), post-traumatische stress stoornissen (Buytaert et al., 2009) en bipolaire stoornissen (Swinnen & Selten, 2007) worden vastgesteld dan bij autochtone Europeanen. De resultaten van studies rond depressies en angststoornissen zijn echter minder duidelijk (Bhugra & Mastrogianni, 2004; Doornbos et al., 2013; Lay et al., 2007; Levecque, et al., 2009; Lindert et al., 2008; van Beelen, 2013).

⁴⁴ We gebruiken de notie ‘diasporisch’ om te verwijzen naar de culturele, economische en politieke wijzen waarop historisch bepaalde ‘genealogieën van migratie en om de relaties binnen verschillende migraties doorheen velden van sociale relaties, subjectiviteit en identiteit te onderzoeken. De notie diaspora bekritiseert ook de discours rond vaste origine. Diaspora’s bestaan vaak uit verschillende reizen naar verschillende delen van de wereld. De notie diaspora focust op machtsformaties die diaspora’s intern onderscheiden als ook hoe ze zich situeren in relatie tot elkaar. Als gevolg is de identiteit van de diasporische imaginaire gemeenschap niet vooraf gegeven (Brah, 1996).

Aan de andere kant observeren we ook dat veel mensen de weg naar de geestelijke gezondheidszorg (GGZ) nog steeds niet lijken te vinden. Een derde van de Belgische bevolking krijgt ooit te maken met psychische problemen. 70 percent daarvan gaat hiervoor eerder naar de huisarts. We stelden vast dat diasporische migranten nog minder hun weg lijken te vinden naar de GGZ dan autochtone Belgen, ook al kunnen we verwachten dat ze meer mentale problemen hebben.

Deze vastgestelde tegenstelling (meer psychische problemen, minder toegang tot GGZ), is al op verschillende manieren bestudeerd: kwantitatieve epidemiologische studies, studies gefocust op de ongelijke verdeling van psychische problemen onder sociale groepen, studies naar institutionele dynamieken en impliciete (voor)oordelen binnen geestelijke gezondheidsinstituten en tot slot, kwalitatief onderzoek naar de socio-culturele constructie van mentale gezondheidsproblemen. Het ontbreekt echter nog aan diepgaand en dynamisch onderzoek naar wat er net gebeurt in de interacties tussen hulpverleners en diasporische migranten. Met een intersectionele benadering hebben we getracht na te gaan wat er in de interacties tussen professionals in de GGZ en personen met mentale gezondheidsklachten gebeurt. We hebben dit zowel theoretisch als empirisch aangepakt door te kijken naar processen van subjectivering, maar ook naar frames en oorzaken die de onderrepresentatie kaderen bij professionals en diasporische moslima's.

2. Onderzoeksvragen en hypothesen

Dit onderzoek vertrekt vanuit kwalitatief en interpretatief onderzoek dat gebeurt is in twee synergetische en met elkaar verbonden clusters van empirisch onderzoek. Dit onderzoek is dan ook gestuurd geweest door volgende onderzoeksvragen:

1. het blootleggen, analyseren en theoretiseren van de bestaande frames binnen de GGZ ten aanzien van diasporische moslims met een Turkse en Marokkaanse achtergrond bij een breed spectrum van geestelijke gezondheidsverleners en professionals.
2. hoe diasporische moslima's die hun toevlucht zoeken bij de GGZ, de Westerse GGZ discours en diensten ervaren, welke discours en praktijken

in de moslimgemeenschap leven en het theoretiseren van de strategieën die ze ontwikkelen om geestelijke gezondheidszorg te zoeken.

Hierbij willen we een antwoord formuleren op volgende vragen: *Waar gaan diasporische moslims naartoe met hun mentale problemen? Vinden ze de weg naar de bestaande GGZ? Indien niet, waar gaan ze dan wel naartoe? Indien wel, hoe zien hun contacten met en trajecten door de GGZ er dan uit? En wat vertelt hun onderrepresentatie ons over de sociale organisatie van de GGZ?*

Dit onderzoek is beperkt tot de stad Gent, hoofdstad van de provincie Oost-Vlaanderen. In Gent behoren de Turkse en Marokkaanse diasporische gemeenschap tot de grootste niet-autochtone gemeenschappen. De eerste generaties kwamen in de jaren '60 naar België, maar ook latere generaties blijken nog steeds minder toegang te vinden tot de GGZ.

