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Discussing the unspoken: A qualitative analysis of online forum discussions on mental health problems in young Moroccan-Dutch migrants

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Abstract

Migrants and their offspring are at increased risk of developing mental disorders. Previous research has shown associations between adverse social factors (e.g., discrimination, lack of social support) and mental health problems in migrants, but it is unknown how these associations are understood by migrants themselves. In this study, we aimed to gain explorative insight into the way young Moroccan-Dutch people experience their social environment, and how they relate this social environment to the development of mental health problems. At www.marokko.nl, the largest online discussion platform for young Moroccan-Dutch people, contributors discuss a broad variety of subjects, including societal, cultural, religious, and mental health issues. Combining deductive and inductive approaches to qualitative data analysis, we analysed 22 forum discussions at marokko.nl about mental health problems, after which data saturation was reached. Contributors described feeling isolated and experiencing discrimination in their social environment. Contributor comments identified social challenges arising from Dutch society, Dutch culture (e.g., being too individualistic), Moroccan culture (e.g., strict parenting style), and living between these two cultures. These social challenges are perceived to be associated with mental health problems. Furthermore, we created a model describing the different types of explanations contributors used for mental health problems, being: religious (e.g., possession); medical (i.e., a bio-psycho-social cause); or a combination of both. This model can help clinicians in delivering culturally sensitive mental health care. Lastly, this study shows the taboo on mental health problems in the Moroccan-Dutch population and the opportunity to open up in the online environment.

Keywords

cultural factors, explanations for mental health problems, mental health, qualitative research, social determinants, transcultural psychiatry

Introduction

Migrants are at increased risk of developing psychotic disorders (Bourque et al., 2011; Jongsma et al., 2018) and mood disorders (Mindlis & Boffetta, 2017; Pignon et al., 2017) compared to non-migrants in the receiving countries. Children of migrants, so-called second-generation migrants, are also at increased risk for a broad range of psychiatric disorders (Bourque et al., 2011; Cantor-Graae & Pedersen, 2013). This suggests that not only the migration process itself, but factors within the receiving country increase risk for psychiatric disorders. Although biological factors like vitamin D deficiency are considered to play a role, literature focuses mainly on factors within the social environment to explain the increased incidence of psychiatric disorders in migrants (Morgan et al., 2010; Veling, 2013). The social environment is described as the "immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact" (Barnett & Casper, 2001, p. 1). Research findings indicate

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that psychiatric problems among migrants are associated with negative aspects of the social environment, like experiences of discrimination, social defeat (i.e., being in a subordinate position), and limited social support (Gee et al., 2007; Ikram et al., 2015; Karlsen et al., 2005; van Dijk et al., 2011; Wamala et al., 2007).

In the Netherlands, the Moroccan-Dutch population is the second largest migrant group (Federal Statistical Office, 2016). The majority of the Moroccan-Dutch population is now of the second generation, most of whom are under 35 years of age (Federal Statistical Office, 2018). Moroccan-Dutch migrants, both first and second generation, are at increased risk for developing psychotic disorders (Selten et al., 2012; Veling et al., 2006) and depressive disorders (de Wit et al., 2008; Schrier et al., 2010; Selten et al., 2012). In a previous cross-sectional study using self-report questionnaires in an online community of young Moroccan-Dutch persons, we found high levels of depressive and psychotic symptoms that were associated with discrimination, social defeat, and lack of social support (van de Beek et al., 2017). These previously described epidemiological studies have shed more light on the association between negative aspects of the social environment (e.g., discrimination) and the mental wellbeing of migrants. However, we do not yet know how migrants themselves experience their social environment and understand the influence of negative social factors within the social environment on their mental health.

Like in other Western countries, we have seen a rise of anti-migrant and anti-Muslim sentiments in the Netherlands in the last 20 years (Van Heelsum, 2006). In the public debate, right wing politicians linked Moroccan-Dutch people, in particular, with lack of integration and criminality (Lucassen, 2019). Considering these anti-migrant sentiments in Dutch society, we think it is important to investigate how migrants view their social environment in relation to mental health problems. This knowledge might help to improve the understanding of mental health problems in migrants and identify targets for treatment and prevention strategies. This is important because health promotion of migrants has recently been made a top priority by the World Health Organization (WHO, European Region, 2018), as they form a group for whom mental health care needs are not yet adequately addressed (Bhugra et al., 2014).

Aim of the study

The current qualitative study of online forum discussions on a Moroccan-Dutch website aimed to gain an explorative insight into how Moroccan-Dutch people experience mental health problems and how they reflect on the influence of their social environment on their mental wellbeing by using a combined deductive-inductive analysis approach. We present results of three research questions: (1) How do young Moroccan-Dutch people experience their social environment?, (2) How do they view the association between their social environment and mental health problems?, (3) What different types of explanations for the occurrence of mental health problems are described? The inductive nature of the qualitative analysis resulted in additional findings, which do not directly answer the research question, but are relevant to the study topic. These findings are also presented.

