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Mental health problems in Moroccan-Dutch people

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Chapter 8 Summary and discussion

Summary and discussion

For a long period, there has been an emphasis on the genetic and biological aspects in the development of psychiatric disorders in psychiatric research (e.g. Cichon et al., 2009) while less attention was paid to the social context (Priebe et al., 2013). Recent research has demonstrated the importance of the role of the social environment. On the one hand, the social environment was shown to contribute to people's vulnerability to develop psychiatric problems (e.g. Morgan et al., 2010; Veling, 2013). On the other hand, environmental aspects could more easily be adapted than genetic and biological factors and can therefore potentially be adjusted to prevent the onset of disorder (McGrath & Lawlor, 2011; van Os et al., 2010). Research in migrant populations is of special interest, not only because of their increased disease burden (Cantor-Graae & Pedersen, 2013), but also because they, by moving from one social setting to another, offer the possibility to study the influence of social factors on mental health (McGrath & Lawlor, 2011).

The aim of this thesis was 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 investigated the role of social and cultural determinants in several phases of mental health problems in Moroccan-Dutch people. First, I investigated potential risk factors (see chapter 3, 4 and 5), which might precede the development of symptoms. Second, I examined explanations for mental health problems (chapter 5 and 6). Third, I investigated the cultural context in which mental health problems develop (chapter 5, 6 and 7). Lastly, I investigated how mental health problems were dealt with in relation to the cultural context (chapter 5, 6 and 7). Figure 1 shows different phases of mental health problems, and how the social and cultural determinants are addressed in this thesis.

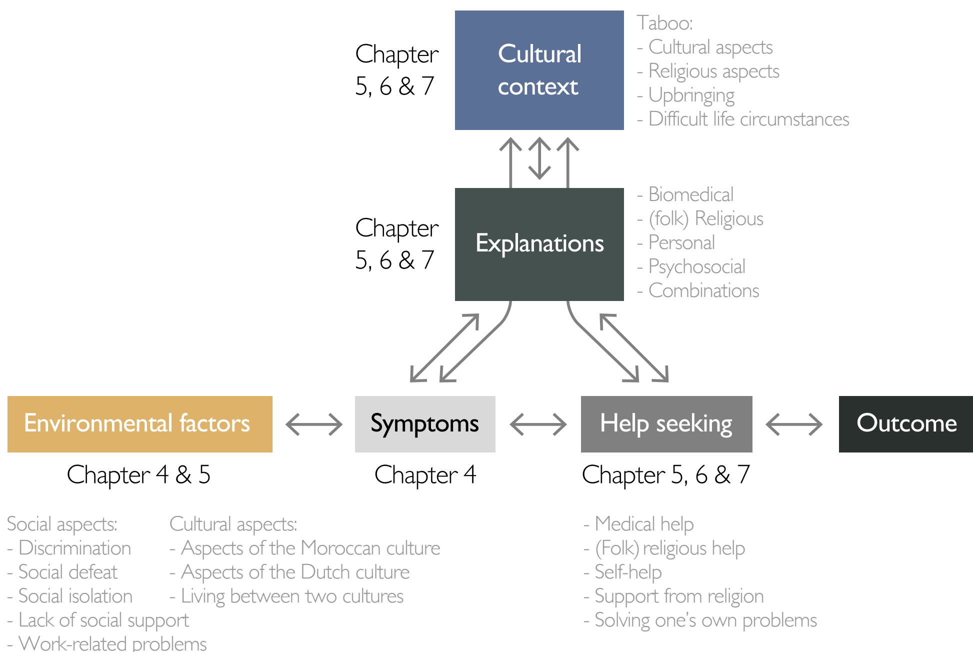

Figure 1: Structure of thesis

Here, in the discussion of this thesis, I will bring results of the individual research chapters together and regard them in relation to the existing scientific literature. I will consecutively discuss: summary of findings, meaning of findings per research aim, methodological considerations and implications and recommendations.

Summary of findings

Chapter 2 describes the website ziekofbezeten.nl (available between 2012 – 2018; archived at: http://www.webcitation.org/6nYdgNbV0). This was an informative website about mental health problems targeting young Moroccan-Dutch people. The website contained information about mental health problems and the mental health care system. It also contained information about (folk)religious explanations. Visitors could fill out self-tests on mental health issues, discuss subjects in online forums and they could get in contact with mental health care workers and imams via email and chat. In the first three months, the site was visited by almost 10.000 unique visitors, over 200 emails were sent and the screener for depressive symptoms was filled out nearly 1000 times.

Chapter 3 outlines the protocol of a quantitative survey (the MEDINA-study), which we performed in the online environment of ziekofbezeten.nl and marokko.nl. Furthermore, the methodological considerations of performing the study online are described. Advantages were that the online environment can provide a unique access for recruiting participants from hard-to-reach populations. Furthermore, digital surveys give more possibilities in the design (for example follow-up questions when a specific answer is chosen). The disadvantage of online recruitment was that is not possible to collect a probability sample. Several previous studies have shown that a non-probability sample (convenience sample) can deliver adequate results, when the influence of selection bias is taken into consideration in designing the study.

In **Chapter 4**, the results of the MEDINA-study are presented. 267 young Moroccan-Dutch participants were included, of whom 87% were female. There were high rates of depressive and psychotic experiences: > 50% for both. Perceived discrimination was associated with psychotic experiences and social defeat was associated with psychotic experiences and depressive symptoms. Social support and higher education were negatively associated with depressive and psychotic symptoms. We hypothesized that these factors decrease experiences of social exclusion (discrimination and social defeat among others). To further explore how people reflect on the influence of social exclusion on mental wellbeing, we performed two follow-up qualitative studies.

Chapter 5, covers the qualitative analysis of 22 online forum discussions, which took place on the online platform Marokko.nl. Forum discussions that focused on mental health problems were selected. Average length was 100 posts per discussion. Participants described many social challenges they encountered. Those challenges could be divided into aspects of Dutch society (e.g. work-related problems), aspects of the Dutch culture (e.g. unsocial climate), aspects of the Moroccan culture (e.g. not sharing emotions) and aspects related the situation of living between these two cultures. Participants described the relation between the social challenges and mental health problems. To our surprise, the major focus in the forum discussions was not at all the negative social environment. Most people discussed explanations and remedies for mental health problems. Explanations varied between religion and medical, with a category of contributors who combined religious and medical explanations. There were many examples of experiences of taboo on mental health problems within the Moroccan-Dutch population. The online platform served as a place to open up about this taboo subject.

In **Chapter 6**, 13 in-depth interviews were performed, to further examine the themes that were described in the forum discussions in chapter 5. All but one participant described that they did not talk about mental health problems with family and friends, because it is considered taboo.

Participants related many different aspects to this taboo: upbringing; difficult life circumstances; religion and the culture in the Moroccan-Dutch community. The cultural aspects were most emphasized. Participants described that not talking about mental health problems increased the feeling of social isolation when suffering from mental health problems. Furthermore, the experienced taboo stimulated solitary solutions for mental health problems and increased the barriers to mental health care. Participants offered several explanations for mental health problems. Next to religious and biomedical explanations (like in chapter 5), they added personal and psychosocial explanations, which emphasised the importance of individual growth in the population.