3. Opzet

In de eerste studie is gebruik gemaakt van een uitgebreide kritische literatuurstudie van internationale sociologische literatuur naar de onderrepresentatie van diasporische migranten in de GGZ. Op basis van dit onderzoek zijn enkele theoretische conclusies geformuleerd. Het bestuderen van sociale theorie is immers handig om onderliggende assumpties, discours en ideologieën in verband met de exclusie van bepaalde individuen en de focus op sociale rollen die als vanzelfsprekend worden ervaren, in vraag te stellen (Goodley et al., 2012). Door de Foucaultiaanse visie te hanteren dat geestelijke gezondheidsinstellingen subjecten vormen doorheen het traject dat ze doorlopen, hebben we gefocust op de rol van subjectiviteit in de onderrepresentatie.

Naast dit theoretische gedeelte steunt deze studie op kwalitatief onderzoek dat enerzijds de bestaande frames onder GGZ verleners in Gent wilde blootleggen en anderzijds biografisch onderzoek bij diasporische Moslima's die geestelijke gezondheidshulp zochten.

De eerste empirische studie focuste op het deel van de professionals in de GGZ. Er gebeurde 31 kwalitatieve interpretatieve interviews bij een gevarieerde verzameling

van professionals uit verschillende organisaties. De participanten werden geselecteerd met een sneeuwbalsteekproeftrekking. Ze bestonden uit sociaal-cultureel werkers, psychologen, psychiaters en huisartsen uit overkoepelende organisaties, stadsdiensten, wijkgezondheidscentra, centra geestelijke gezondheidszorg, praktijken en welzijnsorganisaties. De focus lag meer op ambulante professionals aangezien de deinstitutionalisering hen een belangrijkere rol heeft gegeven.

Het tweede empirische luik bestaat uit een analyse van de andere kant van het verhaal. Er gebeurden biografische interviews bij 12 Turkse en Maghrebijnse vrouwen met mentale moeilijkheden.

4. Conclusie

4.1. Bevindingen

In *'Racism, migration, and mental health. Theoretical reflections from Belgium'* (hoofdstuk 2) werd een algemene tendens binnen de verschillende kritische lenzen geïdentificeerd. Ze zijn allemaal gebaseerd op mechanismen van 'Anders zijn'. De moderne constructie van het Westerse subject is gebaseerd op de tegenstelling met de (geestelijk) zieke, religieuze, niet-blanke, vrouwelijke 'andere'. Een andere observatie was dat er over het algemeen weinig aandacht was voor de agency van diasporische moslims met mentale problemen.

In *'Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent'* (hoofdstuk 3) werd er gewerkt met de eerste interviews met professionals. Deze werden geanalyseerd met een frame gebaseerd op het werk van Nikolas Rose. Dit frame focuste specifiek op processen van subjectiviteit/subjectivering. Daardoor werd de aandacht getrokken naar hoe 'het goede subject van de GGZ' (al dan niet) gecreëerd wordt. Tijdens deze analyse werden vier verschillende aspecten van subjectiviteit geïdentificeerd in het werk van Rose: het ontologische, epistemologische, ethische en technische. Dit perspectief werd uiteindelijk uitgebreid door meer aandacht te besteden aan een logica van cultureel

verschil, gebaseerd op het werk van Edward Said. Uit de analyse bleek echter dat het ons met een blinde vlek achter liet.

In *'Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims'* (hoofdstuk 4) werd de aandacht verlegd naar de frames van de geestelijk gezondheidsaanbieders, zoals geconceptualiseerd door Erving Goffman en Judith Butler. Er werd geprobeerd de verschillende frames, die professionals gebruiken wanneer ze in contact komen met diasporische moslims, te ontwarren. Een focus op frames is interessant, aangezien men de wereld rondom zich altijd al geframed waarneemt. Zulke frames functioneren als wegwijzer of regel om bepaalde fenomenen te herkennen. Gebaseerd op dit empirisch onderzoek werden drie frames geïdentificeerd: een biomedisch frame, een resocialisatie frame en een frame van cultureel verschil. De eerste twee frames waren ook al aanwezig in het werk van Goffman. Het resocialisatie frame is doorheen de tijd echter veranderd in een recovery frame en men mag niet vergeten dat de context waarin Goffman zijn werk schreef ondertussen gewijzigd is. Bijgevolg is het laatste frame een nieuw frame, dat het frame van cultureel verschil werd genoemd.

