Erasmus School of Health Policy & Management

Mental health care in the Surinamese culture

An analysis of Surinamese migrants and their perceptions on mental health and the Dutch mental health care system

Thesis

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Preface

In front of you lies the thesis “Mental health care in the Surinamese culture”, which was conducted for the Master Health Care Management at the Erasmus University Rotterdam (EUR). I worked on this thesis from November 2020 to June 2021. I am extremely proud of myself for presenting this research, especially because it was written in the midst of a pandemic.

None of this would have been possible without my wonderful supervisor Regianne Rolim Medeiros. From the bottom of my heart, I would like to thank her for introducing me to the field of migration research and for thinking alongside with me from the beginning till the very end of the thesis trajectory. Despite my ups and downs during the research, my supervisor remained patient with me and guided me in the best way possible. I appreciate her continuous support, feedback and reassurance. This has helped me to not give up and to overcome my own insecurities. I would also like to thank my respondents for participating in this research and for providing me with their insightful experiences. On top of that, I am grateful for the respondents who have helped me in my search for other respondents. At last, I would like to thank my family and friends for supporting me whenever I needed it.

I have always had a passion for mental health care and firmly believe that mental health care in ethnic minorities deserves more attention. Since I am Surinamese myself, I was very excited to perform this research. I have had interesting discussions along the way and learned lots about the Surinamese culture, more than I initially had imagined. I hope this thesis provides you with new insights about perceptions on mental health care and I hope you enjoy reading it.

Summary

Migration is a global phenomenon which impacts the mental health of migrants. A reason for this can be the acculturation process in a new country as it can bring distress. Therefore, ethnic minorities are more likely to develop mental illness. Still, in the Netherlands ethnic minorities underutilize mental health care. One of the largest ethnic minorities consists of Surinamese migrants. Because there is little qualitative research available as to how Surinamese migrants perceive mental health care, this thesis aimed to explore how first-generation Surinamese migrants perceive mental health and mental health care and how this influences their help-seeking patterns facing the Dutch mental health care system.

For this study 16 semi-structured interviews were conducted with Surinamese migrants, consisting of four sub-groups: Surinam-Hindustani, Surinam-Creoles, Surinam-Javanese and Surinam-Chinese. The findings illustrated that there were diverse reasons for migration. In the Netherlands the acculturation process was dependent on four elements: the family situation and housing, language, discrimination and the interaction between the Dutch and Surinamese culture. The migration, including the acculturation process, had a mental impact on migrants, for some more severe than others. Although respondents appraise good mental health and the presence of the Dutch mental health care system, the Surinamese culture stigmatizes mental illness and mental health care. Consequently, seeking help in mental health care becomes difficult for those with mental issues. The Dutch mental health care system has challenges as well, such as the bureaucracy of mental health care, the lack of culturally sensitive care and the narrow approach towards migrants.

This thesis has shown that the stigma in Surinamese culture and the shortcomings of the Dutch mental health care system create problems with respect to help-seeking. Future research is needed further to investigate this stigma. This can be done by acquiring in-depth experiences of Surinamese migrants within mental health care together with the perceptions of the mental health professionals and by analyzing how second-generation Surinamese migrants view mental health care.

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1. Introduction

Approximately 24% of the residents in the Netherlands have a migration background (Centraal Bureau voor de Statistiek, 2020). This includes both first-generation and second-generation migrants. Migrants of the first generation are born abroad and migrants of the second generation are born in the Netherlands but of whom at least one parent is born abroad (CBS, 2020). Migration can be described as: "*the process of going from one country, region or place of residence to settle in another"* (Bhugra et al., 2011, p. 2). Migration is a universal phenomenon and a heterogeneous process (Bhugra, 2004). There are various types of migration such as seasonal, temporary or permanent and voluntary or forced. To illustrate, it can concern a student who migrates temporarily to study as well as a permanent reconciliation with family members who already migrated. The process of migration can happen individually or group-wise (Bhugra et al., 2011). People are more likely to migrate alone due to educational or economic issues, while people are more likely to migrate in a group because of political issues and wars in their home country. Consequently, this diversity of experiences and heterogeneity implies that individuals will have different migration experiences (Bhugra, 2004).

Migration involves three essential steps (Bhugra et al., 2011). First, there is a pre-migration which merely entails the arrangement to migrate. This stage is influenced by factors such as social skills and social, biological and psychological vulnerabilities (Bhugra, 2004). Thereupon, these factors are affected by whether the migration is voluntary or forced. Then comes the second step which is the actual migration, meaning moving from one place to another (Bhugra et al., 2011). In this stage, there is an emphasis on factors such as life events and bereavement problems regarding for example the loss of relationships (Bhugra, 2004). It is at this stage where the acculturation of the migrant commences. Finally, we have the post-migration which is about the social and cultural assimilation of the immigrant within the new place (Bhugra et al., 2011). It can be argued that in the later stages of migration, mental and physical health issues are more likely to occur because of poor acculturation and poor fulfillment of ambitions (Bhugra et al., 2011). Also, the longer the migrant stays in the new country, the chances increase that they will be impacted by challenges such as employment and housing (Bhugra, 2004). It is important to note that the stress that migration can cause will affect migrants differently as every individual responds differently to stressors (Bhugra, 2004). However, during the whole process of migration the mental health of individuals can be affected (Bhugra et al., 2011). Moreover, there are certain aspects that predispose migrants to mental illness (Bhugra et al., 2011). Pre-migration aspects can be forced migration or persecution. Migration aspects are about cultural bereavement. Post-migration aspects entail culture shock and acceptance in the new country among other things (Bhugra et al., 2011). Stressors during post-migration can cause cultural confusion, loneliness and depression. In general, if the migration process brings distress the mental health of an

individual is more likely to be affected (Virupaksha et al., 2014). Additionally, those who are already susceptible to mental illness are more prone to develop an illness following migration.

Studies have shown that ethnic minorities compared to native residents have a higher chance of developing mental illness and differ in the usage of mental health care (Klaufus, Fassaert, & De Wit, 2014). The latter can be problematic if the utilization of mental health care differs due to inequitable access. Research in the Netherlands has implied that non-Western migrants utilize less mental health care compared to the native Dutch (Klaufus et al., 2014). Correspondingly, ethnic minorities have low help-seeking patterns regarding mental health care services. Also, the use of mental health care is not guaranteed to be effective as it can result in no diagnosis and therefore no improvement of mental health. It can further be indicated that ethnic minorities do not search for mental health care due to the stigma surrounding mental illness (Gary, 2005). Some individuals wish to use mental health care, but are too afraid of the possibility to be discriminated by others.

In addition, the COVID-19 pandemic had an enormous impact on people's mental health. Experts in the Netherlands, for example, have stated that the mental health of certain groups was more affected because of COVID-19 than others, such as: young adults, students and migrants (NU.nl, 2021). Additionally, the International Organization For Migration (IOM, 2020) mentions that migrants can experience a worsened mental health due to being far away from their home country.

In the Netherlands a large group of non-Western migrants are originally from Surinam, a former Dutch colony. Surinam lies in South America and is surrounded by French Guiana, Guiana and Brazil. Surinamese migrants consist of various ethnic groups. Two big groups are the Hindustani, who originate from India, and the Creoles, who originate from Africa (Knipscheer & Kleber, 2001). Two smaller groups of Surinamese migrants are of Chinese and Javanese origin (Boissevain & Grotenbreg, 1986). Surinam became independent from the Kingdom of the Netherlands in 1975 (Knipscheer & Kleber, 2001). During the past decades the Surinamese relocated themselves to the Netherlands. Arguments for migration included study and job possibilities as well as political persecution (Jubithana-Fernand, 2009; Knipscheer & Kleber, 2001). The study of Knipscheer & Kleber (2001) shows that migrants generally form an ethnic minority due to the retainment of culture and behaviours. This notion is applicable to Surinamese migrants in the Netherlands.

As already stated before, several studies have shown that migration can impact the mental health of individuals and that migrants have a low utilization of mental health care (Bhugra et al., 2011; Klaufus et al., 2014; Knipscheer & Kleber, 2001; Virupaksha et al., 2014). Related to Surinam, the study of Knipscheer & Kleber (2001) assessed help-seeking patterns and attitudes of Surinamese migrants with respect to mental health. Their research showed that migrants who had a short length of

residence in the Netherlands were more reliant on education about the usage of mental health care. Although the help-seeking patterns were not that different compared to the native Dutch, ethnicity still was a crucial determinant. Overall, migrants were content with mental health care, yet they vouched for more practical support that can be utilized on a daily basis (Knipscheer & Kleber, 2001). Notwithstanding, their study relied mainly on quantitative methods. This research will have a qualitative approach to provide a more in-depth understanding of how Surinamese migrants perceive mental health and the Dutch mental health care system and how this shapes their help-seeking patterns. Understanding this phenomenon is a key factor towards improving the current mental health care system in the Netherlands, as Surinamese migrants are one of the biggest ethnic minorities in the country (CBS, 2020). Furthermore, mental health professionals and policy makers can gain more insight in how Surinamese migrants view mental health care and whether changes within the current mental health care system are needed.

This research aims to investigate how mental health and mental health care is perceived by first-generation Surinamese migrants and how this influences their help-seeking patterns regarding the Dutch mental health care system. The perspective of the Surinamese migrants will be divided into Surinam-Hindustani, Surinam-Creoles, Surinam-Javanese and Surinam-Chinese. Thus, in this thesis the main research question is: *"How do Surinamese migrants perceive mental health and mental health care and how does this influence their help-seeking patterns facing the Dutch mental health care system?"*

In order to answer this question, three sub-questions are developed:

1. *How do Surinamese migrants view mental health and mental health care in general?*
2. *How does the Surinamese culture influence the perception of mental health and mental health care?*
3. *What challenges do Surinamese migrants face when it comes to seeking mental health care?*

In the next chapter a theoretical framework will be presented in which we will have a closer look at the history of Surinamese migration and the concepts of acculturation, help-seeking patterns and stigma in mental health care. Chapter 3 specifies the research methods used to gather the data and to ensure the validity and reliability within the research. The results of this qualitative research are extensively presented in chapter 4. At last, there is a discussion and conclusion in which there will be a critical reflection of the research and answers to the main research question and the sub-questions. We will conclude by describing limitations of the research and providing recommendations for future research.

