Mental health problems in Moroccan-Dutch people

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Chapter 1 General introduction

General introduction

"I really think the taboo and the shame… It is not only for Moroccan Dutch people here, but already in Morocco. So many things are left unspoken, kept private. Sometimes even a wife does not have the courage to tell her husband. That goes back ages and is passed on from generation to generation." (Participant 6)

This thesis explores different aspects of mental health in the Moroccan-Dutch population. In this introductory chapter, I will briefly introduce the complex nature of mental health problems, before highlighting the special position of migrants within mental health care and research. Background will be provided about migrants in the Netherlands, followed by specific information about the Moroccan-Dutch population. The chapter ends with the study aims and an outline of this thesis.

Mental health

Mental disorders are among the most prevalent health problems, responsible for an extensive burden of disease in the population worldwide (World Health Organization, 2013). Most mental disorders are not present at birth but develop in the course of adolescence and (early) adulthood. The causes for mental disorders are multifactorial, resulting from the interplay between genetic risk profile, (negative) social environment and traumatic events, and individual vulnerabilities and coping (Hankin & Abela, 2005). The influence of the social environment is extensive and occurs on several levels: the individual level (e.g. poverty), school and neighbourhood level (social support, discrimination), up to factors on a national level (e.g. political climate, social conditions) (World Health Organization, 2013). The focus on the role of the social environment is important, since environmental risk factors for mental disorders can potentially be prevented or avoided (McGrath & Lawlor, 2011; World Health Organization, 2013).

Migrants and mental health problems

Migration is one of the indisputable environmental risk factors for mental disorders. International epidemiological research has established this conclusion for a broad spectrum of mental disorders (Cantor-Graae & Pedersen, 2013), and in meta-analyses focusing on psychotic disorders (Selten et al., 2019) and depressive disorders (Mindlis & Boffetta, 2017). These findings in meta-analyses do not apply to the same extent to all migrant groups. There is some variation based on country of origin and country of destination. Some examples for psychotic disorders: migrants to Israel and Canada for example seem less prone to develop a psychotic disorder; migrants to Europe however, especially people with a dark skin colour and from developing countries outside Europe, were shown to be at much greater risk for developing a psychotic disorder (Selten et al., 2019). The risk for mental disorders does not only apply to persons who have migrated themselves. Also their children, second generation migrants, have a higher risk of developing depressive disorders (Mindlis & Boffetta, 2017; Missinne & Bracke, 2012; Pignon et al., 2017) and psychotic disorders (Bourque et al., 2011; Leaune et al., 2019). Among migrant populations, refugees and asylum seekers are considered a distinctive group, due to the traumatic events before migration, often unvoluntary departure and aspects related to asylum procedures (Bäärnhielm et al., 2017; Hocking et al., 2015). Refugees are not discussed within this thesis.

Mechanisms

The increased incidence of psychopathology immediately raises the question: what mechanisms lie behind this association? In 1932, Ödegaard suggested that people who were more at risk for developing schizophrenia might be more restless and therefore more inclined to migrate. This became known as the 'selective migration' hypothesis (Ödegaard, 1932). However, many scientific arguments discard this theory. Research has shown that incidence of psychopathology is increased in second generation migrants; a lower age of migration is related with

a higher risk for psychotic disorder (Veling et al., 2011); and mental illness is associated with a decreased instead of increased probability of emigration (Pedersen et al., 2011). Several review articles have elaborated on the mechanisms behind the relation between migration and mental health problems (Bhugra & Gupta, 2010) and, more specifically, the relation between migration and psychotic disorders (Morgan et al., 2010; Veling, 2013). In these reviews, there is consensus about the importance of factors migrants encounter in the so called 'receiving countries' (countries of destination of migrants). In their review, Morgan et al integrated the available evidence for social risk factors for psychotic disorders in migrants and presented the "sociodevelopmental pathway". In this model, they emphasised the importance of "social experiences and contexts", like exposure to social adversity in the receiving countries, in combination with other aspects (childhood adversity; genetic risk) (Morgan et al., 2010). This sociodevelopmental pathway does justice to the broad variation of individual aspects that contribute to the development of mental health problems in migrants (Bhugra & Gupta, 2010)