Dit laatste frame dat niet terug kan gevonden worden in het werk van Goffman, werd vervolgens verder geanalyseerd. *"'But that is a cultural given.'": Diasporic Muslims, mental healthcare professionals and the cultural-difference frame'* (hoofdstuk 5) focust meer op dit frame van cultureel verschil. De conceptualisering van cultureel verschil varieert tussen de professionals, maar ze construeren bijna allemaal een verschil tussen 'wij' en 'zij'. Dit frame kan vervolgens ontrafeld worden in drie tropes: druk vanuit de gemeenschap, spirituele genezing en psychosomatisering.

Als gekeken wordt naar de specifieke inhoud van de frames, dan valt op dat de professionals zowel naar structurele als culturele elementen verwijzen om de onderrepresentatie van diasporische moslims in de GGZ te verklaren. Structureel gaat het om zaken zoals een te hoge kostprijs of het feit dat psychologische hulp nog steeds niet terugbetaald wordt. Dit zou moeilijk zijn voor diasporische moslims die vaak een lagere sociaaleconomische status hebben. De culturele elementen waar men naar

verwijst, zijn het feit dat er te weinig professionals uit etnische minderheidsgroepen te werk gesteld zijn in de GGZ, het gebrek aan voldoende tolken en onvoldoende uitwisseling en contacten tussen de verschillende gemeenschappen.

'How to make sense of cultural difference in mental health care: Analysing the biographies of diasporic Muslim women with mental health problems' (hoofdstuk 6) brengt de resultaten van het tweede empirische luik. De studie bracht aan het licht dat hulp zoeken bij geestelijke gezondheidswerkers slechts één strategie is die de moslima's gebruiken. Ook andere strategieën worden gebruikt, zoals hun positionering binnen de familie en de gemeenschap, hun opleiding en werktrajecten en religie. Overkoepelend aan deze observaties was de vaststelling dat de vrouwen aan een hybridiseren van cultuur doen. Er viel te concluderen dat cultureel verschil niet deterministisch of essentialistisch opgevat mag worden, maar wel als voorbijgaand aan het onderscheid tussen 'zelf' en 'ander'. Cultureel verschil kan opgevat worden als affirmatief in plaats van pejoratief. 'Andersheid' is niet enkel negatief, maar eerder positief en productief. De hybridisering van cultuur resulteert in een heterogene, aanpasbare groep met interne verschillen. Een eveneens essentialistische opvatting van culturele identiteit lijkt geen recht te doen aan de complexe interpretatieschema's en wijzen van omgang met mentale problemen die deze vrouwen hanteren. Daarnaast is het ook belangrijk meer aandacht te besteden aan de agency en tegenreacties van diasporische moslims zelf. Er werd bij dit deelonderzoek ook getracht om voorbij de eerder negatieve of deterministische opvattingen van subjectivering te kijken, door het subject uit de dialectiek te halen en te transplanteren naar een niet-unitaire constructie van het zelf, opgevat als onderling gerelateerde krachten en dus ook een louter humanistische liberale opvatting van agency naast zich neer te leggen. Agency dient niet enkel opgevat te worden als kritische tegenstand, gefocust op de constructie van tegen-subjecten, maar kan ook opgevat worden als een belichaamde subjectivering (Braidotti, 2013; Mahmood, 2012).