2. Theoretical framework

This chapter commences with an overview of the history of Surinamese migration, including migration patterns and reasons for migrating. Afterwards, we are zooming in on the acculturation process and help-seeking patterns of migrants. At last, there will be a focus on stigmatization in mental health care.

2.1 History of Surinamese migration

The country Surinam was colonized by the English from 1650 to 1667 (Davis, 2009). Subsequently, the English colony was seized by the Dutch in 1667, which eventually resulted in the so-called cohabitation system (Games, 2015). This cohabitation of Surinam refers to an uncomfortable and extensive agreement between the English and Dutch in which the two parties, despite all the conflict and violence, created ways to explore the colony together (Games, 2015). The cohabitation was successful at times, but in the end the Englishmen left Surinam to explore other destinations (Games, 2015). The European colonization of Surinam was based on plantation[1] and yielded sugar and tropical crops (Van Amersfoort, 2011). The first laborers consisted of slaves forcibly brought from Africa. During the period of 1853 and 1873 Chinese contract laborers were brought into the country and after slavery was abolished in 1863 the first group of contract laborers from India arrived (Jubithana-Fernand, 2009). Not long after that the Javanese contract laborers from Indonesia also came to Surinam (Jubithana-Fernand, 2009). The fact that slavery was abolished was the main reason why these groups were needed for labor on the plantations.

During the previous century the influx of Surinamese migrants to the Netherlands increased rapidly (Van Amersfoort, 2011). As of 1980 there were approximately 145.000 Surinamese migrants residing in the country. As of today, the number of Surinamese migrants is about 358.000 (CBS, 2020). Overall, there are three essential phases in the migration process (Jubithana-Fernand, 2009). First, after the independence in 1975 circa 10% of the population migrated to the Netherlands, because there was a fear of the independence and possible oppression. Second, in 1980 a military coup in the country led to a new phase of migration. People that departed from Surinam did so primarily due to political reasons. Third, a new wave began when there was a civil war between 1986 and 1990 (Jubithana-Fernand, 2009).

The general reasoning behind the migration can be divided in two categories: push and pull factors (Jubithana-Fernand, 2009; Knipscheer & Kleber, 2001; Virupaksha et al., 2014). This distinction makes clear which factors push people from the old place and which factors attract people to the new

[1] The process of plantation includes the production of goods that are meant to be exported (Byerlee, 2014). The products from the plantations in Surinam were destined for the European markets (Van Amersfoort, 2011).

place (Virupaksha et al., 2014). To specify this for the Surinamese migration the push factors were mainly about the decolonization, the military coup and the execution of the opponents of the military regime, whereas the pull factors included the possibility to study, job opportunities, better living conditions and security. Later on, the linkage with family and economic advancement became crucial pull factors to migrate (Knipscheer & Kleber, 2001).

2.2 Acculturation

2.2.1 The acculturation process of migrants

After migrants have arrived in the new country the acculturation process begins. The process of acculturation is an essential factor of migration and can manifest on group-level and individual-level (Berry, 1992). In this thesis we will work with the following definition of acculturation: *"Acculturation comprehends those phenomena which results when groups of individuals having different cultures come into continuous, first-hand contact, with subsequent changes in the original cultural patterns of either or both groups"* (Redfield, Linton, & Herskovits, 1936, p. 149). Further developing the concept, Bhugra (2004) emphasizes that the acculturation process depends on factors such as the level of exposure, the gap between cultures and eagerness of the migrant to change. Acculturation leads to an assimilation of cultural values, customs, beliefs and language (Bhugra et al., 2011) and can operate on a covert and overt level (Bhugra, 2004). The overt level merely encompasses behavioural patterns which each individual uses during his or her lifetime and the covert level encompasses knowledge, psychological aspects and attitudes and values. Importantly, even though there is a requirement that both cultures go through change, in practice usually one culture holds superiority over the other (Bhugra, 2004).

2.2.2 Behavioural shifts and acculturative stress

The acculturation process can have two psychological implications for migrants: behavioural shifts and acculturative stress (Berry, 1992). First, the so-called behavioural shifts apply to changes in values, attitudes, skills and motives. Identities and attitudes of migrants alter and perceptions about how to engage in acculturation arise. Second, there are social psychological issues often categorized under the name of acculturative stress. Overall, acculturative stress negatively influences the health of individuals on a physical, psychological and social level (Berry, Kim, Minde, & Mok, 1987). When it comes to acculturative stress, usually a set of stress actions are in place such as a decrease in mental wellness (e.g. anxiety and depression), feelings of separation and identity confusion (Berry et al., 1987). The study of Hwang, Myers, Abe-Kim, & Ting (2008) further explicates how culture can impact mental health. It states that the adjustment to a new environment and its culture can result in acculturative stress. Stressors such as language problems, being apart from family and experiencing discrimination

can affect the mental health of immigrants. Research shows that the amount of acculturative stress depends on pre-post migration aspects, including education and the availability of networks (Hwang et al., 2008). Lueck & Wilson (2011) add that acculturative stress is the psychological influence on cultural adjustment and within ethnic minorities it is characterized by a decrease in mental health. Eventually acculturative stress can cause problems with adjustment (Lueck & Wilson, 2011).

It is important to note that acculturative stress is impacted by a variety of factors, of which one is the type of acculturating group (Lueck & Wilson, 2011). Research has shown that the acculturative stress of groups varies based on the migration status (e.g. refugees, immigrants or sojourners) (Berry, 2008). Those who migrate voluntarily have less acculturative stress compared to those who had little to no choice (Berry et al., 1987). Especially, the amount of stress that refugees experience is quite high. Not to mention, first-generation migrants experience more acculturative stress than subsequent generations, of which each succeeding generation has less stress (Mena, Padilla, & Maldonado, 1987).

2.2.3 Acculturation strategies and cultural bereavement

The amount of acculturative stress experienced can be related to the way the migrant acculturates. In existing literature, the author Berry provided a categorization of four strategies of how migrants acculturate: assimilation, separation, integration and marginalization (Berry, 2008; Weichold, 2010). It starts with assimilation, which is characterized by not wanting to uphold the cultural identity and by starting to interact with other cultures. Nevertheless, the second strategy, separation is the opposite in which individuals hang on to their original culture and do not want to get into touch with others and their culture. Integration lies between these two, as one wants to preserve the original culture and is still actively interacting with others. A migrant for instance still retains some cultural integrity and attempts to engage as an integral part of the broader social network. The final strategy is marginalization and is characterized by a lack of opportunity or interest in cultural preservation which can be a result of exclusion and discrimination (Berry, 2008; Weichold, 2010).

When it comes to these acculturation strategies both integration and assimilation are connected to the concept of cultural bereavement. As a matter of fact, they are effective strategies to reduce cultural bereavement as migrants get acquainted with a new culture (Bhugra et al., 2011). Bhugra and colleagues (2011) add the notion of cultural bereavement as a consequence of migration and further state that acculturation can help culturally bereaved migrants to regain some sense normalcy. In this research we will utilize the definition of cultural bereavement by Eisenbruch (1991): *"An experience resulting from loss of social structures, cultural values and self-identity."* In essence, cultural bereavement is about the loss of social structure and culture which results in grief (Bhugra et al., 2011). This grieving process can be either positive or negative. One the one hand, it can be positive

in the sense that it is a normal reaction and a result of migration. On the other hand, it can be negative if the symptoms are distressing and no progress is made. If the acculturation process goes well, migrants have a feeling that they belong in the new country. They can strengthen their network and social support (Bhugra et al., 2011).

2.3 Culture and help-seeking patterns

In mental health care it is important for clinicians to understand acculturation so that psychological issues of individuals can be better analyzed in light of their cultural change in identity (Bhugra, 2004). Cultural interpretations of mental illness can eventually impact help-seeking patterns (Hwang et al., 2008). Help-seeking patterns entail aspects like from whom, when, why and how is help actually being sought, which then influences treatment outcomes among other things. Help-seeking patterns are determined by the experience one has with the mental illness and how one shows distress. For instance, one might believe that the issue is somatic whilst being aware of the stigma surrounding mental illness and therefore decide to go to a primary care physician instead of a mental health professional (Hwang et al., 2008). Especially ethnic minorities have a tendency to seek mental care from their primary care physician instead of mental health professionals. Nonetheless, this can result in primary care physicians being more likely to not recognize the mental illness and issues. In the case of ethnic minorities there lies a choice to seek help formally or informally as they may have more trust in indigenous, informal help instead of professional, formal help (Hwang et al., 2008). It is important to realize that people from various cultures view their illness differently, which can imply that they experience less stigma according to the label they give themselves (Hwang et al., 2008).

It is crucial to be aware of the link between cultural beliefs regarding causes of mental issues and help-seeking patterns (Hwang et al., 2008). Research shows that non-Western people have different assumptions about causes of mental illness compared to Western people. One might believe the cause is supernatural while the other might believe it is biological. A consequence of this is that people have different coping mechanism and therefore different help-seeking patterns. Hwang and colleagues (2008) illustrate this with an example in which a huge part of depressed Chinese Americans did not view their problem as a mental illness. Few actually went to a mental health professional, whereas some actually sought informal help.