Methods

We used an 'informed grounded theory' approach, as described by Thornberg (2012). Results of preceding studies (Ikram et al., 2015; Veling, 2013), including our own (van de Beek et al., 2017), were used to formulate the research questions and create search terms, creating a deductive framework for data selection. This deductive framework was used as a starting point for a codebook used for data analysis. The code book was then extended with an inductive approach based on grounded theory, to analyze and interpret the data in a circular process (Hennink et al., 2011).

Data collection

We collected our data from the publicly available website www.marokko.nl in May 2016. This website was, at the time of the study, an important meeting place for young Moroccan-Dutch people, using the Dutch language. It was visited at least weekly by 75% of the young Moroccan-Dutch population (van de Beek et al., 2013). The website had 50,000 unique visitors per day, 55% aged 15–25, with excellent coverage in the geographical areas where Moroccan-Dutch people reside (Urban Connect, n.d.). The website visitors formed an active online community in which all kinds of subjects were discussed, including mental health problems, a subject that is rather taboo to bring up offline (Schoenmakers et al., 2017). From the thousands of forum discussions available, we selected discussions about mental health problems, using the Google Search function within www.marokko.nl. In order to find the 'richest' discussions, which contained the most content relevant for our research question, we used search terms related to psychopathology, terms for a negative social environment (discrimination, social support, social isolation), and combinations thereof (all search terms are listed in Tables S9a and S9b, Supplementary Material). Based on a first reading round, in which we familiarized ourselves with the material, we decided to select, by consensus, discussions in which (a) the content was deemed relevant for the research questions, (b) at least four people had joined, and (c) at least 10 reactions were given. These latter two criteria were formed to exclude discussions that would be too short to contain sufficient information or too one-sided in information. We

continued searching until we had included 35 relevant discussions. If data saturation had not been met during analysis, we could have gone back to include more discussions. The selected discussions took place between 2003 and 2016, more than half between 2011 and 2016, a period in which political parties with an anti-immigrant ideology were dominant in the public debate.

Data analysis

Qualitative data analysis involved a circular process of reading, categorizing, and interpreting the data (Hennink et al., 2011), consisting of the following tasks:

Preparing the data. We read the forum discussions and prepared an excel file, with information per discussion (number of posts, number of participants etc.) and a short description of each discussion topic. We assessed the relevance of each of the discussions, based on a consensus judgement of how the discussion content reflected the research questions at first reading (EL and MB). We used this to determine the order in which the discussions were coded, starting with the most relevant discussion and then adding discussions to the analysis process in decreasing order of relevance. After coding 22 discussions, we had assembled enough information for each of the research questions to continue to the next analysis step. Data saturation was then reached, and we stopped including more discussions in the analysis.

Coding the data. We started off with a deductive subset of codes based on our research question, adding new (inductive) codes to the codebook during the coding process (see Table S1, Supplementary Material for all codes). We imported the full discussions and coded the relevant text fragments, using ATLAS.ti (Version 7, Windows). Coding was performed in close cooperation by two researchers (MB and EL), discrepancies were discussed, and decisions were made by consensus. We reread all quotes for the different subsets of codes, relevant per research question, using constant comparison. We described the emerging themes and categorized them in Excel sheets. For the second research question, we additionally used the cross tables function in ATLAS.ti.

Conceptualizing the data and developing theory. We conceptualized the emerging themes in a visual way, by creating graphical networks of the data in which themes and subthemes were interconnected for each research question and constantly adapting them during the process. We further developed these visual presentations of the results into a theoretical model, which was subsequently checked using negative case analysis (Shenton, 2004). Negative cases were quotes that contradicted the explanatory models that we built. After finishing the data analysis and model development, we carried out the negative case analysis in two ways: (1) during analysis, we had assembled a list of potential contradictory quotes, which we now reread, discussed together, and assessed for inconsistency with the models; (2) we took one of the included 35 forum discussions, which was not yet coded and analyzed, and two researchers read it and checked the discussion content for contradictions with the models we created. Had we found a negative case, we would have had to reconsider the model we created.

In all parts of the analysis, categorization and conceptualization were discussed between two researchers (MB and EL). Reflexivity was included in these discussions, in which we considered our own ethnic, religious, and cultural backgrounds and how this might influence data analysis. In the early phase of the analysis process, the first and second author openly spoke with each other. We found many similarities (e.g., both white native Dutch, educated in university), as well as differences (e.g., one female, other male; one psychiatrist, other social scientist experienced in qualitative research; one participating in a conservative Christian church, the other being a-religious). We also discussed the differences between ourselves and the population we studied. Furthermore, we reflected on the influence of our professional backgrounds on the interpretation of the data and noticed, for example, that the psychiatrist was more inclined to use a diagnostic framework compared to the social scientist.

All analyses were performed in Dutch. The quotes, presented in the paper, were translated from Dutch to English by one author (MB) after which translation was carefully checked by another author (LK). We performed a member check by discussing our results of the analysis and our interpretation of quotes with a Moroccan-Dutch researcher in the field of mental health (but not involved in this project), who also works as a clinical psychologist with ethnic minorities in the Netherlands.

