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ORIGINAL ARTICLE

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

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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 indicate 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 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.

Keywords Mental health · Diasporic Muslims · Mental health professionals · Frames · Goffman

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Introduction

Although diasporic Muslims often experience mental health problems[1] (see Buytaert et al. 2009; Hilderink et al. 2009; Hoffer 2009; Inhorn and Serour 2011; Chakraborty et al. 2010), research demonstrates that they are under-represented in the established mental healthcare system[2] (Doornbos et al. 2013; Heinz and Kluge 2012; Vardar et al. 2012; Vlaanderen 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 and 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,

[1] 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 to 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).

[2] 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 health care, 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 health care is not sufficiently adapted to ethnic minorities, and a similar share referred to the numerous problems that 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 we interviewed expressed the belief that shame, different expectations and a passive attitude among the diasporic Muslim population keep them from seeking mental healthcare (Hilderink et al. 2009).

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 and Mösko 2012; Crammond and Carey 2016; Heinz and Kluge 2012; Kapilashrami et al. 2015; Kluge et al. 2012; Vardar 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 and 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 2014; Buytaert 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 have access, 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 and Carey 2010, p. 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 and Carry 2010, p. 318). We also consider alternative approaches to framing (see Pilgrim and Carey 2010). Drawing particular inspiration from Butler's (2009) approach of framing, we revisit Goffman' in the light of criticisms of his work, as well as 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.

Framing mental health: an exploration of the work of Erving Goffman

Sociological interest in frames and framing inevitably leads to Erving Goffman (Pilgrim and 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) argues 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).

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.

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, pp. 55–56). Such actions are considered in terms of psychiatric relapse and framed as the personal responsibility of the inmates (Goffman 1961).

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 drew 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 (Rondelez et al. 2017; Bachrach 1995a, b; Pieters and Peuskens 1995; Rissmiller and Rissmiller 2006; Stein 1995; Stockman 2000; Traustadóttir and 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 and 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.

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, pp. 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 and 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 and 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 and Fadil 2008; Braidotti 2006), this essentialist understanding of the subject is devoid of physical, social and historical context (Sermijn 2008).

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 Foucauldian, 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,[3] 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, p. 4; Brickell 2003; Lawler 2014; McNay 2000). Lawler (2014) is another author who regards 'identities' as social and collective processes[4] 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

[3] 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.

[4] 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.

(1988), the subject is constituted by performative actions, and 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 reality of mental health problems can be deemed performative; 'it is real only to the extent that it is performed' (Butler 1997, p. 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, p. 4).

These approaches allow the 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 and 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, analyzing, persuading, and acting' (Schön and Rein, in Ponzoni 2016, pp. 46–47). In other words, frames are dynamic and changeable, rather than fixed.

Research methodology

Research context

We conducted a qualitative interpretative study (Denzin and 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, second-generation Moroccan migrants of the second generation with mental health problems were less likely than Belgian people were 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%).

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 respondent was asked to suggest other interesting contacts for our study, thus allowing a snowball sample to unfold (Esterberg 2002). The respondents 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 and Waege 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 respondents than others did: private psychiatrists, 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 respondents might have been too similar to one another to provide the diverse perspectives that we sought to obtain.

Of all respondents, 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 respondents 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 respondent 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.[5] The duration of the interviews ranged from 46 min to 2 h. They were all recorded and fully transcribed. Our sample included 10 men and 21 women, 24 of whom 24 were ethnic Belgians, with 7 being of Turkish or Moroccan descent.

Strategies of data analysis

We chose to conduct a qualitative content analysis, understood as 'the subjective interpretation of the content of text data' (Hsieh and Shannon 2005, p. 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 and 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 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

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

results by offering examples and descriptive evidence for each code/frame, as is customary in the application of a directed approach to content analysis.

Research findings

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

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 and 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 and Halligan 2004). The final proposition is the implied reductionism that ignores socio-psychological explanations (Borrell-Carrió et al. 2004; Engel 1977, 1980; Wade and 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 and 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. (int 7, psychologist, community healthcare 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. (int 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. (int 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.

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 and 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, p. 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. (int 5, psychologist, city service)

> They expect that they will change by taking a pill, without doing anything themselves. We observe this often with foreigners: the moment you start speaking about the willingness to change or when you let them work

> themselves, they drop out. (int 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. (int 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. (int 17, psychologist, group practice)

Most respondents 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 respondents question the recovery frame. In the following quotation, the respondent 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 health care. In this case, the respondent 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'. (int 9, social cultural worker, city service)

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 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 respondents, one important reason that diasporic Muslims fail to access established mental healthcare institutions is the cultural disparity existing between clients and counsellors. Some respondents construct cultural differences as an indicator of a progressive, independent 'we', as opposed to a religious, dependent 'they'. The respondents admitted that, for this reason, they would rather refer diasporic Muslim clients to diasporic Muslim counsellors. Another reason that our respondents 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. (int 31, social cultural worker, psychiatric hospital)

Another reason has to do with the spiritual healing practices existing within these communities. Our respondents 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. (int 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. (int 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. (int 23, psychologist, welfare organisation)

In contrast, other respondents 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 respondents 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. (int 2, social cultural worker, umbrella organisation)

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 respondents: 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 empirical data 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 resocialization frame, the responsibility to recover is imposed on 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; Niewenhuijsen 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. The selected organisations and individuals may disproportionally represent the more culturally sensitive organisations and individuals rather than biomedically oriented actors. Although our data were gathered from a broad selection of respondents, 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.

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