2.4 The stigma of mental health care

2.4.1 The stigma surrounding mental illness

Being from an ethnic minority, mentally ill and actively using mental health care can lead to being stigmatized. The stigma towards mental illness is a global phenomenon (Hwang et al., 2008). This thesis will work with the following definition of a stigma in mental health care provided by Gary (2005, p.

980): *"A collection of negative attitudes, beliefs, thoughts, and behaviors that influences the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders"*. A stigma may be recognized in speech and behaviour. This creates a barrier for those who need mental health care and are afraid to seek help. Corrigan (2004) adds that people want to dodge the label of mental illness and the damage it causes. Labels result in a stigma in two manners (Corrigan, 2004). In the first place, people can get labelled by others, such as a psychologist who notifies someone that a client is mentally ill. In addition, people can get labelled by association. For example, leaving a psychologist can lead to assumptions that one is mentally ill (Corrigan, 2004).

Especially in ethnic minorities, being mentally ill is often referred to as being crazy (Hwang et al., 2008). Research has shown that ethnic minorities compared to Western people are less prone to believe that mental health care is beneficial (Corrigan, 2004). Those suffering from mental illness can feel ashamed, hide their problems and not seek help as a result of the stigma. An essential part of help-seeking patterns is actually wanting care (Nadeem et al., 2007). Research has shown that stigmatization has an association with a lower desire for care. Effectively tackling a stigma can result in more desire for mental health care.

2.4.2 Public stigma and self-stigma

The stigma of mental illness can be divided in a public stigma and a self-stigma (Corrigan, 2004). Public stigma entails the acts of the public to the stigmatized group when the prejudice about that group is affirmed (Corrigan, 2004). Stereotypes, prejudice and discrimination have serious effects on those who carry the label of being mentally ill. They are bereaved from essential life opportunities needed for life goals. Often, people with mental illness are simply not able to have adequate jobs or housing due to the prejudice that employers and landlords carry. The unfortunate influence of public stigma can also be witnessed in the health care system. Those who are labelled mentally ill have a lower tendency to benefit from physical health services compared to those who are not mentally ill. Sequentially, the public identification of being mentally ill results in people avoiding harm by avoiding the stigma. This is a central reason how stigma interferes with help-seeking patterns (Corrigan, 2004).

Self-stigma encompasses the acts of the stigmatized group to themselves after they embody the public stigma (Corrigan, 2004). When a stigmatizing culture in in place, those with mental illness can have low self-esteem, self-efficacy and confidence about the future. The stigma that is present in society gets internalized, which can lead to mentally ill people believing they are less valued. Self-prejudice and self-discrimination severely impact one's life goals and the overall quality of life. Those who are ashamed of being mentally ill are also less likely to seek help. Furthermore, if one believes that family members would have a negative response to mental health care, one is more likely

to avoid it, especially when one has learned that being mentally ill is a disgrace to the family. The interaction between the public stigma and self-stigma has a strong influence on help-seeking patterns (Corrigan, 2004).

2.4.3 Prejudice, discrimination and double stigma

There are two concepts related to stigma of mental health care, namely: prejudice and discrimination (Gary, 2005). Prejudiced people have a tendency to carry stereotypes about others. Prejudice stands for thoughts and feelings people have about others which is often based on stereotypes and unsupported information. Those who are prejudiced enhance pessimistic stereotypes which results in negative emotional responses (Corrigan, 2004). An example is framing all people with a certain mental illness as a danger to society. It has been stated that prejudice fully hinders the life of ethnic minorities and especially those who need mental support (Gary, 2005). Prejudice is a cognitive and affective reaction, which can result in discrimination, the behavioural response (Corrigan, 2004). Therefore, prejudice can be viewed as precedent to discrimination (Gary, 2005). Discrimination is in place when individuals stereotype and express pessimism regarding ethnic minorities. This can manifest in decision-making and behavioural aspects. Such individuals that discriminate grant themselves privilege that ethnic minorities cannot obtain. One might be negative towards the so-called out-group or solely positive towards the so-called in-group. To illustrate, employers can choose to not hire those who are mentally ill or landlords can choose to not rent to those who are mentally ill (Corrigan, 2004).

Combining discrimination with the viewpoint of ethnic minorities further complicates the issue. For this reason, the author Gary (2005) has introduced the concept of a double stigma, which entails that mentally ill people from ethnic minorities experience discrimination by various actors within society, such as researchers, politicians and clinicians. The concept is twofold. On the one hand, it emphasizes the discrimination of those who are mentally ill and on the other hand, ethnic minorities face prejudice and discrimination which up to this day still affects peoples' lives (Gary, 2005). Likewise, there are too few mental health professionals from ethnic minorities present within mental health care. Thereupon, health disparities remain intact (Nelson, 2002). Hwang and colleagues (2008) do not explicitly name the double stigma, but strengthen this argument by mentioning that many believe that non-Western groups experience more severe stigma which influences their help-seeking patterns. An explanation of this can be that ethnic minorities might not be so educated about mental health issues and help. Also, there might be a misalignment between cultural beliefs and Western psychiatric help. Lastly, there might be little confidence and trust in the treatments available (Hwang et al., 2008). Another example of a double stigma is visible in the relationship between mental health and the criminal justice system (Gary, 2005). Those who are mentally ill are often viewed as criminals and therefore placed in facilities such as prisons, unsure whether they are effectively treated.

The concepts of acculturation and stigma, which in turn can help to explain help-seeking patterns, will be used as a theoretical understanding of how Surinamese migrants perceive mental health care.

3. Methods

In this chapter we concentrate on the research methods of this thesis. We will start by discussing the study design after which we will dive into the data collection. Afterwards, the data analysis will be described as well as the validity and reliability of this study.

3.1 Study design

This study is based on a qualitative research method to gain more insight in how Surinamese migrants perceive mental health and mental health care and how this influences their help-seeking patterns. There is an emphasis on the Surinamese culture and what challenges Surinamese migrants face with respect to help-seeking. Qualitative research aims to describe and fathom phenomena in terms of the meanings that are assigned by people (Jones, 1995). Qualitative research was suitable because the thorough experiences and stories of the respondents were necessary in order to answer the research question.

3.2 Data collection

The data collection of this study consisted of semi-structured interviews. Semi-structured interviews were chosen because they give the researcher the opportunity to ask follow-up questions and provide room for input of the respondent (Kallio, Pietilä, Johnson, & Kangasniemi, 2016). Often, when conducting semi-structured interviews a topic list is used, which includes relevant questions and topics (Harrell & Bradley, 2009). The topic list was created before conducting the interviews with help of the theoretical framework (Appendix A). It must be noted that during the data collection the topic list underwent some minor changes. Overall, the main topics during each interview were: migration background, life situation in the Netherlands, mental health care and seeking mental health care, mental health, culture and COVID-19. The main language used during the interviews was Dutch, because Surinam used to be a Dutch colony. Nevertheless, relevant quotes for this research were translated to English.

During the data collection all regulations and measures provided by the Dutch government with respect to the COVID-19 pandemic were strictly followed. Initially, the intention was to conduct the interviews face-to-face if the circumstances surrounding COVID-19 were suitable. However, most respondents preferred the interviews to take place digitally. Therefore, only 1 interview was face-to-face and the remaining 15 were digitally via either Zoom or telephone. As the researcher has a Surinamese-Hindustani background, it remained manageable to put the respondents at ease and create a safe environment during each interview. Conversely, as migration can be a traumatic experience, it was mentioned during each interview that the migrant can share what he or she feels

comfortable with. It was the responsibility of the researcher to know when sensitive questions were appropriate to ask.

The respondents for this study had the sole requirement that they have to be Surinamese migrants of the first-generation, meaning that they are migrants whom were born in Surinam (CBS, 2020). Hence, there was no particular age requirement in place. The first 8 respondents were approached and selected with help of the network of the researcher. The remaining 8 respondents were selected by snowball sampling, meaning that after an interview the respondent was asked whether they know other Surinamese migrants who are qualified and willing to participate in this study (Robinson, 2014). This has led to a final study population of 16 respondents (N = 16), with four migrants per sub-group. The four sub-groups of Surinamese migrants that are investigated were Surinam-Hindustani, Surinam-Creoles, Surinam-Javanese and Surinam-Chinese. The Surinamese migrants in this research vary in sex, decade of arrival in the Netherlands and type of Surinamese migrant. Table 1 presents the main characteristics of the study population. All interviews were audio-recorded and all respondents gave their consent to participate knowing their contribution is completely anonymous.

Variable		***N = 16***
Sex	Male	7
	Female	9
Decade of arrival in the Netherlands	1960 – 1969	1
	1970 – 1979	5
	1980 – 1989	7
	1990 – 1999	2
	2000 - 2009	1
Type of Surinamese migrant	Hindustani	4
	Creoles	4
	Javanese	4
	Chinese	4

Table 1. *Characteristics of the study population*

3.3 Data analysis

After the interviews were transcribed, the data was analyzed. A thematic analysis was applied, which entails that the researcher dove deep into the data to identify themes based on the phenomena that is being researched (Peterson, 2017). On a practical note, this means that the data from the interviews was coded. During this process the data was analyzed and attached with a certain meaning. These meanings can be related to thoughts or relationships. Two steps can be distinguished regarding coding (Peterson, 2017). The first step was open coding where initially codes or descriptions such as activities were classified. Important to realize is that open coding is an iterative process, that is to say that often transcripts were read multiple times so that basal thoughts and reflections can be analyzed. The second step was focused coding or axial coding. The essence of this step was to relate the observations in the data to each other by creating patterns (Peterson, 2017). These patterns ended up being the main themes and sub-themes which will be presented in the upcoming chapter.

3.4 Validity and reliability

Validity describes the degree to which the results reflect the data and are in line with the data (Noble & Smith, 2015). To ensure the validity in this research there was a member check for each interview. A member check means that the respondents were approached after the interviews to provide them with the results (Mortelmans, 2018). The respondent can then give feedback and opinions about the interpretation of the results.