Ethical considerations

Contributors to the website www.marokko.nl are anonymous, using a pseudonym. The website is publicly available, and the analysis did not contain private content. Contributors to the forum were informed by the marokko.nl terms and conditions that all content was publicly available and could be used for various purposes. Marokko.nl included a link to the project website www.ziekofbezeten.nl (being ill or being possessed), in which cooperation with researchers was discussed. Because quotes have been translated to English, it is not possible to identify the specific contributor (a specific pseudonym) on the marokko.nl website who authored them. Since this is not medical-scientific research with participants, as described in Dutch and international legislation, no approval of the Medical Ethical Committee was necessary. This study

was performed in accordance with the Dutch Medical Research Involving Human Subjects Act, the European General Data Protection Regulation, as well as the Declaration of Helsinki.

Results

We analyzed 2,162 forum posts in 22 discussions, with a length ranging from 12 to 296 posts, and an average number of 100 posts per discussion (see Table S1, Supplementary Material for the codebook with all codes and their frequencies). Results for the three research questions are described in separate paragraphs below. In addition, we describe further findings on the taboo of mental health care in the community.

How young Moroccan-Dutch people experience their social environment

Contributors described both positive and negative aspects of the social environment, although the negative aspects outnumbered the positive. An example of the positive aspects of the Dutch society is that it was described as a country with many educational possibilities. Other examples concerned the Moroccan culture, which was described as valuing social engagement within the Moroccan community, strong family ties, and religion as sources of support. Some contributors described living in two cultures as a valuable experience.

In the negative remarks, the social setting in the Netherlands was characterized by the way the Dutch society 'treats' the Moroccan-Dutch population. For example, one contributor wrote, "Fear that one is not and will not be accepted as the person he or she is (…) Further increased by true incidents of violence, which are widely reported in the press" (q2: quote 2; Table S2, Supplementary Material). Contributors mentioned lack of support from the government (q1) and being negatively portrayed by the media (q2). Contributors described being denied jobs and internships, being discriminated against, and feeling excluded and isolated from the Dutch society. For example, one contributor wrote, "Those boys are sent off everywhere and do not get jobs/internship because their name is Achmed etc." (q3; see also q4, q5).

A negative aspect of the Moroccan culture was the 'Moroccan' parenting style, being more strict compared to the Dutch parenting style, especially with a strict father, and experiencing little parental love and care. For example, one contributor wrote: "In 2014, most Moroccans still believe you have to punish your child with beatings. If you talk about normal upbringing, they think you are westernized" (q6). Furthermore, the way people in the Moroccan culture deal with emotional distress was considered problematic: not sharing emotions and keeping silent about problems.

> That is because we don't talk, we don't show our emotions, we don't express our feelings. If that happens, we are either aggressive or hysterical. We did not learn that [to express feelings] from our parents and they do not know it either. (q7)

One contributor referred to the Moroccan culture as a "shame culture" and, in a forum discussion, a comparison was made with the Catholic confession culture. Finally, contributors described experiencing social pressure from within the Moroccan community and from family in Morocco (q8).

The Dutch culture, on the other hand, was described as being too liberal, thereby lacking social norms: "There are some structural problems in the white population: drinking problems, drugs problems, divorces, not taking care of one's elderly family members" (q11). Furthermore, the Dutch culture was considered too individualistic, for example: "Well, it is PROVEN that native Dutch people are very individualistic. In contrast to us immigrants, who are open and hospitable" (q10). Lastly, contributors experienced the Netherlands as an unsocial climate, for example: "(…) They build walls around Europe to keep migrants out. They make life difficult for the migrants who are already here" (q9). Living in two cultures was considered difficult, due to the double identity and the problems to bridge the gap between the different cultures in different social settings (q13). One contributor wrote: "I think Moroccans … that is, we Berber Moroccans, are trapped between different identities. What am I? Berber? Moroccan? Dutch? Muslim?" (q12). Contributors described different strategies to deal with the situation of living between two cultures. Some tried to participate within the Dutch society and culture as well as possible (q40), some tried to integrate their own culture with the Dutch culture (q38), while others described adhering to the Moroccan culture (q39). The variety of negative remarks about the social environment were categorized based on the context in which they were used by contributors. We could distinguish societal factors (aspects of the Dutch society as a community of people interacting with each other and sharing a country) versus cultural factors (factors related to social behavior, norms, values, and other phenomena that the society produces). All factors are presented in Figure 1 and examples of quotes for all categories are presented in Table S2, Supplementary Material.

Perceived associations between social environment and mental health problems

Most of the negative aspects of the social environment presented in Figure 1 were linked to mental ill-health by the