4.2. Discussie – implicaties voor beleid en praktijk

De observatie dat frames gehanteerd door geestelijke gezondheidsprofessionals en door diasporische moslim(a)s invloed uitoefenen op de toegankelijk van de GGZ kan belangrijke implicaties hebben voor het beleid en de professionals. In de eerste plaats moet men zich er bewust van zijn dat een cultureel homogene opvatting van de Belgische samenleving, waarbij iedereen die anders is, gestigmatiseerd wordt, schadelijk is. Het alternatief is dat we evolueren naar een meer pluralistische visie door onder andere de GGZ aan te passen aan de veranderende bevolking. Een belangrijke algemene conclusie is dat we de ‘Oriëntalistische’ frames die professionals gebruiken daarom moeten aanpakken. Het zou de situatie van diasporische moslims vooruit helpen als men ‘wij’-‘zij’ tegenstellingen, die mensen het gevoel geven dat ze anders en niet welkom zijn, vermijdt. Dit kan het gevolg zijn van het feit dat er weinig leermogelijkheden zijn of momenten die tot verandering kunnen leiden, momenten waarop men zich kan realiseren dat diasporische moslims met mentale problemen ook gewoon burgers zijn, net als autochtonen. Dit zou in een ander frame kunnen resulteren.

Eén van de belangrijkste barrières die naar voor kwam uit de interviews met de professionals zijn de lange wachtlijsten. Deze zouden aangepakt kunnen worden door zowel de GGZ als de huisartsen meer te ondersteunen. Deze laatsten zijn vaak de eerste stap voor mensen met mentale gezondheidsproblemen. Huisartsen ervaren een grote druk en zijn vaak niet genoeg opgeleid om met deze problemen om te gaan. Eerstelijns professionals zouden daarom opgeleid moeten worden om het hogere voorkomen van mentale problemen bij diasporische migranten te herkennen. De huisarts zou ook een rol kunnen spelen in het organiseren van preventieve maatregelen, door informatie en opleiding te geven binnen de diasporische families of gemeenschappen over de mogelijke rol van sociale en familiale invloeden. Huisartsen moeten hierbij ondersteund worden door intensieve samenwerkingsverbanden met andere disciplines, zoals sociaal werkers en psychologen die in de eerste lijn tewerkgesteld zijn. Wijkgezondheidscentra doen dit al 40 jaar en zijn ideaal gesitueerd in de gemeenschap

om deze rol te vervullen. Recent kan de eerste lijn ook ondersteund worden door eerstelijns psychologen, psychologen die samen werken met huisartsen of wijkgezondheidscentra en die advies of kortdurende hulp bieden.

Diasporische moslims gaan op hun eigen manier met mentale problemen om, zoals bleek uit dit onderzoek. Ze doen dit echter ook omdat ze drempels ervaren naar de gevestigde GGZ, vb. door het taboe binnen hun gemeenschap. Om de stap naar de GGZ te vergemakkelijken, kan het helpen om meer te investeren in sensibilisering en preventie. Het zou bijvoorbeeld kunnen helpen als men tijdens sensibilisercampagnes, zoals Te Gek, ook het gezicht laat zien van sommige diasporische migranten, in plaats van enkel een ‘witte’ campagne te voeren. Ook andere campagnes hebben baat bij meer diversificatie. Een andere oplossing om de onderrepresentatie tegen te gaan, is meer contact met de GGZ of welzijnsorganisaties, eveneens als meer contact met mensen met mentale gezondheidsproblemen. Dit zou ook het stigma in de diasporische moslimgemeenschap kunnen tegengaan.

Daarnaast kan het interessant zijn om te investeren in een aanpassing van hun verwachtingen ten aanzien van de GGZ. Dit kan gebeuren in de praktijken van huisartsen, die de eerste stap naar de GGZ vormen en zeer toegankelijk zijn. Het kan echter ook plaats vinden tijdens andere instromen naar de GGZ. Huisartsen en andere GGZ-instituten kunnen geadviseerd worden om diasporische moslims van duidelijke informatie te voorzien over vb. wat de GGZ kan betekenen voor hen, hoe het werkt, het doel en de duur van een behandeling. Het kan ook belangrijk zijn om te verwijzen naar het mogelijk gebruik van tolken, die niet gekend zijn door diasporische moslims met mentale problemen, die betrouwbaar zijn en ook zwijgplicht hebben.