Reliability is about the stability of analytical processes, which includes holding accountability of possible biases on the results (Noble & Smith, 2015). In qualitative research every study is unique and is not expected to be reproducible (Mortelmans, 2018). Nonetheless, the provided topic list makes it possible to get insight with respect to the content of the interviews and the questions asked. Consequently, to ensure reliability there was a self-reflection. Thus, the researcher aimed to write down the expectations before each interview and after conducting the interview this was compared with the actual data. In such way, it could be visible how the vision of the researcher may have influenced the data collection (Mortelmans, 2018). It can be stated that the role of the researcher in influencing the data collection was negligible.

4. Results

This chapter presents the results gathered from the qualitative data collection. It begins with illustrating the migration experiences of the respondents, including the push and pull factors in section 4.1.1. This is necessary because, as we have seen in chapter 2, the migration experience can influence the cultural adjustment and exert an impact on a migrant's mental health. The acculturation process and the impact of migration on mental health are presented in 4.1.2 and 4.1.3. Next, in section 4.2 a closer look is provided on the perceptions on mental health and the Dutch mental health care system, consisting of the Surinamese culture and its views on mental health, help-seeking patterns and challenges related to the Dutch mental health care system. We will end with the impact of the COVID-19 pandemic on the mental health of Surinamese migrants in section 4.3.

The data-analysis revealed that there are minor differences between the four sub-groups. Therefore, in this chapter no specific distinction is made per sub-group. When there is a particular difference between the sub-groups, it will be pointed out explicitly.

4.1 Migration experiences

4.1.1 Push and pull factors

Amongst the respondents there is diversity in the period of migration from Surinam to the Netherlands, which spans from the 1960s to the 2000s. Approximately half of the respondents migrated in the 1980s. The study showed that there are various push and pull factors, which are in line with the literature discussed (Jubithana-Fernand, 2009; Knipscheer & Kleber, 2001; Virupaksha et al., 2014). It is important to be aware that the push and pull factors in practice are often intertwined, implying that there were usually multiple reasons to migrate.

A majority of the respondents migrated due to education and work-related factors. Correspondingly, some respondents emphasized that they came here for a brighter future, out of curiosity and to seek adventure. The education system in Surinam at that time was limited, notably with respect to education after high school. Consequently, those who really wanted to study further had to go abroad. In comparison with Surinam, the Netherlands had more educational opportunities and as a former colony of the Netherlands the language barrier was minimal. Some respondents were also acquainted with the Netherlands as they had been here before on holiday, which, in their view, would make the migration process a bit easier.

> *"I finished high school in Surinam and it was self-evident that you need to go the Netherlands if you wanted to study. It was difficult at the time because you had to apply for a student visa to come. Everything became more expensive and it was difficult to get. Still, I came here as*

soon as possible after my visa was approved and before I knew I was on a flight to the Netherlands." (Respondent 10)

Multiple respondents migrated because of the political situation. Especially during the 1970s and the 1980s the political situation in Surinam was unstable, which resulted in an influx of migrants. There was a military coup and opponents of the military regime were brutally murdered. For some this was a traumatic experience.

"I came here because of the injustice that me and my family experienced and because of the legal system that was not working properly. So, I just made the decision and left, without being influenced by anyone. Me and my children left, as there was simply no future for them in Surinam. I was thinking: just go and see what you can do there in the Netherlands." (Respondent 4)

Not to mention, respondents declared that there was lots of corruption, leading to their desire to aspire a better future life in a different country.

"If I am honest, I was quite discouraged in Surinam and I still wanted to achieve something but that was not possible in Surinam. I was following a scholarship at the time, but during that period all my teachers were going to jail. Therefore, I decided to come to the Netherlands." (Respondent 1)

4.1.2 The acculturation process

Once the migration process has occurred, the acculturation process begins (Bhugra, 2004). The conducted study revealed that respondents wanted to adjust and integrate in the Dutch society and culture. Yet, for some it was difficult as they wanted to maintain and uphold their original Surinamese values. This struggle is reminiscent in literature on acculturation processes as part of the cultural adjustment, where two cultures start to interact and changes can occur in one or both of them (Redfield et al., 1936). Respondents mentioned that in the Netherlands, compared to Surinam, you are not surrounded by your big family, therefore, you are expected to be more independent and responsible. For example, migrants who came here to study also had to do the dishes, cook, wash clothes on top of studying, which was different compared to life in Surinam, where a lot is done collectively by the family. This was a learning process for migrants.

"It was pretty intense because you grow up in a family, in a small community, it's safe and there is a lot of social control. Then you arrive here in the Netherlands and you have to adapt to the cold, it was already autumn. I was in a big city and even though I was staying with my sister… you go from being raised protected to getting a great deal of freedom that you have to learn

to deal with. The income that you have to live on is limited, so that was a big change from my protected environment." (Respondent 10)

"It is adjusting of course, it is really processing the grief, leaving everything behind there in Surinam, family, home, everything. It is a really big turnaround, a big change because I had to start a different life and see what I can do now for the sake of my children and how I can raise them now. Also, how should I treat myself now." (Respondent 4)

When it comes to the acculturation process of Surinamese migrants in the Netherlands there are four determinants involved, which will be discussed subsequently, namely: the family situation and housing, language, discrimination and the interaction between the Dutch and Surinamese culture. These determinants can be linked to the earlier discussed pre-post migration factors that influence the amount of acculturative stress (Hwang et al., 2008).

In the first place, the degree of cultural adjustment highly depends on the family situation and housing once migrated. As discussed earlier, the presence of a strong social network can be beneficial for a migrant's acculturation process (Hwang et al., 2008). Those who had both a planned migration and migrated with family members relatively had better housing at first, as they had more preparation time. Furthermore, having family and friends made it easier to adjust and feel at ease in the Netherlands.

"Fortunately, we had a lot of family, my parents were here and they took care of us. It all went pretty smoothly because for us, at least for me, it was not that difficult to find your place. We also had a lot of friends here, so you did not feel lonely. You actually felt right at home." (Respondent 12)

The second determinant is language. As stated before, for Surinamese migrants language was not really an issue once they first arrived in the Netherlands. In their view, they actually had a big advantage compared to migrants from other non-Western countries, who first have to master the Dutch language, which makes it more difficult for such groups to adjust. Nonetheless, several respondents said although they spoke Dutch, it was challenging at times to understand the meaning of what the native Dutch were saying. The nuance in a conversation could be missed and there were new words to be learned. This observation is to a certain extent in line with the notion of Bhugra et al. (2011), which states that acculturation results in an assimilation of language, in this case it is the interpretation of language.

Discrimination is the third determinant. Multiple respondents mentioned that they are were aware that ethnic minority groups are often discriminated compared to the native Dutch. Respondents

had different experiences with discrimination, which can be classified in severe discrimination, subtle discrimination and barely any discrimination. Few respondents said that severe discrimination was more common to happen at an older age, for example in high school. Another respondent illustrates that he got discriminated when he tried to get his own place to stay. According to respondents, such cases of severe discrimination are impactful.

> *"As we got older, you started to see a change. We were called names, they said go back to your own country and what did you come here to do. You can see very clearly that small children are really unbiased, but apparently as they get older, they learn ideas from adults."* (Respondent 2)

> *"I did not get the room I wanted, but my white friend did get it. At that point I knew they discriminate here in the Netherlands. I was unsure whether I wanted to stay here, it was awful. I am black but at one point it seemed like I ended up in hell. I tried somewhere else and called again, but he immediately said: I do not rent to black people. I was like damn what have those black people done?"* (Respondent 5)

Next, several respondents faced subtle discrimination. Discrimination manifested for example in being mocked for the Surinamese accent and in being treated differently.

> *"I ended up in kindergarten here and I was 5 years old. I was introduced as someone who came from very far away from a very distant land, while I was thinking it was not that far. That comment, which was well intended to the rest of the class, made me feel a bit different. It was well meant, but I do not think it was necessary."* (Respondent 2)

Finally, there were also respondents who barely experienced any discrimination. Respondents in this group further argued that a migrant's attitude plays a big role in how discrimination is experienced.

> *"I have not been faced with discrimination. I personally think that it has to do with your position in life. I am not saying that there is no discrimination, but if you stand firmly in your shoes, you are less likely to be affected by discrimination."* (Respondent 7)

The final determinant is the interaction between the Dutch and the Surinamese culture. This is about how migrants maintained one or both cultures and what type of acculturation strategy they had (Berry, 2008; Weichold, 2010). The main acculturation strategy of the respondents was integration. That means they tried to blend into Dutch society and its corresponding norms and values, but still preserve the Surinamese culture, although some expressed that this was an unconscious process. A respondent said that keeping the Surinamese accent was a way of maintaining the

Surinamese culture. Others described that it was essential to hold on to traditions and to not pay attention to the opinions of others. However, the Surinamese culture is often practiced within households and outside migrants also incorporate the Dutch culture.

> *"Actually, we have retained our culture but we also have adapted in society. You are here in a new country and I think you should stick to the rules, the Dutch laws and we tried to do that, but in addition we had our own Surinamese cuisine and food for example. So, I kept that, but on a social level you have to adjust. You have to go with the flow."* (Respondent 4)

For few respondents the Dutch culture completely dominated the Surinamese culture. This can be related to the acculturation strategy marginalization, which is characterized by little cultural preservation (Berry, 2008; Weichold, 2010). The adaptation to Dutch society led to a neglect of the Surinamese culture, which on long-term meant that the Surinamese culture became less and less prominent.