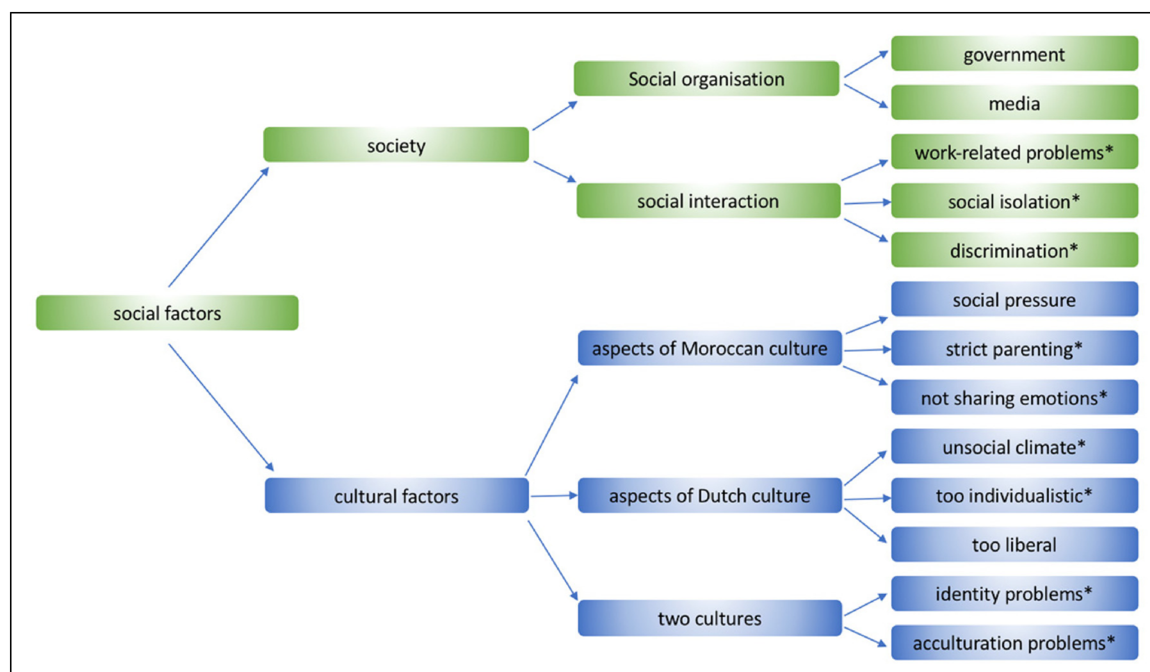

Figure 1. Negative aspects of the social environment described by marokko.nl contributors. *Note.* * These factors were reported to be associated with mental health problems by the contributors. See also Figure 2.

contributors (factors marked with an * in Figure 1). The four categories that summarize these aspects—social interaction, aspects of Dutch culture, aspects of Moroccan culture, and two cultures—were all related to 'social isolation,' which was explicitly referred to as a contributing factor for mental health problems by the contributors. One contributor wrote: "I do ask myself whether it might be a disorder that you encounter in western countries. (…) I think that causes include being isolated in the west and that humans live far from nature" (q15).

Social interaction was associated with mental ill-health, through discrimination and negative social interactions or —when people were unemployed—a lack of interactions in the workplace (q14). Contributors felt abandoned:

> As a Moroccan boy or man in the Netherlands, you are treated like a thief and a piece of rubbish. From a young age on, you experience discrimination and exclusion, and this just goes on until older age. Some people can cope with it, but others don't, and they become mentally damaged …. (q16)

Specific Dutch cultural aspects were mentioned as potential causes for mental problems when contributors referred to an inhospitable climate and individualism in the Netherlands (e.g., q19, q20). Specific risks of Moroccan cultural identified by contributors were the lack of expressing emotions and strict parenting (e.g., q17, q18). The ambiguity contributors encountered between two cultures, having felt forced to deal with 'double identities' (q21) and acculturation problems caused by opposing values and norms from Dutch and Moroccan culture, was also considered a risk: 'The many adjustments a person in a foreign country has to make creates a lot of stress in people who are vulnerable and they can become schizophrenic" (q22).

In Figure 2, we have summarized the aspects/factors of the social environment, both societal and cultural, that contributors related to mental health problems. Examples of quotes for all social factors are included in Table S3, Supplementary Material.

Explanations for mental health problems and suggestions for remedies

In our search for explanations contributors used for mental health problems, we noticed that discussions often started with a case description (e.g., 'I suffer from …,' or: 'my mother suffers from') followed by various types of reactions. Those were social support (e.g., 'I feel sorry for you,' 'I wish you the best'), remedy suggestions (e.g., 'Visit an Islamic healer,' 'Visit a doctor,' 'Start running'), and explanations for the mental health problem (e.g., 'You are possessed,' 'Your disease has a genetic cause').

A common way of explaining mental disorders among contributors was to place them in a religious context.

> Besides Voodoo, is it also possible that you are plagued by Jinns [supernatural invisible creatures that can possess a