Moving to a new country can be experienced in different ways. A Dutch medical student going abroad may have a positive feeling of excitement during traveling and internships in a foreign country. This can however turn into stress and anxiety when the balance between challenges and coping skills shifts in the wrong direction. The feeling of alienation one can experience in a foreign country is nicely depicted in the film 'Lost in translation', in which an American actor stayed in a hotel in Tokyo for work and felt at a loss because he did not understand the language and culture. This feeling of alienation is also described in the scientific literature. A study in Swedish secondary school children for example showed that first-generation migrants felt more alienated than second-generation migrants, who in turn felt more alienated than native Swedish children (Safipour et al., 2011). In most cases, migrants meet many more challenges, compared to a Dutch medical student going abroad. For migrants, the reason to move may not be a positive search for new experiences, but more often an escape from poverty or poor living conditions. The setting in a new country may not be welcoming, and sometimes even hostile (experiences of discrimination). Often, all necessities, such as housing, income etc. need to be (re-)acquired. The cultural and social circumstances are often very different after migration, and bridging this gap is a difficult task. This adaptation to new circumstances is called acculturation (Berry, 1997). Difficulties in this process can deliver acculturative stress (Berry, 2005). Important supportive factors, like social support from family and friends, are often missing. Not surprisingly, many of the above-described challenges, such as discrimination (Bardol et al., 2020) and lack of social support (Kuo et al., 2008), are associated with the development of mental disorders in migrants.

Challenges concerning socio-economic status or familial situation for example, are not restricted to migrants: non-migrants too face such challenges. Studying the mental health of migrants may therefore also increase our understanding of environmental risk factors for mental disorders in general (McGrath & Lawlor, 2011). In mental health care, the search for a better balance between challenges and supportive factors to preserve or restore mental health is recognisable in everyday practice (with migrants and Dutch patients alike). The challenges, suffering and resilience of patients with a migrant background, as well as the broader scope and clinical relevance of migrant studies have motivated me to study this topic for my thesis.

Migrants in the Netherlands

The Netherlands is a small and densely populated country with 17.5 million inhabitants, of whom 25% have a migration background (Centraal Bureau voor de Statistiek, 2020). 'Migrant' in this statistic includes all people born abroad, i.e. 'first-generation' migrant (13% of the total population) and all children with at least one parent who is born abroad, i.e. 'second-generation' migrant (12%). Migrants may also be categorised in terms of their country/region of origin. In the Netherlands, 11% of migrants have a Western background, versus 14% with a non-Western background (CBS, 2022). Currently, the two largest migrant groups are people from Turkey (430,733) and Morocco (419,631) (CBS, 2022). Other migrant groups are people

from Surinam and Indonesia (former Dutch colonies), people from Western countries and a diverse group of asylum seekers / refugees from various countries.

Moroccan-Dutch population
This thesis focuses on the Moroccan-Dutch migrant population. In the sixties and seventies of the twentieth century, migrants from Morocco (as well as Turkey) were encouraged to come to the Netherlands to perform unskilled labour. The first migrants from Morocco were mostly young men, who were poorly educated (Praag, 2006). Initially, it was thought that the labour migrants would return to their countries of origin after several years. However, the opposite happened. In the following years, Moroccan females and children arrived for family reunification. Migration from Morocco continued for family formation: many first- and second generation Moroccan-Dutch people married a person from Morocco and settled in the Netherlands (Praag, 2006). Lastly, childbirth in Moroccan-Dutch families further increased the population towards almost 420,000 people in 2022 (2.4% of the Dutch population). Second-generation Moroccans, now form the majority (58%) of the Moroccan-Dutch group (CBS, 2022). There is no information about the third generation Moroccan-Dutch people, since they are classified as Dutch by the federal statistical office (CBS, 2020). Most of the Moroccan-Dutch people live in the largest cities in the Netherlands (Rotterdam, Amsterdam, Utrecht and the Hague). 94% of Moroccan-Dutch people consider themselves as Muslim (Huijnk, 2018). A study in young Moroccan-Dutch (age 15-32) additionally showed this group felt a strong connection to the Islamic religion and to the Moroccan community (Azghari et al., 2015).