Anderzijds is het ook belangrijk dat professionals binnen de GGZ gesensibiliseerd worden over de invloed van hun eigen frames. Ze zouden deze misschien meer in overweging moeten nemen. Ook zou het kunnen helpen als ze reflexief zijn over hoe hun eigen (professionele) achtergrond en verwachtingen, hun opvattingen over bijvoorbeeld therapietrouw beïnvloeden. Het gevaar bestaat immers dat de incompatibiliteit tussen de frames van professionals en van diasporische moslims resulteert in het conceptualiseren van diasporische moslims als niet passend in het

systeem van de GGZ en als moeilijke of slechte cliënten. Dit werd aangetoond door voorliggend onderzoek. Professionals mogen dus niet starten vanuit de veronderstelling dat deze moslima's naar de GGZ geleid moeten worden. In plaats daarvan zou men ook wat de vrouwen zelf zeggen en doen, mee in overweging moeten nemen. De vrouwen situeren zich tussen verschillende culturen en het is belangrijk deze interne diversiteit binnen de gemeenschap mee in overweging te nemen.

Er dient bij deze aanbevelingen bijzondere aandacht besteed te worden aan cultuur sensitieve professionals, omdat ze zich situeren op de confrontatie tussen beide partijen. In dit onderzoek werden beiden apart benaderd. Cultuur sensitieve methoden en hulpverleners zijn noodzakelijk om de drop-out onder diasporische moslims terug te dringen. Men moet de culturele competenties onder de hulpverleners beter ontwikkelen. Diasporische gemeenschappen hopen dat ze een hulpverlener kunnen vinden die empathisch is en kennis heeft van of open staat voor ander culturen. Hulpverleners anderzijds geloven dat het hen ontbreekt aan dergelijke kennis of attitudes. Het is dus belangrijk dat instituties binnen de GGZ investeren in opleiding of interculturele contexten waarin hulpverleners kunnen leren uit ervaring.

Referenties

- Bhugra, D. & Mastrogianni, A. (2004). *Globalisation and mental disorders. Overview with relation to depression*. British Journal of Psychiatry, 184: 10-20.
- Brah, A. (1996). *Cartographies of diaspora. Contesting identities*. London: Routledge.
- Braidotti, R. (2013). *The Posthuman*. Cambridge: Polity Press.
- Brown, T.N. (2003). *Critical race theory speaks to the sociology of mental health. Mental health problems produced by racial stratification*. ProQuest, 44: 292–301.
- Buytaert, E., Vandedrinck, E. & Lemmens, G. M. D. (2009). *Psychiatrische stoornissen bij migranten: feiten en hypothesen*. Tijdschrift voor Geneeskunde, 65: 1-8.
- Cantor-Graae, E. & Selten, J-P. (2005). *Schizophrenia and Migration: A Meta-Analysis and Review*. American Journal of Psychiatry, 162(1): 12-24.

- Chakraborty, A.T., McKenzie, K.J., Hajat, S. & Stansfeld, S.A. (2010). *Racism, mental illness and social support in the UK*. *Social Psychiatry and Psychiatric Epidemiology*, 45: 1115–1124.
- Doornbos, M. M., Zandee, G. L., Degroot, J. & Warpinski, M. (2013). *Desired Mental Health Resources for Urban, Ethnically Diverse, Impoverished Women Struggling with Anxiety and Depression*. *Qualitative health research*, 23: 78-92.
- Fossion, P., Ledoux, Y., Valente, F., Servais, L., Staner, L., Pelc, I. & Minner, P. (2002). *Psychiatric disorders and social characteristics among second-generation Moroccan migrants in Belgium: An age- and gender-controlled study conducted in a psychiatric emergency department*. *European Psychiatry*, 17: 443-450.
- Fossion, P., Servais, L. Rejas, M.-C., Ledoux, Y., Pelc, I. & Minner, P. (2004). *Psychosis, migration and social environment: an age-and-gender controlled study*. *European Psychiatry*, 19: 338-343.
- Goodley, D., Hughes, B. & Davis, L. (eds.) (2012). *Disability and Social Theory. New Developments and Directions*. Basingstoke: Palgrave Macmillan.
- Gramaglia, C., Gambaro, E., Rossi, A., Toso, A., Feggi, A., Cattaneo, C. I., Castignoli, G., Mainini, P., Tarricone, I., Torre, E. & Zeppego, P. (2016). *Immigrants' Pathways to Outpatient Mental Health: Are there Differences with the Native Population?* *Journal of Immigrant and Minority Health*, 18: 878-885.
- Hoffer, C. (2009). *Psychische ziekten en problemen onder allochtonen Nederlanders: beleving en hulpzoekgedrag*. Assen: Van Gorcum.
- Karlsen, S., Nazroo, J.Y., McKenzie, K.J., Bhui, K. & Weich, S. (2005). *Racism, psychosis and common mental disorder among ethnic minority groups in England*. *Psychological Medicine*, 35: 1795–1803.
- Lay, B., Nordt, C. & Rössler, W. (2007). *Mental hospital admission rates of immigrants in Switzerland*. *Social Psychiatry and Psychiatric Epidemiology*, 42: 229-236.
- Levecque, K. Lodewyckx, I. & Bracke, P. (2009). *Psychological distress, depression and generalised anxiety in Turkish and Moroccan immigrants in Belgium: a*