> *"I had to set aside a lot. Otherwise, you will not be able to make it here in the Netherlands. You have to. Society here is different and you just have to adapt, there is no other option."* (Respondent 15)

4.1.3 Impact of migration on mental health

The migration, including the acculturation process, can have a mental impact on migrants, as earlier discussed (Berry, 1992). The impact of migration on mental health varied amongst the respondents as for some it was more challenging than others. Those who migrated with family, those who had family and friends here and those who had no difficulties with making new friends did not have long-term mental problems. This is in line with the notion of Hwang et al. (2008), which states that the amount of acculturative stress can decrease when a strong social network is in place.

For some, the mental distress started at the pre-migration phase. Migrants had to say goodbye to friends and family members, as well as their belongings and the country.

> *"Yes that was painful because you had to leave your family there, your house, your belongings, I left everything there. So, you had to start all over again (…). It was excruciating to leave your family, your mom and dad. And your friends, you had to leave them behind too."* (Respondent 4)

Then, the mental health is further affected during the post-migration process. The acculturation process is a crucial aspect that impacts mental health during this phase. Respondents indicated that being in a new country and adjusting to it can endure feelings of loneliness. Those who did not have a solid social network and were busy with work and/or study had enhanced feelings of

exhaustion. The struggles that migrants faced due to the migration had an impact mentally and emotionally on their lives.

> *"Gradually you go on, you go on, you go on. I was in college and also had two jobs. Physically, mentally and emotionally it is tough. You are still young of course, but it caught up with me when I look back. Many years later I also ended up with a burnout."* (Respondent 10)

Respondents who migrated at a young age were not affected heavily, but adolescents and adults were. For instance, respondents migrating at the age of 5 or 8 had less trouble with adjustment and therefore fewer mental problems on the long-term. Thus, the struggles with acculturation and impact on mental health happened at an older age. Some have expressed that their older siblings at the time, who were in high school faced more adjustment issues and more severe discrimination. Likewise, discrimination is a stressor that can directly impact mental health (Hwang et al., 2008).

Respondents who had an unplanned migration because of traumatic experiences were seriously affected, as there was more distress and uncertainty involved. Besides the effects of migration to a new country and the acculturation process, they also had to deal with the trauma itself. In addition, respondents said that the trauma can have a psychical impact as well. Later on in life the manifestation of these traumatic events became visible via diseases or deficiencies of the body. This is in line with the fact that acculturative stress can have a physical, psychological and social impact (Berry et al., 1987).

> *"All the mental tortures have an effect on your body. Then you see that they still have trauma left over. And I also have that: as soon as something happens, something painful that touches me very deeply, then everything comes up again. For real. From childhood. Then all the sad things come up again. That should not be underestimated. As soon as there is another painful incident, is has an effect on the person, you see everything go by like a movie. You relive it again."* (Respondent 4)

All things considered, on the short-term most respondents were impacted mentally by the migration process, whereas on the long-term respondents did not develop severe mental health problems. Only a few respondents ended up with burnouts. Respondents kept trying to emphasize the positive side of their migration and how they overcame their mental struggles, which is as a part of their adjustment process. They agreed that the migration made them stronger as individuals and helped them to grow, both professionally and personally. Respondents made it clear that it is essential to learn from your experiences, to be proud of who you are and where you come from in order to get the best out of life.

"All my life I have seen it as a strength that I am from Surinam and I was always proud of it. It is a special feature in my experience that you come from a different culture and perhaps Dutch society does not see it that way. I find out more and more they do not see it that way, but I do see it as a special feature as an individual from Surinam." (Respondent 2)

4.2 Perceptions on mental health and the Dutch mental health care system

4.2.1 Perceptions on mental health

Now that we understand how the migration has impacted the mental health of respondents, it is necessary to know how the respondents view mental health in general. Several respondents have emphasized the importance of good mental health. It is characterized by being able to live your life as you desire and by continuing to work on yourself physically, mentally and emotionally. Multiple respondents have directly related physical health to mental health and how they influence each other. There are various manners as to how Surinamese migrants take care of their mental health. Respondents indicated that they for example do relaxation exercises, meditate or go on walks.

"I do fitness and that helps mentally as well. When I am done with you, I will go outside. I will go for a walk in the sun, I eat or drink something, I read my newspaper and I read my phone. I enjoy myself that way. I do not need anyone besides me in the form of friends." (Respondent 1)

Furthermore, the essence of good mental health is growing through pain and learning from difficult life events. It is about how you feel and how you deal with your emotions. Good mental health does not mean one is happy all the time, but how one can deal with lesser times.

"You have to try to get through them, you have to be strong, you must not let yourself go, be strong. I go through them, save them and then you know for the next time when you get into such a situation that you can use what you learned from the first time and be stronger in a second case." (Respondent 5)

Some respondents found peace and meaning in spirituality, which helped them to further understand their experiences and the purpose of life. In their view, mental health is much broader than one might think. Respondents reported that mental health relates to your soul, heart, spirit and body.

4.2.2 The stigma of mental health care in the Surinamese culture

Though respondents acknowledged the importance of mental health and actively work on maintaining good mental health, within the Surinamese culture a stigma lies on mental health and the usage of mental health care. This was often addressed in terms such as shame and can be further linked to a

public stigma (Corrigan, 2004). Moreover, respondents stated that nowadays in Surinam the topic of mental health is still a taboo.

> *"In Surinam if someone acted weird, they would say go a psychiatric centre, so it is already a taboo. In other words, it is a great shame for the family and parents and what they have to undergo because their child is not perfect or ends up at a psychologist. Here, in The Netherlands, it is much more accepted."* (Respondent 11)

According to respondents, talking about your mental health issues is problematic and it is shameful to say you have sought mental, emotional and psychological help or support. In Surinamese culture there is an expectation that you fix your own problems before seeking any help. Those with mental illness are often viewed as crazy or incompetent, which corresponds to the article of Hwang and colleagues (2008). Such labels reinforce the stigma for the person with mental health issues.

> *"You are not going to hang your dirty laundry outside. That is basically it. It also has a bit to do with honour. Not showing others that you have problems, that is not possible, that is not allowed."* (Respondent 16)

The public stigma results in a self-stigma, as earlier said (Corrigan, 2004). The public stigma in the culture is often enforced by parents and previous generations. In some families there are certain expectations that parents put on their children. Children at home are taught to stay strong, to go along, to be flexible and to not end up in situations in which a psychiatrist or psychologist is needed.

> *"I remember when my father passed, you are sad but you do not show your sadness. You do that when you are alone in your room and you do not talk about what it does to you."* (Respondent 16)

On the long-term, not being able to show your emotions and talk about them can be extremely harmful. Especially in cases where the stigma was already present during childhood. The following quote adds to this by explaining how the typical happy appearance of an individual does not mean they are mentally fine.

> *"You try to be strong for the outside world, but they do not know what you are going through. When you are at home, people do not see how you feel. When you cry, they do not see it, so they do not know (…). The outside world will never understand you."* (Respondent 4)

In some cases, it can also be a shame to the family when a family member has a mental illness. As a result, Suriname migrants can find it difficult to share their mental issues and henceforth have a self-stigma. Respondents declared that during their youth they thought that going to a psychologist

meant that there is something wrong with you. As they grew older, they became aware that the stigma should not be there in the first place and no taboo should lie on mental health. The following quote illustrates a self-stigma.

> *"From my own experience when I mentioned I had a burnout, that was also breaking through something. You already feel like you have failed and it is painful. It was such a big barrier and that shame of feeling like you have failed, whilst at home I have the most diplomas of all children, but then you see how relative that is. In Surinam we are raised based on expectations."* (Respondent 10)

Despite the awareness and existence of the stigma, it is important to realize that not all respondents experienced this stigma in their own childhood and family. Respondents disclosed that the manifestation of the stigma within a household differs per family. There are respondents who have grown up in families in which you could talk about all your issues, and where parents created a safe environment to speak up.

> *"My mother was very open, especially as a single mother there was no barrier. I could discuss everything with her. Even now when we are in the car, we can talk about everything and really laugh. Then, I think I am blessed to be able to discuss this with my mother."* (Respondent 11)

Otherwise, there are respondents who have said that mental health was not something talked about at home. Usually, this lack of openness starts in the childhood of the migrant. It is more difficult to change beliefs surrounding mental health, when a migrant has grown up in a family which stigmatizes mental health issues.

> *"Within our family we just do not talk about that. You just do not do that and I think I talk a little bit more about it than the others but it is very strange to talk to my mom about this, you just do not. I also notice that towards my children that I find it difficult to talk about."* (Respondent 16)

Most of the respondents expressed that in the Netherlands the stigma is less present or even non-existent. The Dutch culture is said to be very open and transparent. Speaking about mental health and mental health issues is not shameful. Another key point is that the acculturation process led Surinamese migrants to acquire different beliefs and views on mental health. Some respondents declared that this has helped them to think different and gain awareness of the fact that it is normal to talk about mental health and that mental health care can be beneficial.

> *"There is no taboo here. If a normal Dutch colleague or neighbour has to go to a psychologist because he has mental problems, then he simply says that I am being treated by a psychiatrist*

or a psychologist and they see that as normal. They also see that that can make you better and can make you function better." (Respondent 8)

In essence, in the view of the respondents the double stigma proposed by Gary (2005) is not present amongst the study population. The Dutch culture and its openness regarding mental health has helped respondents to tackle the singular stigma in Surinamese culture.

"I do not think it is just Surinamese migrants but also people from other countries in the sense that people are used to differently. In third world countries, non-Western countries you are always put away as a madman or mentally disturbed. Those people are treated differently. In the Netherlands they deal with it differently, more lovingly, they do not impose, you keep your freedom a bit." (Respondent 8)

Additionally, respondents proposed two ways to break the stigma and the shame around mental health care. The first suggestion is to spread information so that people who stigmatize have a better understanding of mental health. The second and most direct way to break the stigma is by making the step to seek help and talk about your mental health issues. Respondents declared that it does not necessarily have to be a mental health professional, but someone you can trust, which can be a friend or family member.