Mental health problems in the Moroccan-Duch population
Previous research has shown that Moroccan-Dutch people have an increased risk for developing psychiatric disorders. Increased risk for developing a psychotic disorder was first shown by Selten and Sijben (Selten & Sijben, 1994) and later replicated (Selten et al., 2001, 2012; Veling et al., 2006). Furthermore, studies have shown an increased risk for mood disorders in Moroccan-Dutch adults (de Wit et al., 2008; Schrier et al., 2010; Selten et al., 2012), anxiety disorders in Moroccan-Dutch adults (de Wit et al., 2008) and depressive symptoms in Moroccan-Dutch elderly (der Wurff van et al., 2004). There is no evidence for increased risk for bipolar disorder in Moroccan-Dutch people (Selten et al., 2012). Furthermore, there is no information on the ethnic variation of several other disorders, like personality disorders and eating disorders.

Determinants for mental health problems
In the Moroccan-Dutch population, there are several social aspects that should be considered in relation to the increased vulnerability for mental health problems. Moroccan-Dutch people have a lower level of education, compared to native Dutch people. Over the last ten years, however, this education gap has narrowed (CBS, 2020). Moroccan-Dutch people are also more often unemployed, dependent on welfare, or on lower incomes, compared to native Dutch people. Although the social-economic situation is better in the second generation than in the first generation, there is still a gap with the native Dutch population (CBS, 2020). Both lower education level and lower socio-economic status are considered universal risk factors for mental health problems (Allen et al., 2014). Another risk factor for mental health problems is childhood adversity (Fryers & Brugha, 2013; Kessler et al., 2010). Traumatic experiencing were found to be associated with psychiatric symptoms in Moroccan-Dutch children (Adriaanse et al., 2016). There are indications that Moroccan-Dutch youth is more prone to experiencing childhood adversity than native Dutch youth, although there is limited research within the Moroccan-Dutch population. One study showed that Moroccan-Dutch boys are more frequently exposed to childhood abuse (measured as physical assault by a parent, sexual abuse by a family member and/or witnessing physical aggression between parents) compared to native Dutch boys (Lahlah et al., 2013). Considering sexual abuse in Moroccan-Dutch children, the opposite effect was described in a study in 3,426 young adults (including 207 Moroccan-Dutch participants), in which less sexual abuse compared to native Dutch participants was found (Okur et al., 2015). The above-described risk factors for mental health problems (lower socio-economic

status, lower educational level, and childhood adversity) are not specific for migrants. However, these social disadvantages are more prevalent in the Moroccan-Dutch population than in native Dutch people. There are also social factors associated with mental health problems that are more closely related to the ethnic minority position of Moroccan-Dutch people. Discrimination was found to be associated with depressive symptoms (van Dijk et al., 2011) and psychotic symptoms (Janssen et al., 2003; Veling et al., 2007). The level of acculturation was associated with both psychological distress (Fassaert et al., 2011) and with levels of psychiatric symptoms, quality of life and perceived need for care (Nap et al., 2015). On the other hand, people who were living close to other people of the same ethnic group showed lower incidence of psychotic disorders compared to people who were an small ethnic minority in their neighbourhood (Veling et al., 2008). Ethnic density was not associated to psychological distress (Schrier et al., 2014).

Social environment

Since the social environment is shown to influence the mental health of migrants, it matters how migrants are approached and treated in the country they have migrated to. The attitude towards the Moroccan-Dutch population in the Dutch society could therefore influence mental wellbeing within this group. In the 1990's, the growth of several migrant populations in the Netherlands gradually changed the country into a multicultural society. These changes in society have led to a public debate about the success or failure of integration of the largest migrant groups. One of many topics in this debate concerns the criminality figures. Moroccan-Dutch people, especially young Moroccan-Dutch men, were and still are overrepresented in police contacts and to a lesser extent in court convictions (CBS, 2020). Possible explanations are a lower social-economic position (Bovenkerk & Fokkema, 2016), insufficient integration (Blokland et al., 2010), family determinants (Blokland et al., 2010) and experienced discrimination (Loeber & Slot, 2007). Furthermore, there is evidence for the influence of ethnic bias in the police, resulting in more police contacts for non-native people. (Bonnet & Caillault, 2015; Unnever, 2019). This is also shown specifically for Moroccan-Dutch people, who were more overrepresented in police contacts compared to court convictions (CBS, 2020). Negative attention for the Moroccan-Dutch population increased after the 9/11 terrorist attacks, which resulted in fear for radicalism and increased Islamophobia worldwide, and also in the Netherlands (Donselaar et al., 2006; Welten & Abbas, 2021). Negative sentiment of native Dutch people towards migrants is examined in several studies, as described in a review article (Unnever, 2019). One study showed that 50% of native Dutch people have negative attitudes towards Muslims (Velasco González et al., 2008). Other studies showed that Moroccan-Dutch people experienced discrimination on several levels in the society (Andriesen et al., 2020; Maliepaard et al., 2015). Since experienced discrimination is associated with mental health problems in Moroccan-Dutch people, these social circumstances might negatively affect mental health in this population.