- general population study*. *Social Psychiatry and Psychiatric Epidemiology*, 44(3): 188-197.
- Lindert, J., Schouler-Ocak, M., Heinz, A. & Priebe, S. (2008). *Mental health, health care utilisation of migrants in Europe*. *European Psychiatry*, 23:14-20.
- Livingston, G. & Sembhi, S. (2003). *Mental health of the ageing immigrant population*. *Advances in Psychiatric Treatment*, 9: 31-37.
- Mahmood, S. (2012). *Politics of Piety. The Islamic Revival and the Feminist Subject*. Princeton: Princeton University Press.
- Marwaha, S. & Livingston, G. (2002). *Stigma, racism or choice. Why do depressed ethnic elders avoid psychiatrists?* *Journal of Affective Disorders*, 72: 257-265.
- Swinnen, S. G.H.A. & Selten, J-P. (2007). *Mood disorders and migration. Meta-analysis*. *British Journal of Psychiatry*, 190: 6-10.
- Van Beelen, N. (2013). *Migratie en migranten in Nederland*. In Wolffers, I., van der Kwaak, A. & van Beelen, N. (eds.) *Culturele diversiteit in de gezondheidszorg* (pp. 45-58). Bussum: Countinho.

Contributions Elise Rondelez

1. Racism, migration, and mental health. Theoretical reflections from Belgium
Rondelez, E., Bracke, S., Roets, G. & Bracke, P.

Rondelez E.: 75% Bracke S.: 10% Roets G.: 10% Bracke P.: 5%

2. Diasporic Muslims, mental health, and subjectivity: Perspectives and experiences of mental healthcare professionals in Ghent
Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P.

Rondelez E.: 70% Bracke S.: 10% Roets G.: 10% Vandekinderen C.: 5%
Bracke P.: 5%

3. Revisiting Goffman: Frames of mental health in the interactions of mental healthcare professionals with diasporic Muslims

Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P.

Rondelez E.: 70% Bracke S.: 10% Roets G.: 10% Vandekinderen C.: 5%
Bracke P.: 5%

4. “But that is a cultural given.”: Diasporic Muslims, mental healthcare professionals and the cultural-difference frame

Rondelez, E., Bracke, S., Roets, G., Vandekinderen, C. & Bracke, P.

Rondelez E.: 60% Bracke S.: 20% Roets G.: 10% Vandekinderen C.: 5%
Bracke P.: 5%

5. How to make sense of cultural difference in mental health care: Analysing the biographies of diasporic Muslim women with mental health problems
Vandekinderen, C., Rondelez, E., Roets, G., Bracke, S. & Bracke, P.

Vandekinderen, C.: 60% Rondelez, E.: 15% Roets, G.: 15% Bracke, S.: 5%
Bracke, P.: 5%

2018-01-31

Ghent

I, Caroline Vandekinderen,

give permission to include the article

“How to make sense of cultural difference in mental health care: Analysing the biographies of diasporic Muslim women with mental health problems”

written by Vandekinderen, C., Rondelez, E., Roets, G. Bracke S. & Bracke, P.

in the dissertation of Elise Rondelez titled

“Identity constructions at the intersection of mental health, religion, ethnicity and gender in Belgium”.

Signature

A handwritten signature in blue ink, appearing to be 'C. Vandekinderen', written over a horizontal line.