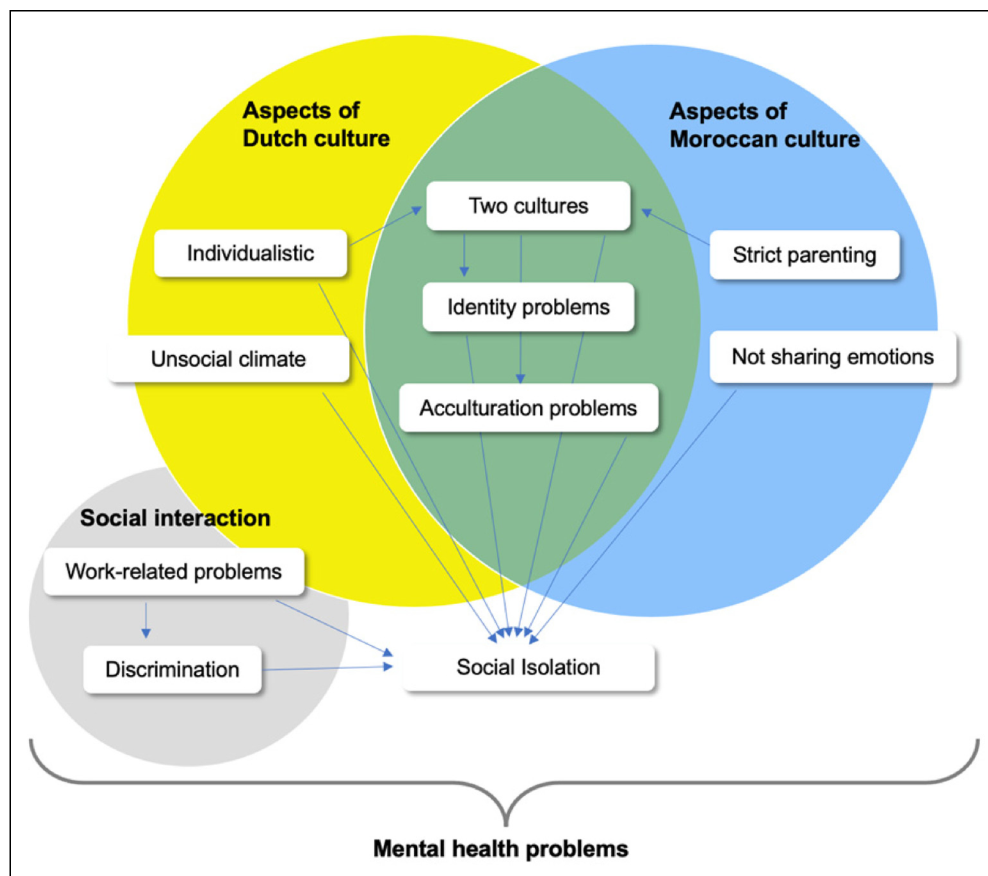

Figure 2. Model of interplay between social factors on category level that were all related to psychiatric problems. *Note.* The aspects of Dutch culture are grouped in the yellow circle and the aspects of the Moroccan culture are grouped in the blue circle. The green overlap area between the two circles represents the tension of living in two cultures. In the grey circle are the associated societal factors. All social factors that were related to each other in the data are connected with an arrow.

> person], which is mostly when you have a weak Imaan [faith]. Then you are an easy subject to them. Nowadays, they call it: depression, schizophrenia etc. But they are just the Shatien [evil spirits]. And the best medication is not a pill, but your prayers. (q24)

The different religious explanations included being possessed by Jinns, being the victim of an evil spirit or of Satan, having sinned to religious rules, and a range of other religious causes. Corresponding remedies suggested were religious practice (e.g., visit an Islamic healer, prayer), performing Ruqyah (exorcism by reciting Quran verses by yourself or with others), and performing Hijama (Islamic treatment with vacuum cups).

Another subset of the contributors used explanations fitting with the bio-psycho-social disease model (Engel, 1977) dominant in the medical world. These explanations are therefore referred to as 'medical' explanations.

One contributor wrote: "Since last year, I have depression and manic problems (too busy, doing everything at the same time, the opposite of depression). And now I take (Lithium), which supplements what I fall short of in my brain" (q25).

Whereas the above quotes showed either a religious or a medical explanation and can be considered presenting a dichotomous perspective on psychiatric illness and remedies, other contributors combined religious and medical explanations.

The first method for combining religious and medical explanations was to use remedies for one explanation (e.g., religious) and when there is no effect, to subsequently use remedies for the other explanation (medical):

> I investigated the use of medication for this disease, because I felt guilty towards the Islam. In several sources, I read that you first have to try Ruqyah and Islamic healing methods. If that does not work, Islamic herbs. If that does not work, you can use medication. Allah cures whoever he wants. (q26)

The second method for combining religious and medical explanations was to use religious and medical remedies at the same time.

> If the person turns out to be not possessed, he has to find other help for his complaints. Ruqyah is always good, also when you are not possessed. So why would you stop someone from doing Ruqyah, if you can combine it with visiting the psychiatrist. (q28)

Next to religious or medical remedies, also more ‘non-specific’ remedies were suggested. These ‘non-specific’ remedies were characterized as neither religious nor medical and they were therefore supported by most contributors, across the explanation types. These were: social strategies (e.g., social support, sharing problems) (q33), self-help (e.g., reading self-help books) (q32), and physical remedies (e.g., healthy diet, physical exercise, healthy sleep pattern) (q31). Figure 3 provides a visual presentation of the model of explanation, in which we represent the above-described categories, connected to the corresponding remedy suggestions.

We found several examples of persons who were contemplating about their explanation type for psychiatric problems. Even when contributors were not sure how to interpret for instance psychotic symptoms, their very reflection on these doubts showed that they, too, assumed a distinction between a ‘religious’ versus a ‘medical’ explanation. An example is: “A few years ago, I was not sure whether being possessed could be real, or in fact a psychiatric disorder …” (q43). The doubt contributors expressed about the explanation they use (either religious or medical in this case) indicates that the categories are considered distinct entities within the target population. See Table S4 for quotes for all categories and remedies. See Table S8 for categorization of remedy suggestions.