"If you are going to hide it and you are not going to talk about it, then people cannot help you. You just have to talk about it and then you can really get help. Conversations are very important. You also have to be very tactical with people, because sometimes they have very heavy, deep things that they do not want to bring out, it is also a feeling of shame." (Respondent 4)

In addition, respondents indicated that in the current generation mental health is much more talked about, for example on social media. Therefore, a stigma will eventually cease to exist when a majority of the population has no shame talking about mental health. Having a safe environment and a strong network can help for mentally ill migrants to overcome the stigma.

"I think they should have the right people around them. Maybe not a loved one per se, but you have all kinds of institutions and organizations that you can go to and talk about your problems. Your family does not even have to know. You can just start a conversation." (Respondent 1)

4.2.3 Help-seeking patterns within the Dutch mental health care system

The stigma imposed in the Surinamese culture creates an interference with help-seeking, which can worsen the mental health state of a migrant. This corresponds to the argumentation that the stigma creates a barrier for those in need of help (Gary, 2005). Moreover, respondents said that labelling

mentally ill people only makes it more difficult for them to seek help. It is disclosed by several respondents that Surinamese migrants have habituated to certain beliefs and judgements with respect to mental health and help-seeking patterns and therefore find it difficult to change their thinking.

> *"If you look at our people and of course there are outliers, the majority is a bit stuck with certain ideas that do not transform. People are not aware that, for example, a psychologist can be useful when you have a headache instead of constantly worrying and getting frustrated. It remains a high barrier and perhaps fear. Fear of that people are going to find out you are going to a psychologist, you know."* (Respondent 7)

Respondents argued that these viewpoints in the culture lead to Surinamese migrants not realizing how beneficial mental health care can be. The Dutch mental health care system is there for everyone, yet Surinamese migrants do not have any knowledge about it. Consequently, a big barrier is present to seek help.

> *"The problem within mental health care is that the threshold is often high for migrants, in the sense that people have a different view of mental health care. Mental health care in the Netherlands is extremely humane and there is a lot of space, there are many bodies that supervise, there are many opportunities for participation, there are interest groups and so on. That is not something that non-Western migrants with a nice name are used to. That makes it that a migrant has no feeling with it, one cannot imagine that someone who has mental problems can be treated so neatly, one is used to it differently."* (Respondent 8)

Within Surinamese culture mental health issues usually stay within the household and do not go beyond that, which makes seeking professional help immensely tough for those who need it. Some respondents added that Surinamese migrants might not know the specific ways to seek formal help. Consequently, seeking informal care is then the best alternative. The step to informal care has less barriers compared to formal care, as the stigma is primarily about the usage of professional help. Examples of informal care are opening up to a friend or a family member and explaining what exactly is going on. Respondents further said that this should be someone you trust, such as a counsellor (in Dutch: *vertrouwenspersoon*). Also, when the informal caregiver understands the Surinamese culture and its viewpoints relating to mental health, it might be easier for migrants to feel at ease and be in a safe environment. The reasoning of Hwang et al. (2008) in which ethnic minorities might have more trust in informal care than formal care is applicable here. On top of that, informal care might even lead to less stigmatization as there is no professional diagnosis and therefore no labelling in place.

> *"When there is something, tell it to someone you trust and see what that person can do for you. That person can help you and that person can seek help for you if that person is willing to.*

If that person is able to request that help for you and walk the paths to help you. He or she will help you but it has to be someone you trust and only then things will come loose." (Respondent 4)

A respondent further made the argument that Surinamese migrants are more likely, besides informal care, to seek help at the general practitioner. This is backed up by the literature, which discusses that general practitioners are often sought because migrants might not believe that there is a mental issue, whilst knowing that a stigma lies on mental illness (Hwang et al., 2008).

"It has been statistically proven that in the Netherlands Surinamese migrants make much more use of the general practitioners and the specialist, but very little of the psychologists and psychiatrists, while it is the other way around for the native Dutch. For the smallest thing they are already looking for a psychologist or a psychiatrist. That is because in Surinam we learned to solve our problems on our own." (Respondent 1)

Nonetheless, respondents made it clear that informal care is not always enough and, in some cases, professional help is the only option left. When formal care is sought, we are talking about the Dutch mental health care system, including psychologists, psychiatrists and other mental health professionals.

Several respondents stated that mental health care is accessible nowadays and that there are many mental health institutions in the country. In comparison with the mental health care system in Surinam, most respondents are overall content with the Dutch mental health care system and the fact that there is help present. In addition, some respondents would not hesitate to seek help if necessary.

"If I feel like I need mental health care, then I do not hesitate to make use of it. I think it is easier to talk to a stranger than an acquaintance." (Respondent 9)

Few respondents made it clear that mental health care usage was beneficial, based on their own experience or from what they have seen in their social network. The professionals were able to help them get their life back and deal with whatever was necessary.

"That self-healing, the meditation that actually helps me. Working on my trauma's. I also have conversations and I have a psychotherapist who helps me. So, I also seek help outside of my own piece and I am also open to getting help so I can transform myself. I am very open to mental and emotional support." (Respondent 10)

Nevertheless, there are several respondents who have less optimistic experiences with mental health care. Respondents claimed that it was not really effective for them. There are three insightful

examples. First, a respondent was advised to go to a psychologist or psychiatrist because of the traumatic events she experienced in Surinam. When she got help, the mental health professional made it clear she processed her issues very well and that help is not needed at all. Second, another respondent sought help because of the melancholic feelings he was experiencing. Nonetheless, he mentioned that the formal care was not effective, mainly because the professional did not dive deep into the Surinamese culture of the respondent. The professional might have not had the cultural knowledge. Eventually, the respondent found help in spirituality, which focused on the Surinamese culture, the acculturation and how that affected the wellbeing of the respondent. Third, a respondent was receiving medication from a psychiatrist but declared that it was not working properly and eventually she quitted the treatment. The respondent did mention that her viewpoint regarding mental health changed according to the acculturation process and therefore she was more open to receiving professional help.

These experiences and the perspectives of respondents have led to three additional challenges, on top of the stigma as the primary challenge, with respect to help-seeking in the Dutch mental health care system. In the first place, respondents said that mental health care can be quite bureaucratic, as there are a lot of regulations and rules within the system. Additionally, being in mental health care can be a tiring process.

> *"I think it is very bureaucratic, from pillar to post. It is a terribly long process and you have to fill in everything. I wonder whether the experts understand enough how it works in a different culture."* (Respondent 16)

In addition, the second challenge is the lack of culturally sensitive care and culturally conscious professionals, meaning that the Surinamese culture is not incorporated enough in the Dutch mental health care system. Respondents shared that there can be a mismatch between a Surinamese migrant and the mental health care system. On the one hand, this has to do with the stigma itself and that a migrant can be quite sceptical of mental health services. On the other hand, the mental health professionals might not be aware of the culture and therefore may not be effectively treating the migrant in question.

> *"Because Surinamese migrants keep mental health in a taboo atmosphere, they keep giving it a certain place and when you enter such an institution, the approach is completely Western and it does not tie in with different cultures."* (Respondent 8)

A very practical example of a cultural issue is a language barrier in mental health care specifically for the Surinamese-Chinese migrants. Respondents stated that they sometimes had to translate for a parent and that it was difficult to translate. Translating is not just translating words, but

also the emotions, the intentions and the content. An example in mental health care is illustrated below.

> *"My mom was doing a psychological exam because of her dementia and the doctor asked how she was feeling mentally, whether she was inwardly content. I tried to describe it and then she responds: I am not satisfied because I cannot walk well. But they are asking about her mental state, if she is satisfied with life. But in our culture you do not talk about that, so she cannot indicate that either."* (Respondent 16)

Thereupon, mental health professionals in general should be more culturally sensitive and understand how another culture might view mental health. Respondents not only referred to the Surinamese culture, but other ethnic minority cultures as well where a stigma on mental health care also exists. Bhugra (2004) argues that professionals should understand the acculturation process to treat psychological issues more effectively. Respondents said that it can be problematic when mental health professionals lack knowledge on the Surinamese culture and its perceptions on mental health or are not sensitive to the cultural differences. In their view, professionals should also know more about informal care, such as traditional help and self-help practices. Comparatively, for them, it can be beneficial when mental health professionals have an ethnic background themselves. This is so, because for them, having an ethnic background, could make them more culturally sensitive. But in general, the main aim is that professionals are aware of various cultures and perceptions on mental health. The respondents brought some nuance to this cultural challenge and said that in the Netherlands, in big cities such as Amsterdam there is more cultural and ethnic diversity amongst mental health professionals. Similarly, respondent stated that there are increasingly more institutions in mental health care that deal with such cultural differences to close the gap between migrants and mental health care.

The final challenge is that the mental health approach towards Surinamese migrants is too narrow. As stated by multiple respondents, mental health problems can occur because of traumatic experiences or difficult times during the pre-migration, migration and post-migration, which is in agreement with the article of Bhugra and colleagues (2011). Mental health care should not solely be about clinically treating symptoms. In fact, respondents vouched for a holistic approach towards treating migrants, meaning that professionals should understand their past, childhood struggles, acculturation and how that contributed to their current mental state. If mental health care can make such a transformation, this would be positive for Surinamese migrants and migrants in general. In the following two quotes, a respondent illustrates that the mental health care needs to go deeper than for

instance providing medication and dig deeper into the actual causes of issues. Mental health care deserves a massive change from her perspective.