In the results presented in chapter 4, 5 and 6 the Islam plays an important role in relation to mental health problems in Moroccan-Dutch people. However, there is hardly any scientific literature available about the relation between Islam and mental health problems in the Dutch psychiatric literature. Therefore **Chapter 7** covers an essay in Dutch to inform clinicians about the relation between Islam and psychiatry. Background information about the Islam was given. Various explanatory frameworks for mental health problems that Muslims in the Netherlands can use were discussed, including biomedical explanations, religious- and folk religious explanations. Djinn explanations was elaborated in more detail since this is a common phenomenon in Muslim patients. Muslims can experience several barriers when seeking help. First of all, there are practical barriers, such as language problems. Furthermore, taboo on mental health problems can deter people from using mental health care services. Some information was given on the practices of (folk)religious healers. Lastly, it was emphasised that the Islamic religion is an important source of support and advice to clinicians was given how they can make use of it during treatment.

Discussion

This section relays the main findings of this thesis for each study aim in the context of available literature.

Aim A: Investigate how social and cultural determinants are related to the development of mental health problems in Moroccan-Dutch people.

Social environment

Epidemiological studies have shown an increased incidence of psychopathology in most migrants populations (Mindlis & Boffetta, 2017; Selten et al., 2019), also in the second generation (Leaune et al., 2019; Pignon et al., 2017). Environmental factors in the country of destination are considered to play an important role in this increased risk of psychopathology (Alegría et al., 2017; George et al., 2015; Veling, 2013). The most frequently described risk factors for psychopathology in the international literature were discrimination (Bardol et al., 2020), lack of social support (Kuo et al., 2008), and low ethnic density (which could well be related to social support) (Das-Munshi et al., 2012; Veling et al., 2008), amongst many others. The MEDINA-study, we added to this body of research by showing an association between several social determinants (measures of discrimination, social support, and social defeat) and psychopathology in Moroccan-Dutch people (chapter 4).

In the qualitative analysis of forum discussions, we have the described how the Moroccan-Dutch forum contributors experienced various facets of the social environment. Perceived negative influences of the Dutch society, the Dutch culture, the Moroccan culture and also living in two cultures were related to mental health problems in the quotes of contributors.

The negative social factors that were experienced seriously diminishes the experienced safety of the environment for Moroccan-Dutch people, and may well have an influence on the mental health of this population. To the best of my knowledge, no previous literature has described the

wide range of social determinants that (Moroccan-Dutch) migrants experience, thereby showing how they relate these social determinants to mental health problems.

Some migrant groups are in a more vulnerable situation than others: they experience more discrimination and have higher levels of psychopathology, like migrants of non-European descent in Europe and people with a black skin colour (Selten et al., 2019). In the Netherlands, non-Western migrants are mostly Moroccan- and Turkish migrants, with a Muslim background. Muslims have been under increased societal pressure since the last two decades. Following the 9/11 terroristic attacks, we have seen an increased public focus on radicalism, combined with an increase in islamophobia worldwide (Sheridan, 2006), and also in the Netherlands (Welten & Abbas, 2021). An EU report showed that Muslims in the Netherlands experienced the highest levels of religious discrimination (FRA, 2018). An international study that compared five European countries, the USA and Canada showed that anti-Muslim sentiments were again highest in Germany and the Netherlands. This study showed that a higher percentage of Muslim inhabitants was associated with increased anti-Muslim sentiments. Furthermore, a higher unemployment rate was associated with more anti-Muslim sentiments, although the Netherlands was the exception to this, with the lowest unemployment rate of the studied countries (Savelkoul et al., 2012). Samari et al described that islamophobia (defined as discrimination of Muslims) has a negative influence on the mental health and help-seeking behaviour of Muslims in a review (Samari et al., 2018). The anti-Muslim sentiments in the Dutch society and the effect of Islamophobia on mental health should be taken into account in relation to our study results on social exclusion and mental health problems.

Considering the many negative social determinants that Moroccan-Dutch people may encounter, I expected participants in our qualitative study to put emphasis on these potential risk factors. This expectation was also based on our findings in chapter 4, where we found social exclusion to be associated with depressive symptoms and psychotic experiences. The qualitative follow-up again suggested a relation between social determinants and mental health problems. However, contrary to my expectation, contributors did not put emphasis on social risk factors that might have contributed to the development of their mental health problems, but on explanations and solutions for their problems instead. Apparently, contributors who experienced symptoms did not look back on the possible preceding environmental factors but looked forward for explanations and solutions (figure 1). The reason why contributors did not put emphasis on risk factors, may be that they experienced the social setting as 'static' and did not see possibilities to change their social situation. Discussing it would therefore not result in improvement. This interpretation however was not checked with participants again.

Aim B: Investigate how social and cultural determinants affect the way mental health problems are experienced and explained by Moroccan-Dutch people.

Explanations for mental health problems
In the qualitative analysis of forum discussions, explanations for mental health problems could be categorised as religious and/or medical explanations, which in turn were related to corresponding remedies (chapter 5). One of the most important results in this study was that medical and religious explanations were often combined in various ways, as represented in our model (see figure 3, in this chapter 5). In the following interview study, medical and religious explanations was again described (chapter 6). The possibility of in-depth interviewing created a more detailed view on explanations, resulting in the additional categories of personal and psychosocial explanations.

To the best of my knowledge, the interplay between religious and medical explanations for mental health problems is not previously described in Moroccan-Dutch people. Such studies are also scarce in other populations. In the Netherlands, an interview study in Turkish-Dutch females with depressive symptoms described idioms of distress in terms of somatic complaints, anxiety and agitation together with mood complaints (Borra, 2011). Explanations in terms of

medical or religious attribution were not discussed. Our study results on the combination of medical and religious explanations might therefore be compared with the results from a study by Weatherhead et al, who interviewed 14 Muslim participants in the UK. The participants in this study were mostly first-generation migrants (10 out of 14), of very diverse nationalities, including Indonesian, Iranian, Egyptian. In the analysis, they describe a central position for the interplay between religious and secular perspectives on mental health problems (Weatherhead & Daiches, 2010). Other studies on this subject are based on study populations that differ from the Moroccan-Dutch population. An example is a mixed-methods study on explanatory models and coping strategies in Somali refugees in Norway. In that study, depressive symptoms were explained as a cognitive or emotional problems, a sign of spiritual possession, effect of trauma and due to social isolation. (Markova & Sandal, 2016). The religious explanation of Somali refugees was comparable to our results. However, the Somali refugees also used other explanations, referring to "thinking too much" and "sadness", and they did not refer to biological explanations.

Another example is a qualitative study into causal attributions on mental health problems in Jamaica that shows another spectrum of explanations: biological, psychological, social and religious (Arthur & Whitley, 2015). Here, we see that the explanatory categories are comparable to our findings, although the population is very different. Altogether, the explanations for mental health problems that we have described in this thesis are to some extent comparable with studies on this subject in other populations. The broad variety of explanations and the combination of various explanations in one person are similar across the cited studies.

Religious and supernatural explanations

As we have seen, religious explanations for mental health problems are common in Moroccan-Dutch people. In chapter 7, we further elaborated on religious explanations for mental health problems in Muslims, and described how mental health problems can be perceived as a test of Allah. An important verse in the Koran says: "Allah does not charge a soul except [with that within] its capacity." (The Quranic Arabic Corpus - Translation, n.d.). The experience of a test of Allah can therefore also be seen as a sign of strength, for which you will be rewarded after accomplishment (Weatherhead & Daiches, 2010). People however can feel they are not able to handle their problems (also in chapter 6), a common phenomenon in mental disorders. In relation to this Quran verse, this feeling could result in the impression of being 'weak' in the eyes of Allah. Another viewpoint is the belief that correctly practicing faith can protect against mental health problems. Mental health problems can thus also be seen as the result of falling short in the practice of true faith by patients or family (de Jong & van Dijk, 2020; Mitha, 2020). Our interview study showed that the 'test of Allah' was the most important religious explanation for our participants (chapter 6).