Explanations and help seeking

The scientific literature shows increased risk for mental health problems in Moroccan-Dutch people and the role of social determinants that are associated with this risk. However, to understand the consequences of these findings for Moroccan-Dutch people, it requires a more in-depth investigation on an individual level. We could learn a lot from knowing how mental health problems and social adversities are perceived by Moroccan-Dutch people, and how they deal with it. The way people perceive and respond to mental health problems can vary greatly. There is increasing scientific and clinical interest in these differences in the perception of complaints and the response to it, which is studied interdisciplinary in the field of cultural psychiatry (de Jong & van Dijk, 2020; Lewis-Fernández & Kleinman, 1995). An important contribution was made by the anthropologist Kleinman, who was the first to acknowledge the influence of cultural elements in relation to mental health problems and the interpretation of these problems (A. M. Kleinman, 1977). This cultural influence on the experience of mental health problems applies to all people, but is probably more prominent in people whose cultural

background is different from the society they live in. In order to explore how a person experiences symptoms, Kleinman introduced the 'explanatory models framework'. In this framework, the explanation of complaints is explored in a non-medical way, which enables the patient to share personal thoughts about the problem, including for example cultural or religious explanations (Kirmayer & Bhugra, 2009; A. Kleinman et al., 1978; Weiss & Somma, 2009).

Although there is very little research on explanatory models for mental health problems in Moroccan-Dutch people to date, knowledge about the explanatory models in minority populations has significant clinical relevance (de Jong & van Dijk, 2020). Cultural elements do not only influence the explanations for mental health problems, but also the way in which people deal with these problems. One aspect of dealing with mental health problems is whether regular mental health care services are used. Several studies investigated help seeking behaviour in migrants. Previously, studies reported underrepresentation of migrants in regular mental health care (Stronks et al., 2001). Although recent studies showed more equal representation (Fassaert, de Wit, Verhoeff, et al., 2009; Klaufus et al., 2014), this may still mean relative underrepresentation due to the increased incidence of psychopathology. In another study, Fassaert et al indeed found an underrepresentation of Moroccan-Dutch respondents in regular mental health care when correcting of the prevalence of psychopathology (Fassaert, de Wit, Tuinebreijer, et al., 2009). There are several studies that report about possible barriers for the use of mental health care in migrants (Fassaert, de Wit, Tuinebreijer, et al., 2009; Kirmayer et al., 2011; Priebe et al., 2011). Taboo is suggested as one of the possible barriers that might discourage migrants from using regular mental health care, e.g. (Priebe et al., 2011). However, the influence of taboo in relation to mental health problems in migrants is not often described, and I am not aware of research on this subject in the Dutch setting.

The topics introduced here (explanatory models, help seeking behaviour, taboo) are complex and more difficult to study with quantitative methods. They are however important phenomena, and information about these topics can help to improve health care practices. Therefore, combining qualitative studies with the epidemiological knowledge can create a broader perspective on mental health symptoms and illness experiences (de Jong & van Ommeren, 2002).

Study setting

At the start of this PhD-project, I joined the project 'ziekofbezeten' (being ill or being possessed), a collaboration between Marokko.nl and Arkin (mental health institute in Amsterdam). Ziekofbezeten was not designed as a research project, but as a tool to get in contact with young Moroccan-Dutch people about mental health problems. A website was created to inform this population about mental disorders in relation to religious explanations for mental problems, hence the title "being ill or being possessed (ziekofbezeten). The website used many sources of information, including text, video, self-tests, forum discussions, and e-mail-interaction with Imams. The website ziekofbezeten.nl was directly linked to the platform Marokko.nl. Marokko.nl is a discussion forum and online community, which at the time of study had a remarkable reach within the Moroccan-Dutch population. My PhD research commenced with the design and implementation of the MEDINA-study (chapters 3 and 4), using the platform of ziekofbezeten.nl and Marokko.nl. The collaboration with the founders of the website Marokko.nl created the unique opportunity to get in touch with the Moroccan-Dutch population via the Internet. Based on the results of the MEDINA-study, I carried out follow-up qualitative studies, again using the ziekofbezeten.nl and marokko.nl network for data collection.