> *"I look at the root cause and work at the root cause level. That imbalance that is manifested is that depression for which you are in mental health care, but what I have learned is that you should go down a layer to that root cause. So mental health care deserves quite a transformation."* (Respondent 7)

> *"We live with a lot of outdated systems that are no longer served at this time and the problem is that we as humans do not transform with it, because if we can transform with it, these types of outdated systems will also change."* (Respondent 7)

4.3 Mental health impact of COVID-19 on Surinamese migrants

The COVID-19 pandemic was an unforeseen event no one could have predicted and has had a major impact on all of us. Considering the fact the data-collection took place during the pandemic, it was almost inevitable to not talk about it during the interviews. It became even more crucial to spend time on the topic as research has shown that the pandemic impacted migrants heavily, as they are incapable of visiting family abroad (IOM, 2020). This is applicable to Surinamese migrants as visiting family in Surinam or the other way around is extremely common. The push and pull factors have shown that families have become quite dispersed as some family members migrated to the Netherlands, whilst other family members stayed in Surinam. In essence, the impact of the COVID-19 pandemic on Surinamese migrants deserved some attention.

The impact was minimal for respondents who have good connections with family and friends here in the Netherlands. Respondents argued that where your family is, your home is.

> *"Surinam… I do not think about that at all now. For me there is no reason to go back because we do not have that much family there anymore. Everyone is here."* (Respondent 12)

Regardless, several respondents found it difficult to not see family on a regular basis, both in the Netherlands and abroad. It remained challenging for some not being able to visit your loved ones. It is characterized as an obstacle, especially by those who are used to seeing family often. Respondents shared that it is becoming more and more exhausting as it seems quite endless.

> *"On the one hand, I find it though because if you suddenly want to go to Surinam, you think oh but if I go, I am taking all kinds of risks and so on, so then you are considering should I go or not. However, I do feel like that freedom must be there and you must be able to ground yourself at home again, which is not the case right now."* (Respondent 3)

Still, respondents have accepted the situation as it is and eventually habituated to it. The majority of the respondents found ways to cope with the pandemic and the loss of social contacts. Respondents said that due to the severity of the pandemic you appreciate the smaller moments in life. Technology is a great tool and has been useful to stay connected with family and friends. Respondents stated that the ability to face-time, call or text others has really helped. Some disclosed that they still try to make time to physically meet up with friends or family, of course with the necessary measures taken. Besides all the measures and precautions, respondents addressed that it is crucial to remain positive.

> *"It is of course a pity that you cannot go to Surinam, but that's the way it is now and it is not just us, it is the whole world. It is truly a world crisis; it is a phenomenon that no one really thought would happen. Never. So, you just have to see how you deal with it, be careful and still take your fellow human into account."* (Respondent 4)

Some respondents believed the pandemic resulted in a self-reflection on humanity as we now see what matters in life. Additionally, it is important to work on your immunity mentally, spiritually and physically.

> *"Corona forced us to sit down, look at how we should do things differently, how we can let go of old things and I think corona is inherent in time. It is not a blessing, but in some ways it has taught us to look at quality of life. How can we stop ourselves, be less selfish and start helping more?"* (Respondent 7)

5. Discussion and conclusion

In this chapter we will reflect on the findings of the qualitative study with help of the theoretical framework. There will be connections made to further understand what the contributions of this study are. Following that, the main research question and the three sub-questions of this thesis will be answered. Sequentially, the shortcomings of this study are presented. At last, there will be several recommendations for future research provided.

5.1 Discussion

In this section we will briefly reflect on the findings of the study through the lens of the theoretical framework. The qualitative research showed that respondents migrated from Surinam to the Netherlands between the 1960s and the 2000s. The general pull factors were education and work, whereas the general push factors were the political instability and corruption in Surinam. These push and pull factors of the respondents are in consensus with the literature, provided by Jubithana-Fernand (2009), Knipscheer & Kleber (2001) and Virupaksha et al. (2014).

Respondents underwent various changes in either one or both cultures, which is part of an acculturation process (Redfield et al., 1936). There are some individual factors related to acculturation such as the willingness of the migrant to change, which can further explain why some respondents have acculturated better than others (Bhugra, 2004). There were four determinants in the acculturation process: the family situation and housing, language, discrimination and the interaction between the Dutch and the Surinamese culture. A strong social network along with good housing made it easier to acculturate. However, interpreting the Dutch language was demanding at the beginning of the post-migration phase. Respondents varied in their experiences with discrimination, which spans from severe discrimination, to subtle discrimination, to barely any discrimination. Finally, the interaction between the two cultures demonstrated that most respondents had integration as acculturation strategy (Berry, 2008; Weichold, 2010). Additionally, Bhugra (2004) expressed that usually one culture dominates the other, but the majority of the respondents was able to balance both cultures by adapting to the Dutch culture and maintaining their original Surinamese culture. For the few respondents who had marginalization as acculturation strategy the Dutch culture held superiority over the Surinamese culture. Therefore, those respondents had some cultural bereavement (Bhugra et al., 2011). This resulted in a positive grieving process, which means that respondents had no mentally distressing symptoms and had a strong social network which made them feel at home.

Next, we explored the impact of migration on mental health. The acculturative stress, formulated by Berry (1992), is common amongst respondents. The impact started at the pre-migration phase, where respondents left the country and started a new life. Moreover, the study confirms the

argumentation that acculturative stress differs depending on the type of acculturing group (Lueck & Wilson, 2011). Surinamese migrants who migrated voluntarily had less stress compared to those whose migration was unplanned and involuntarily. The acculturation process during the post-migration further affected the mental health, as the adjustment to a new country might bring distress. Respondents at a young age were affected less compared to adolescents and adults. The amount of acculturative stress amongst respondents varied based on their social network, which is in line with the notion of Hwang and colleagues (2008). All in all, on the short-term respondents had mental issues, but the majority of the respondents had no harmful long-term mental issues.

Consequently, we paid attention to how respondents perceive mental health which showed that they appreciate good mental health and try to maintain it. Despite all this, in Surinamese culture the topic of mental health is a stigma. According to respondents, mental help-seeking is a taboo and Surinamese migrant have maintained these beliefs. The stigma of mental health care, defined by Gary (2005), and the harms of labelling mentally ill migrants are recognizable in practice. Respondents mentioned that there is both a public stigma and a self-stigma in the Surinamese culture. Those who are mentally ill people might be viewed as less valuable and Surinamese migrants might believe mental health care is not effective. Despite the singular stigma in Surinamese culture, the respondents themselves have changed their thinking on mental health. This can be explained by the acculturation process where respondents changed their beliefs by witnessing how the Dutch culture is very open with respect to mental health care and thereupon there should be no shame on the usage of it. Respondents mention that the stigma can be overcome by spreading information and by seeking help and talking about your issues.

5.2 Conclusion

This thesis commenced with the process of migration and the practicality of this process. We saw that migration affects migrants' mental health in different manners and to different degrees. The cultural adjustment in the new country plays an important role. Uniquely, in ethnic minorities the risk of acquiring mental illness is higher and ethnic minorities are also less likely to seek for mental health care, which can be explained by the stigma. We chose Surinamese migrants as an ethnic minority as qualitative research was lacking as to how Surinamese migrants perceive mental health and the Dutch mental health care system. Consequently, the following research question and three sub-questions were developed: *"How do Surinamese migrants perceive mental health and mental health care and how does this influence their help-seeking patterns facing the Dutch mental health care system?"*

1. *How do Surinamese migrants view mental health and mental health care in general?*

2. *How does the Surinamese culture influence the perception of mental health and mental health care?*
3. *What challenges do Surinamese migrants face when it comes to seeking mental health care?*

To answer the first sub-question, it was essential to acquire the general and unbiased views of Surinamese migrants. The respondents found mental health to be an important topic and believe good mental health is extremely valuable. Respondents indicated they take care of their mental health in various manners. It was stated that good mental health is about developing yourself as an individual. With respect to mental health care, respondents are glad that there is a mental health care system here in the Netherlands, but opinions about the benefits of the system are mixed.

The second sub-question regards the influence of the Surinamese culture on the perceptions of mental health and mental health care. We found that the culture plays a major role and the problematic side of the culture is the stigma of mental health care. Those who make us of mental health care are seen as crazy. The acculturation process in the Netherlands has helped respondents to not view mental health care with a stigma, as a similar stigma, according to them, is not so visible in the Netherlands. Still, some respondents have grown up in households where mental health was stigmatized and therefore it took some time obtain new beliefs and judgments. Respondents made it clear that Surinamese migrants in general still find it difficult to talk about mental health and that in lots of families it still is a taboo.

The third sub-question is about the challenges when it comes to seeking mental health care. The biggest challenge is the stigma itself. Especially Surinamese migrants who have obtained stigmatizing beliefs surrounding mental health care have difficulty with seeking formal help, according to respondents. Respondents formulated three additional challenges. First, mental health care is too bureaucratic. Second, the Surinamese culture does not tie in with the current mental health care approach, meaning that it should be more culturally sensitive. Third, mental health care lacks a holistic approach in treating mentally ill Surinamese migrants. This implies that mental health professionals should not only treat symptoms but also understand acculturation processes and how that influences migrants' mental health.

Now it is time to answer the main question. The respondents value good mental health and the majority is content with the presence of the Dutch mental health care system, yet the experiences with mental health care varied from effective to not effective. There are some challenges to seek help in the Dutch mental health care system itself, but the main challenge remains the stigma of mental health care within the Surinamese culture.

5.3 Research limitations

There are two limitations of this research. First, the COVID-19 pandemic had the implication that only 1 out of 16 interviews took place physically. It was possible to create a safe space with the 8 respondents that the researcher recruited from his own network. This was quite difficult to do with the remaining 8 respondents recruited via the snowball method that the researcher did not know. A relaxed environment is important to share personal experiences, especially because for some migration is not an easy topic to talk about. This environment was difficult to establish digitally because of poor and unstable internet connections, sound issues, not knowing when the respondent is done talking etc. It was difficult to immerse in the stories of the respondents. Also, the recordings of some interviews at times were very poor and therefore some important information might have been missed.