Besides the above religious explanations, we have also seen several supernatural explanations for mental health problems (chapter 5 and 6). Examples were 'black magic' and the 'evil eye' (which is considered folk religion) and Jinn attribution (which is acknowledged within the 'formal Islam'), as has been described by others, e.g. Dein & Illaiee (2013); C. Hoffer, (2009); and Lim et al., (2015). Research in a Dutch outpatient clinic for transcultural psychiatry has shown that Jinn attribution is a common phenomenon (Lim et al., 2018) and does not exclude receiving regular mental health care. It is important to realize that supernatural explanations for mental health problems do not only occur in the Islam, but in several other religions as well (Dein & Illaiee, 2013).

Many of the religious explanations described in this thesis reflect the importance of the relation between the person and Allah and show an active role for the person. For supernatural explanations on the other hand, the person is more passively involved: supernatural phenomena 'happen to you'. In the studies described in this thesis the 'formal' religious explanations were more often referred to than supernatural explanations. This emphasizes the persons themselves feels engaged in the explanation for the mental health problem.

Bio-psycho-socio-existential model
In this thesis, explanations for mental health problems were sometimes clear and uniform (e.g. problem was caused by a hormonal disbalance), but often explanations were complex, combining several perspectives on mental health problems. This complexity can be decomposed in terms of Engels' bio-psycho-social model (Engel, 1977). This holistic model seeks to integrate biological, psychological, and social determinants of (mental) health problems. In the explanations for mental health problems in this thesis, we have seen that religion can play an important role. This aspect is not covered in the bio-psycho-social model and the need to add this perspective was put forward by the world psychiatric association (Verhagen, 2017). However, adding the religious perspective would not yet cover the broad range of explanations that we have identified in this thesis. The complex explanations did not only describe the symptoms, but also involved elements that were connected to the person who suffered from the symptoms. For example, some participants described how they assessed their personal life when dealing with mental health problems. They evaluated the choices they have made and the path of life they have chosen. They asked themselves the existential questions: what do these problems tell me about myself? In light of mental health problems, one can seek meaning in the problems and in life. De Haan (2017) has elaborated on this aspect of reflection and evaluation in human thinking about mental health problems. She called this: "the sense-making activity of an organism in interaction with its environment", arguing this to be the core description of cognition. She advocated the addition of existentiality to the biopsychosocial-model (de Haan, 2017). Interestingly, there is a parallel with the international recovery movement, in which patients also draw attention to the meaning of their complaints in terms of sense-making and spirituality in addition to the biomedical discourse of clinicians (Delespaul et al., 2018). By embracing a bio-psycho-social-existential-model, the clinician can eventually get better equipped to play a role in the search for explanations- and meaning for mental health problems and is thereby hopefully able to better support the patient (De Haan, 2020). Results in this thesis confirm the value of adding this perspective to the bio-psycho-social model.

Explanatory models
As we have seen above, the literature on explanations for mental health problems is very diverse in population, methodology and aim of the study. Comparisons between studies are therefore often difficult to make. However, there is broad consensus that sensitivity to patients' own explanatory models improve treatment efficacy (Weiss & Somma, 2009). Transcultural psychiatrist Kleinman was the first to emphasise the importance of the personal explanations that patients have for their problems. He recommended investigating patients' personal explanatory model of mental health problems using a set of questions on how the problems are perceived and explained by the patient (Kirmayer & Bhugra, 2009; Kleinman et al., 1978). Explanatory models should not be considered as static entities, but they can be complex and dynamic. The explanations can change over time and in relation to the social environment (Dinos et al., 2017). Assessing the explanatory models at play in clinical practice, including explanatory models of significant others and care-givers, can help the diagnostic process (by preventing to misdiagnosis of cultural phenomena) and improve therapeutic relationship (Bhui & Bhugra, 2002). This is further operationalised in a range of quantitative and qualitative instruments (Dinos et al., 2017), including the cultural formulation interview, which is part of the dsm-5 (Lewis-Fernández et al., 2016). Also in this thesis, we have seen the importance of explanatory models. Moroccan-Dutch people emphasised the importance of this subject in the forum discussions and interviews. Explanations were influenced by the socio-cultural background of participants. And we have seen that explanations were directly related to help-seeking behaviour. Therefore, this thesis underlines the importance of examining explanatory models in individual ethnic minority patients.

Aim C: Investigate how social and cultural determinants affect the conversation about mental health problems and help-seeking in Moroccan-Dutch people.

Taboo

Stigma on mental health problems is a universal phenomenon. However, the extent to which stigma is experienced varies between people with different cultural backgrounds (Bracke et al., 2019; Ciftci et al., 2012). This aspect of stigma as a cultural phenomenon is referred to as "cultural stigma beliefs" (Bracke et al., 2019; Link et al., 2001). The meaning of cultural stigma is closely related to the word taboo and both words are used interchangeably. In this thesis, we chose to use the word taboo to refer to these 'cultural stigma beliefs', since this best fitted the data, which were originally Dutch. In transcultural psychiatric studies, taboo is often described as one of the barriers to mental health care for migrants e.g. (Fassaert et al., 2009). Although several studies refer to taboo/stigma in a superficial way, the concept has not been thoroughly investigated in relation to mental health care in migrants.

In the forum discussions (chapter 5), contributors stated that it is not common to share feelings in the Moroccan-Dutch community, which they referred to as 'taboo'. In the online discussions, contributors did however exchange ideas about mental health problems, feeling protected using pseudonyms. Mental health problems were not commonly discussed with family or friends (interviews, outlined in chapter 6). Participants were not taught to share feelings and they felt they could not complain to their parents, who had often endured worse hardships. Central theme in the interviews was the belief that one must accept the test Allah has appointed to you. This results in the feeling that one has to be strong and wait for the problems to resolve. This response to hardship is related to the cultural value that one should not show weakness. Furthermore, there was shame about disabilities and fear of gossip in the community.

We have seen several negative effects due to taboo in our study. First, participants missed out on acquiring information about mental health problems and possible remedies. This information deficit cannot be quantified in our study and there is no other Dutch study on this subject. In the UK, a recent quantitative study compared several aspects of health behaviour between Muslims and non-Muslims. They found that Muslims were less able to recognise symptoms that non-Muslims regard as pertaining to mental health (Musbahi et al., 2022). Second, people felt embarrassed about their problems, which increased their social isolation which is already frequently present in sufferers of mental health problems. And last, we found barriers to seeking mental health care due to taboo.

In our study, we have seen that problems are often not shared with others. This is in contrast with the finding of the previously described qualitative UK-based interview study in Muslim patients with various nationalities. Although other results in this study were comparable to ours, support from the family was an important finding and source of relief (Weatherhead & Daiches, 2010). This contrasting finding emphasises differences between contexts and cultures.

Although taboo on mental health problems was prominent in our studies, we have seen several signs of change in the interviews (chapter 6). Participants realised it was important to talk about mental health problems. By encouraging their children to talk about their feelings and emotions, they hoped to lift the taboo in the next generation.