Aim and outline of this thesis

Above, I have emphasised the importance of migrant studies, for understanding factors that contribute to mental health problems. Increasing our understanding of psychological vulnerabilities in migrants specifically, can further our understanding of the development of mental health problems in general. Most of the studies that have been performed have an epidemiolog-

ical approach, describing the differences in incidence or prevalence of mental health disorders in specific ethnic populations in relation to specific risk factors. Migration is now an established risk factor for mental health disorders, although the association varies between ethnic populations and specific psychiatric disorders. Furthermore, several determinants have been found to contribute to the development of psychiatric disorders. Both general social factors, such as lower socio-economic status, and migrant-specific factors, such as discrimination, have been associated with the development of mental health problems in Moroccan-Dutch migrants. Our understanding of the role of social determinants in mental health in Moroccan-Dutch people is far from complete. Some determinants, such as perceived discrimination, acculturation and ethnic density are investigated in relation to one or more specific disorders in Moroccan-Dutch people in a limited number of studies and not all results point in the same direction. The association between mental health problems and other migrant-specific factors (social defeat, lack of social support) have not previously been studied for Moroccan-Dutch people. Since most migrant studies were epidemiological designs looking at overall characteristics in larger numbers of participants, the individual perspective of migrants themselves was not always fully explored. There is hardly any research on how Moroccan-Dutch people experience mental health problems; what explanations they have and how they deal with it. Information about these topics can however be helpful in delivering appropriate care to this population. In this thesis, I will elaborate on the knowledge gap regarding the role of social and cultural determinants in mental health problems in Moroccan-Dutch people and how this is perceived by the Moroccan-Dutch people themselves.

The general aim of this thesis is to increase our insight in how social and cultural determinants are related to mental health problems in Moroccan-Dutch people: a. in the development of mental health problems; b. in the way mental health problems are experienced and explained and c. in the conversations about mental health problems and help-seeking for them.

To meet this aim, I have combined the quantitative and qualitative sections in a mixed-methods design. This enabled us to get an overview on associations between social determinants and mental health problems in a larger sample with the quantitative method. With the results of that study, I could further zoom in on the individual perspective of participants in the qualitative sections of this thesis.

In **chapter 2**, the project website "ziekfofbezeten.nl" (being ill or being possessed) is described. It was built to inform young Moroccan-Dutch people about mental health issues. **Chapter 3** outlines the protocol of the MEDINA Study (Migrants Examined for Determinants of psychopathology through INternet Assessment), in which the association between mental health problems and social disadvantages was examined within an online cross-sectional study sample of Moroccan-Dutch people. The chapter includes the description of the online survey and the recruitment strategy via the collaboration with Marokko.nl. The methodological challenges and advantages of the online recruitment of participants are shortly reviewed (since online recruitment was still rather uncommon in 2012). Results of this MEDINA Study are described in **chapter 4**, showing the association between mental health problems and social exclusion in a cross-sectional sample of 267 young Moroccan-Dutch people. To further explore these results, the quantitative results were expanded with two qualitative studies, hence creating a mixed-methods study. **Chapter 5**, covers a qualitative analysis on 22 online forum discussions on Marokko.nl, which dealt with the topic mental health problems. The chapter describes how forum contributors experienced mental health problems, what potential risk factors they saw, what explanations they had for mental problems and what remedies they used. To further increase insight in the themes that emerged from examining the forum discussions, a follow-up interview study was conducted with participants from the MEDINA-study in **chapter 6**. Results are given on explanations and remedies for mental disorders. Furthermore, the lack of opportunity to open-up about mental disorders and the concept of taboo is described. Although

the role of the Islam is important for most Moroccan-Dutch participants, there is hardly any scientific Dutch literature about the role of the Islam in relation to mental health problems. In **chapter 7**, an essay for the Dutch journal of psychiatry is presented, to address this subject for mental health workers, which the international literature is reviewed. Finally, in **chapter 8** the findings are summarized, discussed and placed in a broader context.

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