Mental health care taboo

Due to the inductive methodology, other relevant findings emerged that were not directly linked to the research questions. Many quotes described situations in which the contributor thought mental health care was not used or used too late because of taboo:

> I think the Islam is part of this sad situation. But the biggest cause is probably the shame culture. Disease, especially psychiatric disorders, is taboo in many (north) African countries. It is considered a punishment of Allah, furthermore it is not accepted to share the negative aspects of the family with the outside world (e.g., disease, poverty, criminality). (q35)

This taboo was not seen as a ‘causal’ risk factor for psychiatric problems. However, it was portrayed as influencing help-seeking behavior and recovery. Taboo about mental health care was, in our data, related to shame and often connected to religious explanations of disease.

Furthermore, contributors expressed a need to discuss mental health problems within the context of the Moroccan-Dutch community. One contributor wrote: “I miss the link between mental illness and the Islam and Moroccan culture on Dutch forums. (…) This is a place where we can get things off our chest and maybe we learn to talk about it in the real world” (q37). Opening up about the taboo on mental health care was considered important by contributors and the marokko.nl platform was described as providing a way to talk about thoughts and emotions that would otherwise be left unspoken.

Discussion

In this study of online forum discussions at marokko.nl, which is a large and representative online community of young Moroccan-Dutch citizens, we used qualitative research methods to investigate the way contributors experience their social environment and the extent to which they believe the social environment is associated with mental health problems. We also described the different types of explanations offered for mental health problems. Lastly, we found that contributors discussed a variety of remedies for mental health problems.

Contributors perceived many challenges in the social environment. These included (1) societal factors, predominantly negative social interactions with other Dutch citizens and negative experiences with the Dutch government and media, and (2) cultural factors, consisting of difficulties originating from both the Moroccan culture and Dutch culture, and from living between these cultures. Many of these societal and cultural factors, but not all, were considered to be potential causes for the development of mental health problems and these factors were grouped into four categories.

The first group of factors associated with mental health problems was related to social interaction. Social factors within this category included discrimination, which was associated with mental ill-health because of negative social interactions, and work-related problems because of a lack of interaction (when unemployed). In the literature, many quantitative studies have reported associations between social factors and mental health problems in the Moroccan-Dutch population, including discrimination (Ikram et al., 2015; Wamala et al., 2007). We are aware of only one study in which qualitative methods (together with quantitative methods) were used to investigate the association between discrimination and mental health problems in Haitian migrants in the Dominican Republic (Keys et al., 2015). Haitian migrants experienced ‘humiliation,’ which was not recognized by Dominican citizens, and was associated with mental health problems. Despite differences in the social settings of these Haitian migrants and Moroccan-Dutch migrants, the findings illustrate similarities in their experience of social adversity.

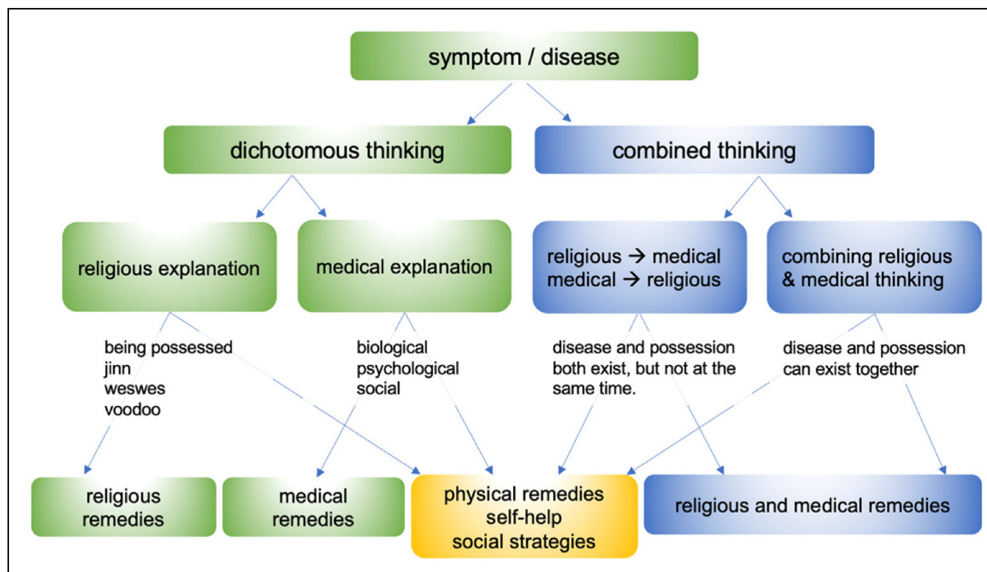

Figure 3. Models of explanations and remedies for mental health problems.

The second group of factors associated with mental health problems was related to the Dutch culture, which was perceived as inhospitable, especially to migrants. This is not a surprising finding, considering the anti-migrant sentiments in the Dutch society. The anti-migrant political party (PVV) has become more popular over time from 2006 onward and their message is dominant in the news (Lucassen, 2019). Many newspaper articles have reported about Moroccan-Dutch people in a negative way, for example about criminality in this population (Toussaint, 2009). In a research project commissioned by the Dutch government (Huijnk et al., 2015), mixed methods were used to investigate experiences of 843 Moroccan-Dutch people and 120 Moroccan- and Turkish-Dutch people. It was shown that many young Moroccan-Dutch people feel that their interests are not represented by the Dutch government and that they are treated merely as a member of a migrant or religious subgroup by the Dutch society.