As described in chapter 7, suicide is probably one of the most prominent taboos around mental health problems. Suicide is prohibited by the Koran and Hadith (the main Islamic scriptures): "[...] And do not kill yourselves [or one another]. Indeed, Allah is to you ever Merciful."(The Quranic Arabic Corpus - Translation, n.d.) In several Islamic countries people can be prosecuted for suicide attempts (Tzeferakos & Douzenis, 2017).

There is a body of literature on cultural stigma on mental health problems (e.g. a review on stigma in Muslim communities: Ciftci et al.,2012; book chapter about stigma in different cultures: Koschorke et al., 2016). The literature that I know focused on: 1) illustrations of stigma

in a certain context or population (e.g. Youssef & Deane, 2006); 2) influence of stigma on social relations (e.g. Kadri et al., 2004) and 3) descriptions how stigma influences seeking mental health (Weatherhead & Daiches, 2010). Because stigma/taboo, as we have shown, is a cultural concept, the interpretation and meaning will vary between different cultures and populations. With this thesis, we add two aspects to the existing literature. First, we have given a detailed description in which we unravelled the different aspects of the concept of stigma/taboo, creating more depth and understanding about this concept in mental health problems. Secondly, we have increased our understanding about the role of taboo in mental health problems in Moroccan-Dutch people.

Seeking help: Relation between help-seeking, taboo and explanations for mental health problems

We have seen that help-seeking strategies for mental health problems by Moroccan-Dutch people were not only based on the kind and severity of symptoms, but also on the explanations for these symptoms and on the cultural context (see figure 1). The first important observation was that external help, either from relatives or professionals, was often not sought at all. Participants often first deal with their problems alone. This can be explained in various ways. First, dealing with the problems alone is related to the category of 'personal' explanations. The problems are perceived as a personal matter, with which one must deal alone. Second, refraining from finding help can be the result of the experienced taboo. The taboo affected help-seeking behaviour in several ways. Religious aspects of taboo increase the tendency to 'hold on' and wait for relief. Furthermore, people can experience fear of gossiping.

There is only a limited number of studies that report about the influence of taboo on help-seeking in migrants. An interview study in a sample with a heterogenous religious and ethnic background showed that taboo on mental health problems prevented people from finding help or support with peers and stimulated private coping strategies (Cinnirella & Loewenthal, 1999). A Dutch study examined help-seeking for internalising problems by discussing vignettes in focus groups of female adolescents of with different ethnicities (Turkish, Moroccan, and Dutch). They state that especially non-Dutch participants feared negative reactions of parents and that friends and this was a potential barrier to seeking help (Flink et al., 2014). Because participants did not discuss their problems, social support was therefore often lacking. This is unfortunate, because the survey study showed social support was a protective factor for mental health problems (chapter 4). In this thesis, explanations that are incongruent with Western notions and taboo on mental health problems were important barriers to seeking help from relatives or professionals

Seeking help: Barriers to mental health care

Above, we have described that the move to professional help is avoided or delayed by participants in our studies. Next to differing explanatory models for mental health problems and taboo on mental health problems, we have also described other barriers to seeking mental health care. Some participants did not know how to find professional help, which was also seen in other studies (Memon et al., 2016; Musbahi et al., 2022). A Dutch qualitative study in elderly migrants showed that they are dependent on their children for finding professional help. Also in this study, taboo and family members who were not familiar with the mental health care system were barriers for finding adequate mental health care (Schoenmakers et al., 2017). Sometimes, professional help was only started when there were no other options left, e.g. with an involuntary admission to a psychiatric hospital. For participants who had relied on mental health care before, the barrier to seek help was much lower. Some participants were advised to seek help by others, which also decreased the barrier. In a systematic review on factors affecting migrants help-seeking patterns, Selkirk described logistical barriers, cultural barriers and preference for other sources of help (Selkirk et al., 2014). These factors are recognisable in our study. It remains important to consider country and population specific factors. For the Dutch setting, it is therefore relevant to compare our results with two studies within the somatic health care. In a study on the satisfaction of patients in primary health care, Harmsen et al

(Harmsen et al., 2008). found that patients with a non-Western ethnic background experienced impaired satisfaction when there were language barriers and when their cultural views where not sufficiently taken into account. Another study in the general health care examined barriers to shared decision-making between clinicians and ethnic minority patients. They found that differences in language, in health values, in role expectations and preconceptions towards each other impedes successful shared-decision-making (Suurmond & Seeleman, 2006). Both studies conclude that it is important that clinicians are trained to recognise possible barriers in communication with patients with a different cultural background.

Seeking help: Religious support and remedies
We have seen that Islam is a very important aspect in the life of most of the participants (chapter 4). It is much discussed in the forum discussions (chapter 5), and it is an important topic of conversation in the interviews (chapter 6). Religion can play an important role in the explanation of mental health problems, which in turn affects help-seeking. If problems are considered a test of Allah, this destiny should be accepted. The idea that Allah can bring relief for the problems and that people can choose to patiently wait until problems will resolve is a common conception (Walpole et al., 2013).

Participants considered the Islam as an important source of support (chapter 5 and 6). When facing problems of any kind, religion is the first thing to hold on to. The Islam is mostly described as a positive factor in life, despite several aspects that can itensify experienced hardships when dealing with mental health problems. This experienced positive influence of the Islam by participants is also described in the thesis on religious perception in young female Muslims in the Netherlands by Van der Valk. She found that a strong connection with Allah was experienced, based on trust and not on fear. Faith strengthened the identity of participants and delivered support (Van der Valk et al., 2009).

Considering religious remedies, we have seen that many religious remedies were discussed on the forum, including: visiting an Islamic healer, prayer, performing Hijama (cupping) and most frequently performing Ruqyah (Quran recitations). In the interviews, participants did rely on their faith, but religious remedies as in chapter 5 were barely used. We have not elaborated on religious remedies in this thesis. In the Netherlands, Hoffer investigated religious healing practices in Muslim patients (Hoffer, 2009; Hoffer, 2000). Similarly to our findings, he describes Ruqyah as the most prevailing remedy, which is also acknowledged as part of the formal Islam (C. Hoffer, 2009). People might also visit religious healers, which are considered as part of folk religion. They practice a wide range of ritual healings (C. Hoffer, 2009). From a Western medical perspective, Ruqyah is a harmless procedure which can be helpful and supportive for patients. Other religious healing practices can be harmful (although certainly not necessarily). It is important to ask your patient about the procedure they follow, before advising about the continuation of these practices.

Since persons with mental health problems can visit either an Imam or mental health care services, the question is whether there is collaboration between both parties. There is a descriptive article about collaboration between mental health care and religious leaders (C. Hoffer, 2005) and about the role of Islamic clergy within the mental health care system (Zacouri, 2011). In a narrative review with focus on the UK context, the advantages and disadvantages of collaboration between mental health care and traditional healers are examined. The author concludes that collaboration is preferred, because it improves the involvement of the cultural context in treatment and it fits with what they call 'parallel belief systems' that can coexist (Pouchly, 2011). Unfortunately, collaboration and reciprocal consultation between religious leaders or religious healers and mental health care workers is still rare in the Netherlands (Groot Zevert, unpublished), as in other countries (e.g. Ali & Milstein, 2012).