The second limitation is that there were no clear criteria on whether the respondents had experience with mental health care. In order to answer the research question, we only needed the perceptions of Surinamese migrants on mental health care. Fortunately, there was a nice mixture of respondents who used mental health care and those who had not. In hindsight it would have been insightful to see how the perceptions differ between those with experience and those without experience in the Dutch mental health care system. The results might not be any different, but the fact that there was no clear distinction between the two groups made it challenging to draw conclusions on this domain.

5.4 Recommendations for future research

There are two recommendations for future research. As we now know that there is a stigma within Surinamese culture, it is recommended to conduct a research on in-depth experiences of mentally ill Surinamese migrants in Dutch mental health care and whether or not the system was accessible. There should also be a focus on the perceptions of the mental health professionals and how they view the treatment of ethnic minorities, in this case Surinamese migrants, and whether that differs from the native Dutch.

As this research only focused on first-generation migrants, it is recommended to study how the second-generation migrants perceive mental health care. Literature stated that this generation is likely to experience less acculturative stress and respondents shared that the current generation does not view mental health care with a stigma. It would be interesting to see whether or not the stigma is present amongst second-generation migrants. Adding to this, there should be an emphasis on how social media possibly impacted the view on mental health.

References

Berry, J. W. (2008). Globalisation and acculturation. *International Journal of Intercultural Relations; Globalization and Diversity: Contributions from Intercultural Research, 32*(4), 328-336. doi:https://doi-org.eur.idm.oclc.org/10.1016/j.ijintrel.2008.04.001

Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *The International Migration Review, 21*(3), 491-511. doi:10.2307/2546607

Berry, J. W. (1992). Acculturation and adaptation in a new society. *International Migration, 30*, 69.

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica, 109*(4), 243-258. doi:https://doi-org.eur.idm.oclc.org/10.1046/j.0001-690X.2003.00246.x

Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J. D., . . . Tribe, R. (2011). WPA guidance on mental health and mental health care in migrants. *World Psychiatry, 10*(1), 2. doi:10.1002/j.2051-5545.2011.tb00002.x

Boissevain, J., & Grotenbreg, H. (1986). Culture, structure and ethnic enterprise: The surinamese of amsterdam. *Ethnic and Racial Studies, 9*(1), 1-23. doi:10.1080/01419870.1986.9993512

Byerlee, D. (2014). The fall and rise again of plantations in tropical asia: History repeated? *Land, 3*(3), 574-597.

Centraal Bureau voor de Statistiek. (2020). Hoeveel mensen met een migratieachtergrond wonen in nederland? Retrieved from https://www.cbs.nl/nl-nl/dossier/dossier-asiel-migratie-en-integratie/hoeveel-mensen-met-een-migratieachtergrond-wonen-in-nederland-

Corrigan, P. (2004). How stigma interferes with mental health care. *The American Psychologist, 59*(7), 614-625. doi:10.1037/0003-066X.59.7.614

Davis, N. Z. (2009). Creole languages and their uses: The example of colonial suriname. *Historical Research, 82*(216), 268-284. doi:10.1111/j.1468-2281.2009.00494.x

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of southeast asian refugees. *Social Science & Medicine (1982), 33*(6), 673-680. doi:10.1016/0277-9536(91)90021-4 [doi]

Games, A. (2015). Cohabitation, suriname-style: English inhabitants in dutch suriname after 1667. *The William and Mary Quarterly, 72*(2), 195-242.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*(10), 979-999. doi:10.1080/01612840500280638

Harrell, M. C., & Bradley, M. A. (2009). *Data collection methods. semi-structured interviews and focus groups.* Retrieved from https://apps.dtic.mil/docs/citations/ADA512853

Hwang, W., Myers, H. F., Abe-Kim, J., & Ting, J. Y. (2008). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. *Clinical Psychology Review, 28*(2), 211-227. doi:https://doi-org.eur.idm.oclc.org/10.1016/j.cpr.2007.05.001

International Organization For Migration. (2020). Migrants and COVID-19: How to take care of mental health. Retrieved from https://rosanjose.iom.int/SITE/en/blog/migrants-and-covid-19-how-take-care-mental-health

Jones, R. (1995). Why do qualitative research? it should begin to close the gap between the sciences of discovery and implementation. *BMJ: British Medical Journal, 311*(6996), 2-2. Retrieved from www.jstor.org/stable/29727943

Jubithana-Fernand, A. (2009). International migration in suriname. *Migração Internacional Pan-Amazônia Na,* 185.

Kallio, H., Pietilä, A., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing, 72*(12), 2954-2965. doi:10.1111/jan.13031

Klaufus, L. H., Fassaert, T. J., & De Wit, M. A. (2014). Equity of access to mental health care for anxiety and depression among different ethnic groups in four large cities in the netherlands. *Social Psychiatry and Psychiatric Epidemiology, 49*(7), 1139-1149.

Knipscheer, J. W., & Kleber, R. J. (2001). Help-seeking attitudes and utilization patterns for mental health problems of surinamese migrants in the netherlands. *Journal of Counseling Psychology, 48*(1), 28-38. doi:10.1037/0022-0167.48.1.28

Lueck, K., & Wilson, M. (2011). Acculturative stress in latino immigrants: The impact of social, socio-psychological and migration-related factors. *International Journal of Intercultural Relations, 35*(2), 186-195. doi:https://doi-org.eur.idm.oclc.org/10.1016/j.ijintrel.2010.11.016

Mena, F. J., Padilla, A. M., & Maldonado, M. (1987). Acculturative stress and specific coping strategies among immigrant and later generation college students. *Hispanic Journal of Behavioral Sciences, 9*(2), 207-225. doi:10.1177/07399863870092006

Mortelmans, D. (2018). *Handboek Kwalitatieve Onderzoeksmethoden* (5de editie). Leuven, België: Acco.

Nadeem, E., Lange, J. M., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and U.S.-born black and latina women from seeking mental health care? *Ps, 58*(12), 1547-1554. doi:10.1176/ps.2007.58.12.1547

Nelson, A. (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. *Journal of the National Medical Association, 94*(8), 666.

NU.nl. (2021). Vooral welzijn jongvolwassenen, studenten en migranten daalde door corona. Retrieved from https://www.nu.nl/coronavirus/6119354/vooral-welzijn-jongvolwassenen-studenten-en-migranten-daalde-door-corona.html

Oudhof, K., Harmsen, C., Loozen, S. & Choenn, C. (2011). Omvang en spreiding van surinaamse bevolkingsgroepen in nederland. Retrieved from https://www.cbs.nl/nl-nl/achtergrond/2011/27/omvang-en-spreiding-van-surinaamse-bevolkingsgroepen-in-nederland

Peterson, B. L. (2017). *Thematic analysis/interpretive thematic analysis.* doi:10.1002/9781118901731.iecrm0249

Redfield, R., Linton, R., & Herskovits, M. J. (1936). Memorandum for the study of acculturation. *American Anthropologist, 38*(1), 149-152. doi:https://doi-org.eur.idm.oclc.org/10.1525/aa.1936.38.1.02a00330

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Null, 11*(1), 25-41. doi:10.1080/14780887.2013.801543

Van Amersfoort, H. (2011). *How the dutch government stimulated the unwanted immigration from suriname.* International Migration Institute.

Virupaksha, H. G., Kumar, A., & Nirmala, B. P. (2014). Migration and mental health: An interface. *Journal of Natural Science, Biology, and Medicine, 5*(2), 233. doi:10.4103/0976-9668.136141

Weichold, K. (2010). Introduction to mobility, migration, and acculturation. *International Society for the Study of Behavioural Development, 2*(58), 1-6.

Appendix

Appendix A: Topiclist

Topic	Content
Introduction interviewer	- Personal introduction - Short explanation research and anonymity
Introduction respondent	- What is your age? - What does your day-to-day life look like?
Migration background	- What is your ethnic background? - When did you come to the Netherlands? - Why did you migrate to the Netherlands? (i.e. pull and push factors) - Was it hard to migrate? - Did you experience problems with migration and if so, how did it affect you? - How was the adjustment to the new country and culture? - Did you face discrimination?
Life situation in the Netherlands	- What is your current family situation and where does your family reside? - Do you still face problems with adjusting to the Netherlands and the culture? - How are you managing today regarding living in the Netherlands?

Mental health care and seeking mental health care	- What are your first thoughts when it comes to the Dutch mental health care system?
	- When does it become a necessity to seek mental health care?
	- Do you have any experience with the Dutch mental health care system?
	  o If yes, what is your experience?
	  o If not, do you think it could benefit you? Would you even consider to use it or is it not needed?
	- Have you experienced or can you name barriers when it comes to seeking mental health care?
	- Do you believe the Dutch mental health care system is easily accessible to Surinamese migrants?
	- How can the Dutch mental health care system improve as a whole?

Mental health (sensitive topic!)	- How do you view mental health? - Do you find mental health an important aspect of life? - How would you describe your mental health? - Have you had any mental problems? - Are there things you do to work on your mental health? - Do you think the migration process has affected your mental health? - Do you think that being a Surinamese migrant impacts your mental health more than the mental health of a native Dutch?
Culture	- What was your experience as to maintaining your Surinamese culture whilst adapting to the Dutch culture? - Did one of the cultures hold superiority over the other? - How does the Surinamese culture view mental health care? And does this differ from the Dutch culture? - Does your culture influence your mental health in a positive light? - Do you think there is a shame (i.e. stigma) around mental illness and using mental health care within the Surinamese and/or Dutch culture? o If yes, what kind of stigma do you face? Why do you think there is a stigma (e.g. provide examples)? What should be done to reduce the stigma? o If not, what makes you think that? - Should there be a cultural change with reference to mental health?
COVID-19 (only if applicable)	- How long have you not seen your family in your home country due to COVID-19? - How does not being able to visit your family impact your mental health?
Closing	- Do you still have something you want to say? - Thank you for your time!