The third group of factors in the social environment that was associated with mental health problems by contributors was related to the Moroccan culture. Contributors described a strict parenting style, and a culture of not sharing emotions. Learning to keep feelings and experiences to oneself is considered to cause mental problems. That the Moroccan parenting style tends to be strict is also shown in a literature review about the parenting styles of different migrant populations in the Netherlands (Pels et al., 2009). This review describes Moroccan parents as more likely to use an authoritarian parenting style, with a focus on controlling their children. Furthermore, communication within families tends to be more one-directional and less open, compared to other ethnic groups; and parents tend to be less responsive to their children. The review describes a change in second-generation migrants towards more open and two-directional communication within families and decreased focus on control of the children. To our knowledge, the association between the Moroccan parenting style and mental health problems is not previously described in the literature. However, a study in 550 Turkish-Dutch adolescents showed that 'not being able to talk to parents about problems' was associated with decreased mental wellbeing (van de Looij-Jansen et al., 2003).

The last group of environmental factors that contributors associated with mental health problems was related to living between two cultures. Contributors described that living between two cultures requires the flexibility to constantly adjust to the large differences between Moroccan cultural values with the family at home and Dutch cultural values in school, work, and social life. Contributors experienced the demanded flexibility as stressful and a potential risk for developing mental health problems.

These findings are in line with the existing literature. The process of adapting to different cultures was described by Berry (1997) as 'acculturation,' and the difficulties deriving from this process referred to as 'acculturative stress,' which has been associated with psychiatric problems (Devylder et al., 2013; Veling et al., 2010). In line with Berry's acculturation theory, Phinney et al. (2001) described ethnic identity as 'the aspect of acculturation that focuses on the subject's sense of belonging to a group or culture.' Both theories are two-dimensional, crossing one's original ethnic identity (low vs. high) with the 'new' national identity (low vs. high), resulting in four possible outcomes: belonging nowhere (*marginalization*), leaving one's original culture and only participating in the new culture

(*assimilation*), only participating in one's original culture (*segregation*), and participating in both cultures (*integration*) (Berry, 2005; Phinney et al., 2001). We found examples of marginalization, assimilation, and integration in our data (Table S6). One quote described how integrating the Moroccan and Dutch culture in one's everyday life contributed to a better chance of a successful life (q38). This was also seen in a Dutch study in the mental health care setting, where higher cultural adaptation was related to a better outcome of symptom levels and quality of life (Nap et al., 2015). However, living between two cultures was considered a struggle with a large impact on a person's identity by the forum contributors, regardless of which acculturation style was used. All of the environmental factors described above conveyed the feeling that one was on their own, while struggling with identity, and having to deal with difficulties without the support of reliable others. Social isolation seems, therefore, to be the central environmental factor that links the others.

The explanations that Moroccan-Dutch contributors used for mental health problems could be grouped into three categories: religious explanations; medical explanations, in accordance with the bio-psycho-social approach; and combined religious and medical explanations. In the discussions, explanations for mental health problems were often accompanied by suggested remedies. Mapping the remedies suggested by Moroccan-Dutch contributors was not part of our original research questions. Nonetheless, exchanging ideas about remedies appeared to be an important topic in the forum discussions, even more so than discussing the causes of mental health problems. A potential explanation for this finding is that contributors might have a better sense of control when discussing remedy suggestions, compared to discussing causes for mental health problems. The remedies discussed were not related to alterations in social circumstances. Contributors may feel they cannot influence their social circumstances, considering their marginalized position in society.

We created a model of how specific remedies follow from different explanations for mental health problems. Medical explanations used by contributors were consistent with the leading ideas in Western medicine about mental health problems and could be biological explanations, for example genetic vulnerability, and/or psycho-social explanations, for example social isolation. All of the environmental factors described above that contributors perceived as increasing the risk for mental health problems can be placed within this group of medical explanations. Medical explanations were accompanied by suggestions of medical remedies, e.g., visiting a doctor or taking medication.

Religious explanations for mental health problems (e.g., voodoo, evil eye) were accompanied by a range of religious remedies (e.g., visiting the Imam, performing Ruqyah). The most frequent explanation was being possessed by a Jinn. Initially, we presumed that psychotic symptoms like hallucinations and delusions might resemble the expression of possession more than depressive symptoms, and that Jinn attribution together with religious remedies would be especially suggested for psychotic symptoms. However, our data suggested the opposite. Although Jinn possession was indeed mentioned as an explanation for psychotic symptoms, there were many examples in which possession was also suggested as the cause for depressive symptoms, followed by the advice to use religious remedies. This is in line with a literature review and a clinical study in the Netherlands in which Lim et al. (2015, 2018) showed Jinn attribution was seen in Muslim patients suffering from a broad range of mental health problems. Although we expected that psychotic symptoms would be religiously explained, we found that for contributors it was often a reason to attend mental health care appointments instead of visiting a religious healer.