There are some initiatives to narrow the gap between medical and religious perspectives. An example is a cognitive behaviour therapy (CBT) protocol, which focuses on Jinns (Van Den

Berg et al., 2015). In the UK, a self-help intervention for behaviour activation was adjusted for Muslim patients. The intervention was positively evaluated by patients and therapists (Mir & Hussain, 2016). Ünlü et al investigated an internet-based problem-solving therapy which was adjusted for Turkish migrants with depression. However, they did not find beneficial effect in the randomized controlled trial (Ünlü Ince et al., 2013). Although collaborative care is complex, it is possible. A successful example is this study in Nigeria, in which collaborative care between traditional/faith healers and primary care givers was effective and cost-effective in people with psychosis (Gureje et al., 2020). However, there is still a wide gap between medical and religious care in the Netherlands, and patients can really benefit from better collaboration with Imam and Islamic clergy (Meer & Mir, 2014; Zacouri, 2011).

Seeking help: Online support
On the forums on the website Marokko.nl, many delicate subjects were discussed by website-users, posting under pseudonym. Contributors reported that they experienced social support by discussing these subjects, that were otherwise left unspoken (chapter 5). The possibility of receiving social support in the online environment on a topic that is otherwise taboo is an important finding. This finding should however be considered within the specific context of the online community on Marokko.nl. Many of the discussions we analysed took place between 2010 and 2016, which was the period that Marokko.nl was best visited. At that time, social media were still in their early days and there were no alternatives to meet large numbers of Moroccan-Dutch people online. The social media landscape as expanded considerably since then. It is unknown whether online social support has therefore diminished or improved for Moroccan-Dutch people.

There are some studies that have investigated the benefits of the online environment for mental health problems. For online support groups in depression, there is some evidence that online support groups can diminish symptoms (Griffiths, 2017). Many more studies emphasised the positive experiences of users, like emotional and informational support and companionship (Griffiths et al., 2015; Johnsen et al., 2002; Kummervold et al., 2002). However, these positive reports should be considered with care, since society has become increasingly aware of negative aspects of social media. Negative social interaction can happen in any online environment and could result in negative outcomes for users of support groups (Dosani et al., 2014). Online forums like 'pro-ana', which stimulate eating disorders, are a well-known example (Norris et al., 2006). In a sensitive topic like mental health problems, it is recommendable that the online forums have 'board' rules, which are moderated (Griffiths, 2017). Altogether, we see a wide practice of sharing personal information in the online environment. As we have shown, this clearly meets a need of people, especially in specific subgroups that are not connected or do not share sensitive topics in the offline world.

Methodological considerations

Mixed-methods studies
In this thesis, we combined quantitative and qualitative methodology, resulting in a mixed-methods project. In a mixed-methods study, the different perspectives of the qualitative and quantitative approach can complement each other, resulting in a better understanding compared to using only one type of method (Creswell & Clark, 2017). The combination of these perspectives is described as "multiple ways of seeing" (Greene, 2007). This pluralistic stance can help to create knowledge which can cover a broad study field and provide deep insight at the same time (Creswell & Clark, 2017). Also in the field of transcultural psychiatry, it has been emphasised that mixed-methodology could add value compared to the separate methods alone (Dein & Bhui, 2013).

In this thesis, qualitative research was employed to explain and better understand initial results from our quantitative study (Creswell & Clark, 2017). The MEDINA-study, a cross-sectional survey showed statistically significant associations between measures of social exclusion (dis-

crimination, social defeat) and psychopathology. However, this study did not inform us how the identified association between social exclusion and mental health problems was perceived by members of the target population. By consequently using qualitative study methods, by examining the material from both forum discussions and interviews, this perspective was added. For example, we first demonstrated the association between social exclusion and psychotic and depressive symptoms and then we further expand our knowledge about the social setting and presented a whole range of social aspects that Moroccan-Dutch people experience. Another example is that we first quantified levels of depressive symptoms and psychotic experiences (although the convenience sample cannot result in prevalence estimates) and then explored how these symptoms were experienced by individuals and how help was sought. These qualitative insights therefore gave depth to the quantitative results.

Although mixed-methods studies may thus be very informative, performing a mixed-methods study can also be challenging. Differences between qualitative and quantitative methods do not only occur in practical aspects (recruitment, number of participants, analysis), but the scientific way of thinking is also very distinct from one another (how do you get to the results, how is validity guaranteed) (Whitley, 2007). Throughout my training as a medical doctor and a psychiatrist, emphasis was on quantitative methods. I was surprised to learn about the richness and relevance of qualitative research in (mental) health care (Pope et al., 2000). In both the quantitative and the qualitative studies, I collaborated with colleagues that were more experienced in those specific methodologies to ensure optimal employment of each of these methods.

Qualitative methodology

Since qualitative studies formed an important part of this thesis, I will zoom in further on the advantages and disadvantages of this methodology. Qualitative research gives the opportunity to investigate a broad range of research questions (Malterud, 2001b), including questions that are different and complementary to quantitative studies. These questions can have direct clinical relevance but can be overlooked when researchers think solely from a quantitative perspective. Qualitative research facilitates zooming in on participants' experience and perspectives.

Qualitative research methodology has several disadvantages. Qualitative analysis is considered time-consuming, although this can also hold for other types of research. Recruiting the most suitable sample for answering the research question can be challenging. Sampling problems can affect the validity (Malterud, 2001a). Related to that, data saturation can be an unclear endpoint of data collection and information can be missed, especially in an insufficiently diverse sample (Ziebland & McPherson, 2006). Because the person of the researcher is more central to qualitative research, one's background or position can influence the study results (Malterud, 2001a). Many different methods in qualitative research are described, some overlapping and some also conflicting with each other (Ritchie et al., 2014). For the interview study (chapter 6), it was helpful to rely on a method which was clearly described (Dierckx de Casterle et al., 2012). Below, we will further elaborate on the specific disadvantages and limitations in our studies.

Online recruitment and selection bias in the quantitative study

Migrants are known to be underrepresented in scientific research (Sheikh, 2006; Yancey et al., 2006). This should be considered as a scientific and public health problem. Underrepresentation of minorities in all kinds of study designs (e.g. epidemiological studies, intervention studies) can decrease generalisability and over- or underestimation of effect sizes (Yancey et al., 2006). Not only equal representation in studies, but specific research in minority populations is therefore necessary (Miranda et al., 2003). It remains a challenge to recruit minorities to participate in studies (Patel et al., 2003). For this thesis, we have carefully designed our studies and recruitment strategies, to overcome this barrier. In this project, we collaborated closely with the founders of marokko.nl and colleagues of Arkin (at that time Jellinek Mentrum) mental health institute on the website www.ziekofbezeten.nl (being ill or being possessed). This collaboration with Marokko.nl created the unique possibility to recruit participants within this

online community of Moroccan-Dutch people. At the time of designing the MEDINA-study protocol (2012), online recruitment strategies were uncommon. In the study protocol (chapter 3) we elaborated on the methodological consequences of online recruitment. Advantages are: possibility of reaching many participants with relatively little effort and costs (Ekman & Litton, 2007; Wright, 2006); more flexible and customised survey design (Van Gelder et al., 2010); no data entry by the researcher reducing time-investment and human errors (Rhodes et al., 2003). Disadvantages are: it is difficult to recruit a probability sample (sample of randomly chosen participants, which is the gold standard in epidemiological studies) and response rates cannot be calculated (Selm et al., 2006). However, several studies have compared non-probability with probability samples, and have shown the value of online studies in convenience samples (Feild et al., 2006; Miller et al., 2010).

The online recruitment for the MEDINA-study (chapter 3 and 4) resulted in a convenience sample. This convenience sample is 'self-selected': participants had to actively click on the invitation to enrol in the study. This is a serious limitation. The consequence is that information on people who chose not to participate is lacking and there could be significant differences between the participants and 'non-participants' of our study. The inclusion of 87% female participants is another example of the self-selection bias, males were clearly underrepresented. Furthermore, because of the online recruitment we probably missed other subgroups, like people who are not active online, for example elder or illiterate people. The levels of psychopathology in the sample were very high (over 50% of depressive symptoms and psychotic experiences). These results are higher than literature suggests, and therefore point towards selection bias. Demographic information was based on self-report, also for important aspects like Moroccan ethnicity. Due to the online recruitment strategy, we could not verify the demographic information of the participants. This could potentially reduce the reliability of the demographic information, (e.g. gender, age, or level of education). Furthermore, participants might have filled out the survey randomly.

We have taken several measures to increase the validity of our results. Firstly, we used two different invitations for recruitment. One was an advertisement for a self-test on depressive symptoms and the other was an advertisement to participate in scientific research. As expected, levels of psychopathology were higher in the subgroup who enrolled via the self-test advertisement. However, subgroup analyses showed no significant differences between the two groups on the main study outcomes. Secondly, we checked the dataset carefully for inconsistencies in the answering patterns. Some examples: we compared name and email address as well as age and level of education. Furthermore, the time to finish the survey was checked. For each participant, we checked for possible patterns in the answering, for example all choices to the far left or far right. We had to exclude a small number of surveys, for example because of multiple entry. These quality checks ensured us that (at least most of) the data were sound. It is difficult to assess whether and how the described biases influence the main outcome of the study, the association between social exclusion and mental health problems.

Considering the advantages and disadvantages of the chosen recruitment strategy, online recruitment has proven to be useful and efficient to reach the Moroccan-Dutch population in this study. There are of course other illustrations of successful online recruitment. An example is the successful online recruitment of Turkish-Dutch participants for a randomised controlled trial via Facebook (Ünlü Ince et al., 2014).

Sampling issues in the qualitative studies

In qualitative research, criteria for validity are different from quantitative studies. The aim is not to collect a 'random' sample, but a 'purposeful sample' (Palinkas et al., 2015). This means the researchers select a sample that is most informative for the research question (Marshall, 1996). Data collection stops when 'data saturation' is reached. Data saturation means that further data collection would not yield new information; the researcher has 'heard it all' (Morse, 1995). For the online forum discussions (chapter 5), we used purposeful sampling, to select

discussions that were most informative for the research question, with some requirements on length and number of contributors to the discussion. Although we have carefully searched and selected the discussions, we might have overlooked discussions that others would have considered important. Furthermore, it is possible that the emphasis on some themes or results was influenced by the contributions of a small subset of contributors who might have expressed a minority opinion. Finally, contributors were anonymous, we had only their pseudonym and gender information. Like in the quantitative study, we therefore missed important demographic information, which increased the risk that discussions depicted opinions of a certain subset of the Moroccan-Dutch population.

For the interview study (chapter 6), we recruited participants from the sample of the quantitative study. Nine people responded, all of whom were included. We had to expand the study sample with recruitment via other sources, including snowball (n=2) and social media (n=2). An advantage of recruiting within the quantitative sample is that we could further examine the research questions within the same people. A disadvantage is that we had to include all participants that responded, and we could therefore not select participants on specific demographic characteristics to increase variance in the sample. A disadvantage of the snowball method is that this might be people from the same social context. A consequence of the recruitment strategy is that we should carefully consider the transferability of the results outside the study population.

Credibility and cultural mismatch

In qualitative research, the extent to which study findings represent 'the real world' is called the credibility criterion (comparable with the internal validity in quantitative research) (Graneheim & Lundman, 2004; Guba & Lincoln, 1989). Here, we will discuss limitations in credibility and the validation strategies we have used: reflexivity, member check and negative case analysis (Creswell & Clark, V. L. P, 2017).

The first validation strategy we engaged was reflexivity in the research team. In both studies, we created an open, transparent, and non-hierarchical atmosphere, in which personal matters, doubt and uncertainties were discussed. Throughout the project, we have been aware that cultural differences between researchers and participants could influence the study results. This is probably the most important threat to the credibility of the qualitative studies. In the analysis of the forum discussions (chapter 5), two Dutch researchers analysed the written contributions of Moroccan-Dutch people. We were aware that we might misinterpret the written content, based on our different ethnic background. For some posts, we did not know how we should interpret them at all. Mostly, uncertainties about meaning became clear in the context of the discussion. We therefore performed a member check, by discussing the results of the analysis and the interpretation of the most important quotes with a Moroccan-Dutch psychologist and researcher. This yielded some minor corrections in interpretation of quotes, but no changes in the analysis results. Furthermore, we performed a negative case analysis by analysing an additional discussion to check the results.

Also for the interview study, we were aware of the mismatch on ethnicity between interviewers (both Dutch females) and participants. We were pleased to experience that the participants shared their problems and explanations in a very open way. This was mostly in contrast to how participants dealt with their problems in everyday life, where they did not share their problems with others. Apparently, the cultural mismatch did not raise a threshold to talk about mental health problems. If anything, we have seen the opposite effect. Some participants told us that they felt comfortable to talk to us about these sensitive subjects because we were not part of the Moroccan-Dutch community and there was no fear of gossiping. Ghane et al studied the effect of ethnically matched or unmatched interviewers in a study into explanatory models for mental health problems. Comparable to our experience, they did not see participants were more open about supernatural explanations with matched interviewers, although there were some differences in explanations between both groups (Ghane et al., 2010). We have performed a member

check, by asking participants for feedback about the short narratives based on their interviews. This did not result in adjustments.

Last, also in the essay about the relation between the Islam and psychiatry, a cultural mismatch could occur (chapter 7). In this chapter, I closely collaborated with Zohra Acherrat, a psychiatrist with a Moroccan-Dutch background who had written about her personal experiences with Islam and psychiatry before (Acherrat-Stitou, 2009). Her knowledge of Islam was fundamental for this chapter.

Although we created a reflexive stance in the research team and participants were open during the interviews, the cultural mismatch might still have affected the results of the qualitative studies. The non-diverse Dutch research teams could have had conscious or subconscious stereotypes and preconceptions about Moroccan people. These pre-existing ideas could have influenced the interview process and the analytic process. We might have missed information or cues, both in the interviews and in the analysis, because we are unfamiliar with the cultural background of the participants. Furthermore, interviewees might have withheld information which they thought inappropriate to discuss. An example is that we found many examples of religious healing practices in the forum discussions, but only some interviewees visited religious healers. One explanation could be that the difference is related to the sample in the interview study, possibly because they were more highly educated. Another explanation could be that they had reservations about talking about such topics with the interviewers. A last possible problem is that Moroccan interviewees may have adapted their answers to the Dutch interviewers. We have seen at least one example: most interviewees used the word 'God' instead of 'Allah', although 'Allah' is more commonly used in the population.