Although some contributors used either medical or religious explanations and remedies—which we refer to as the 'dichotomous thinking' style—we found that other contributors used religious and medical explanations together, at the same time, or one after the other—which we refer to as the 'combined thinking' style. For the people who combined religious and medical explanations, the effect of the remedy was more important than the explanation for the symptoms. We noticed a pragmatic attitude in symptom interpretation and help-seeking behavior.

There is a paucity of literature on the interplay between medical and religious explanations for mental health problems in Muslim patients. In a book chapter on psychiatry and Islam, Acherrat (2012) described her experience on how Moroccan-Dutch people experience mental health problems. Consistent with our findings, Acherrat described that 'Western' medical explanations as well as religious explanations are commonly used by Moroccan-Dutch people experiencing mental health problems. Our finding that individuals often combine religious and medical explanations, as well as religious and medical remedies, has not previously been described.

Strengths and limitations

An important strength of this study is the use of the qualitative research methodology in a large online community visited by the majority of young Moroccan Dutch people, which gave us unique insight into the experience of this population. Another strength is that we used forum discussions that had already taken place, thereby securing that the content could not be influenced by the research process itself. However, the use of existing content also resulted in a limitation: We had no possibilities to further interview contributors to clarify their opinions. Furthermore, we were not able to document demographic information from contributors, other than sex. We were therefore unable to make distinctions in results based on educational level, age, place of birth, etc. We also could not guarantee that all

quotes originated from Moroccan-Dutch contributors, because of the anonymity of contributors on the marokko.nl forum. However, the largest majority on the forum are young Moroccan-Dutch people; only 15% of visitors are native Dutch (Urban Connect, n.d.). Furthermore, the cultural background of the contributor could mostly be inferred from the text, for instance because contributors started their writing with ‘We Moroccans …’ For some quotes, it was clear that they were written by non-Moroccan Dutch people (e.g., ‘in your Moroccan culture’). These quotes were left out of the analyses. We are preparing a follow-up interview study within this population to corroborate findings and explore emerging themes in greater depth.

The trustworthiness of the study can be evaluated in terms of its credibility, dependability, and transferability (Graneheim & Lundman, 2004). In order to enhance the credibility of our study, we included many different discussions in the analysis to ensure sufficient variety in the data and performed all steps in the analysis in close collaboration among the research team up to consensus. Furthermore, we performed a negative case analysis as well as a ‘member check.’ The limitation that we do not have more information on contributors is the main impairment for the credibility of this study. To ensure dependability, we archived the forum discussions, listed all codes and coded fragments, and documented all steps taken and choices made in the analysis process. Although we have investigated young Moroccan-Dutch citizens, the emerging themes and models are not specific to this population. We think that the model of explanations and remedies for mental health problems (Figure 3) may be transferable to other young people whose parents have migrated to Europe from an Islamic country of origin, but further research is needed to explore this.

Conclusion

This study has several implications for the practice of mental health care. First, health professionals should be aware of cultural influences on how mental health problems are conceptualized by migrants, and of the influence of their own sociocultural background and professional practice. Studies have shown that the Cultural Formulation and the Cultural Formulation Interview (CFI), both systematic ways of incorporating culturally relevant information in the diagnostic process, are helpful tools (Groen et al., 2017; Lewis-Fernández et al., 2017).

Our model of explanations for mental health problems in the Moroccan-Dutch population may contribute to improving patient–physician communication in several ways: First, remedies could be a helpful starting point in the conversation about mental health problems and could lead the conversation from there towards the explanation of problems by the patient. Second, the model highlights that explanations for mental health problems in migrants can be either religious or medical (dichotomous) or a combination of both. This may prevent mental health care workers from assuming that patients with a religious explanation will automatically discard treatment as described in medical guidelines. Third, the model can help the practitioner to realize that, depending on the explanation used by the patient, integrating medical and religious remedies within the therapy might increase the working alliance and recovery process. Although our model is based on findings in the Moroccan-Dutch population, we suppose that it might also be applicable in other ethnic minorities, especially with an Islamic background. Whereas the details of the specific explanations will vary between populations, the link between explanations and remedies, as well as the distinction between dichotomous explanations and a combined way of thinking, could have broader generalizability.

In a previous study, we argued that interventions should be developed to increase resilience against social exclusion and thereby contribute to the mental health of migrants (van de Beek et al., 2017). Although the current study documented perceptions of the influence of the social environment on mental health problems, contributors did not put emphasis on how to deal with social circumstances. The central position of social isolation in our current model indicates the importance of social support as a point of intervention. Since the forum discussions we studied deliver social support to contributors in an anonymous format, they may be particularly valuable for minority group members for whom social exclusion and taboo around mental health problems limit opportunities for other offline forms of social support. Further research is needed to evaluate the role of interventions in anonymous online social settings for promoting the mental health of migrants.

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Author contribution

All authors contributed to the design of the study. MB and EL collected the data and performed the analysis. All authors contributed to data analysis and interpretation. MB and LK prepared the first draft of the manuscript and all authors critically revised the manuscript and contributed to and have approved the final manuscript.

Data availability

Data have been collected at the publicly available website www.marokko.nl.

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Supplemental material

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