Reversed causality
In the MEDINA-study (chapter 4) we used a cross-sectional study sample. We found an association between measures of social exclusion and levels of psychopathology. This could suggest that the social exclusion induces the psychopathology. However, due to the cross-sectional design, we have no information on temporality and therefore no causal conclusions can be drawn. A possible explanation could be 'reversed causality', which would mean that psychopathology precedes experiences of social exclusion. In the MEDINA-study, sensitivity analyses were performed to detect reversed causality. We compared participants with and without a history of previous mental healthcare. There were no differences on the level of social exclusion between these groups. Furthermore, the regression models had a better fit in the group without a history of mental healthcare. This strengthens our hypothesis that social exclusion influences psychopathology and not vice versa.

Generalisability and transferability
Generalisability is the main concern in this project. Most of the determinants and themes which are presented in this thesis are found in a certain population and context, and cannot be seen as separate from both aspects. We studied people of Moroccan descent in the Netherlands, a group that may differ from other migrant populations, both in the Netherlands and elsewhere. Incidence of psychotic disorders is for example much more higher in Moroccan-Dutch migrants than in Turkish-Dutch migrants (Veling et al., 2006). Western migrants in the Netherlands do not show such an elevated risk (Selten et al., 2001; Termorshuizen et al., 2020). We should therefore be cautious about generalising our results to other populations and contexts. Generalisability on a broader level would require reproduction of these results in other populations. Even if replicated, this would not immediately overrule the previous results. Rather, it would emphasise the complexity of the study field and the importance of being very specific when reporting about different migrant populations and their (social) environment.

When assessing the generalisability of the different studies in this thesis, the association between social exclusion and psychopathology (chapter 4) is in line with previous studies on social risk factors in several populations and countries (e.g. Bardol et al., 2020; Kuo et al.,

2008; Morgan et al., 2008). It is therefore possible that this result is also valid for other migrant groups.

In qualitative studies, the criterion by which study results can be valid in contexts that differ from the studied context is called 'transferability' (parallel to generalisability or external validity) (Graneheim & Lundman, 2004; Guba & Lincoln, 1989). Transferability is increased by clear description of the methodology and findings (including quotations) (Graneheim & Lundman, 2004). However, transferability is considered mostly a decision by the reader (Graneheim & Lundman, 2004; Guba & Lincoln, 1989). In this study, we focused on social and cultural aspects of one specific migrant population in the Netherlands (the Moroccan-Dutch population). Already in this small population (around 400.000 people), we have seen differences in how mental health problems are explained. Furthermore, there were some differences in results between both qualitative studies. In chapter 5, there was much more emphasis on religious explanations and religious remedies compared to chapter 6. Possibly, this can be explained by differences in study sample. In the interviews (chapter 6) we saw that participants were predominantly highly educated. Several participants were social workers. This example again shows that transferring the results to other populations should be done with care.

Implications and recommendations

Implications for clinical practice

In this thesis, we have evaluated how mental health problems were experienced by Moroccan-Dutch people and which barriers they experience towards seeking mental health care. These are barriers for help seekers. For clinicians on the other side, there can also be obstacles to treating migrant groups. They could have previously experienced that it was more complicated to help minority patients. Furthermore, they could think that they were insufficiently equipped, lacking knowledge and skills to serve this population. In a study in 16 European countries mental health care professionals were interviewed about their experience in delivering treatment to migrants (Sandhu et al., 2013). Challenges that were described by the professionals - language, belief systems, cultural expectations, realising therapeutic relation amongst others - are recognisable in relation to this thesis.

The barriers on both sides, i.e. help-seeker and care-giver, diminish the chance of effective treatment for mental health problems. It is therefore important to work on overcoming these barriers, although they probably will continue to exist to some extent. For health care workers, know-how on treatment of migrants is referred to as cultural competence. This concept combines information and an attitude not only for individual professionals, but also for (health care) systems (Flaskerud, 2007; Kirmayer, 2012). It is important to implement cultural competence in the training of mental health care professionals, although it is a complex concept to teach. Seeleman et al therefore proposed a framework in which cultural competencies are practically operated, to support successful improvement of cultural competency (Seeleman et al., 2009).

Differences in religious background between help-seeker and care-giver is one of the obstacles for mental health care professionals when treating migrant patients (Sandhu et al., 2013). The importance of discussing religion in clinical practice was emphasised by the world psychiatric association in an position paper (Moreira-Almeida et al., 2016) and guidelines for clinical practice are described, (e.g. Cook, 2015). However, the Dutch psychiatric literature on religion and psychiatry focuses on Christianity and adequate information about the relation between Islam and psychiatry was lacking. To be able to adequately address religion in clinical practice, it is helpful to have basic knowledge about the Islam and some tools that can help bridge cultural differences. For clinicians, it is important to: 1) acknowledge the role of religion for patients and the support it can bring; 2) seek explanations together to form a shared narrative; 3) realise religious and medical explanations can exist together and are not mutually exclusive; 4) be open to collaboration with an Imam or religious healer; 5) pay attention to the influence

of taboo and the eventual social isolation as a result of it; 6) and although a taboo, explore suicidal thoughts in psychiatric evaluation. Furthermore, we have seen that Moroccan-Dutch people combine religious and regular explanations for mental health problems and they often visit both mental health care services and religious leaders or healers. Patients might be better served when we improve the collaboration between Imams, Islamic clergy, and regular mental health care.

Last, Moroccan-Dutch people encounter social adversity and discrimination in the Netherlands. Clinicians should be aware of the social adversity their patients might have encountered. Social adversity, taboo and other barriers restrict the opportunity to receive adequate professional care for this population. I therefore encourage clinicians to go the extra mile to understand the barriers ethnic minority patients encounter and establish a supportive therapeutic alliance.

Implications for the mental health care system

With this thesis, we have increased our knowledge about taboo on mental health problems in Moroccan-Dutch people. In this study, taboo is a significant barrier to seek professional help. It is helpful if the taboo would be decreased, to lower the barrier for seeking mental health care. A narrative review described the literature on anti-stigma interventions (Stuart, 2016). They warn that anti-stigma campaigns potentially have a negative effect. Furthermore, many anti-stigma interventions are not or poorly investigated (Evans-Lacko et al., 2014; Stuart, 2016). Several large-scale anti-stigma campaigns that are thoroughly investigated showed mixed results with some improvements. The importance of the social and cultural context is acknowledged for the effect of interventions (Stuart, 2016). In this thesis, we have shown that taboo on mental health problems in this population is mostly a cultural phenomenon. Perhaps attempts to lift the taboo on mental health problems could therefore best come from within the Moroccan-Dutch population itself. Above, we discussed that there is awareness in the young Moroccan-Dutch people about the necessity to change taboo. Individual initiatives can be more impactful when they can connect or work together in a network. This could be regionally or nationally organised. Possibly, the Dutch national platform for mental wellbeing MIND (wijzijnmind.nl) can support anti-taboo initiatives for ethnic minorities. As an example, MIND has performed the campaign #openup, to increase awareness about mental health problems in Dutch youth, in cooperation with national radio and television channels. I would encourage paying more attention to ethnic minorities in future campaigns. Even better would be an awareness-raising campaign that focuses directly on ethnic minorities, since more targeted interventions have proved more effective (Stuart, 2016).

In this thesis, we have seen that mental health problems and the experienced taboo can increase social isolation. This feeling of social isolation is a potential target point for interventions in this population. The establishment of 'positive resources in community' was recommended by Gopalkrishnan (2018) and Marsella (2011) In the Dutch setting, there might be a role for the network of so-called 'social district teams'. These district teams serve as community hubs and help connect help-seekers to help-providers for a wide range of different services. These teams have the advantage of being well-informed about the local population and issues and work in close connection with mental health services. The social district teams could initiate or facilitate meetings for ethnic minorities. We should however be careful about implementing interventions like this for several reasons. First, many migrants in the four largest cities in the Netherlands already live within the proximity of tailored facilities, including shops, mosques, and community centres, in neighbourhoods with close social connections (CBS, 2020). In that context, the suggested meetings might not add to the social support people already experience. Second, a systematic review on interventions to reduce social isolation for people with mental health problems could not recommend effective interventions, due to quality issues of the studies (Ma et al., 2020). Therefore, it is recommended to directly combine implementation of new interventions with research into the effectiveness. To be successful, interventions are needed on multiple levels and formal organisations should collaborate with social projects initiated by

locals. An example of such a network collaboration is 'Thrive Amsterdam'. This 'social movement' aims to improve the mental wellbeing and resilience of the citizens of Amsterdam and is a collaboration of many different organisations (local government, health insurance company, mental health care services, patient organisations, university, and an anti-stigma organisation among many others).

In this thesis, we have seen that the online environment created social support on topics that were otherwise taboo. Online support now often occurs on 'regular' social media. When a specific online location would be facilitated by mental health care organisations, this could increase the safety in the community. However, it might be challenging to actually reach the people that would benefit from such an online setting.

The findings in this thesis also have implications for mental health care organisations. We have shown that Moroccan-Dutch people experience barriers to using mental health care. Like individual clinicians, mental health care organisations too can aim to lower these barriers. First, new mental health care services were founded that specifically serve ethnic minorities and therefore have a special focus on cultural determinants. Examples are: 'De Evenaar', centre for transcultural psychiatry in the province of Drenthe; and iPSY, an organisation that aims to deliver culturally sensitive outpatient care in several locations across the Netherlands. Furthermore, general mental health care services can investigate what potential barriers for minorities are present in their organisation and address those. Recently, several professional organizations, including Dutch Psychiatric Association and NZa (Dutch health care authority), have successfully advocated for reimbursement of translator services by healthcare insurance (NVVP, 2021). Organizations can implement the use of instruments developed to support a culture sensitive exploration of mental health problems, such as the Cultural Interview (Groen et al., 2017). Furthermore, mental health care organisations can stimulate cultural competence training within the organisation and raise awareness of the taboo on mental health problems in mental health care professionals and trainees. Mental health care organisations should ensure that ethnic minority patients do not experience discrimination within the mental health care system. Ethnic diversity within the mental health care teams might help to improve inclusive treatment for patients. Finally, the treatment of patients with a different ethnic background can be perceived as difficult by clinicians. Mental health care organisations can help to facilitate health care workers in their job, for example by establishing consultation teams that can help when there are complicated cultural or diversity issues.

Implications for government policy

The focus of this thesis is mental health problems in Moroccan-Dutch inhabitants. We have given some background information on the social adversities and Islamophobia that Moroccan-Dutch and other Muslim minorities encounter in the last decades in the Netherlands. We have added to the scientific evidence showing that social exclusion is associated with mental health problems in this specific population. Based on the important role of environmental factors, we should consider the mental wellbeing of ethnic minorities from an "interactive perspective" (Phinney et al., 2001). This interactive perspective shifts the emphasis from the members of minority populations as the 'one with the problem' to the interaction between them and the receiving society. Although clinicians are generally focused on individual therapies, for improving mental health of ethnic minorities it is neccessary to focus on society as well. The Netherlands is a wealthy country, in which the government invests in the wellbeing of the population. From the interactive perspective, choices made by politicians and policy makers in societal issues can have considerable effect on the mental wellbeing of minority groups.

It is important that government and politicians are aware of their role model in society and take responsibility for the wellbeing of minority populations. We have seen in this thesis and in other research that social determinants are directly associated with mental health problems. Addressing these social determinants can improve the mental health status of migrant populations. More specifically, mental health problems are associated with lower socio-economic

status and lower level of education (Allen et al., 2014), a policy that aims to decrease social inequality and educational disadvantage in ethnic minorities can eventually result in improved mental health. Another example is the role of perceived discrimination. In this thesis and in many other studies, perceived discrimination is associated with impaired mental health in migrants. Institutional racism is one form of discrimination, also described in this thesis. A recent example in the Netherlands is the 'allowances affair', in which the tax authorities falsely accused civilians of committing fraud. Ethnic minorities were more often a victim than native Dutch people in this affair and it was demonstrated that the tax authority used ethnic profiling in their risk analysis procedures. Governmental organisations could play an important role in prevention of discrimination and institutional racism, starting by investigating their own internal policies and regulations. An example is the city of Utrecht, in which the local government recently decided they wanted to reduce discrimination and promote inclusion within the city. They started this mission by investigating institutional racism in their own city government organisation (Fermin et al., 2022; Omlo & Butter, 2020).

Previous research has shown that inclusive policies improve the relation between migrants and the receiving society (Breton, 2019). Another example of inclusive policy is ensuring diversity within the human resources of governmental organisations, which was investigated by Çelik in her doctoral thesis. She showed that governmental organisations worked on diversity in staffing policy, but the effect could improve when organisations would target their diversity policy more directly on improving the relationship between government and citizens (Çelik, 2016). Besides these examples, many more forms of social inequality can be targeted to improve the social situation of migrants, and thereby eventually their mental wellbeing.

Future research

Although this project has finished, there are of course many other and new questions that can be investigated within this research field.

First, the results within this thesis concern the Moroccan-Dutch population. It would be very interesting to extend this form of research to other migrant populations in the Netherlands.

Second, in this thesis, we have found that Moroccan-Dutch people experience several barriers to accessing regular mental health care, as described for other populations and other countries. There is a body of research on the accessibility of the mental health care system for ethnic minorities in the Netherlands, including topics like the representation of minorities in mental health care and the added value of ethnic matching (Ghane et al., 2010; Knipscheer & Kleber, 2004). The information that is already available can be complemented with the viewpoint of ethnic minorities. Which potential barriers and facilitators do they experience in the utilization of mental health care? How is the mental health care system perceived by ethnic minorities from the general population and how is this perceived by health care users with an ethnic minority background?

Third, follow-up research explore the relation between Islam and psychiatry. Especially the role of Imams in the consultation of patients and advantages of closer collaboration between mental health care workers and Islamic leaders and clergy can be investigated (Ali et al., 2005).

Fourth, I suggest to develop and test methods for modifying environmental factors relevant to the development of psychiatric disorders. After finishing the MEDINA-study (chapter 4), I thought preventive interventions, potentially in the online environment, might increase resilience to mental health problems. An example of such an intervention could be the 'GET. ON Mood Enhancer Prevention training', which consists of six interactive sessions with online guidance (Buntrock et al., 2016). Another possibility is an online mindfulness training, focusing on resilience (Spijkerman et al., 2016). However, in the qualitative follow-up studies, we have seen that participants' explanations and remedies for mental health problems were diverse. It is therefore important to first further investigate needs and expectations of the population so that effective interventions may be developed.

Finally, in this thesis we investigated mental health problems and their social and cultural determinants. Further research could instead focus on determinants of mental wellbeing and resilience, again with a view to developing effective interventions. For many of the above-described research topics, there is an important role for qualitative research methods.

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