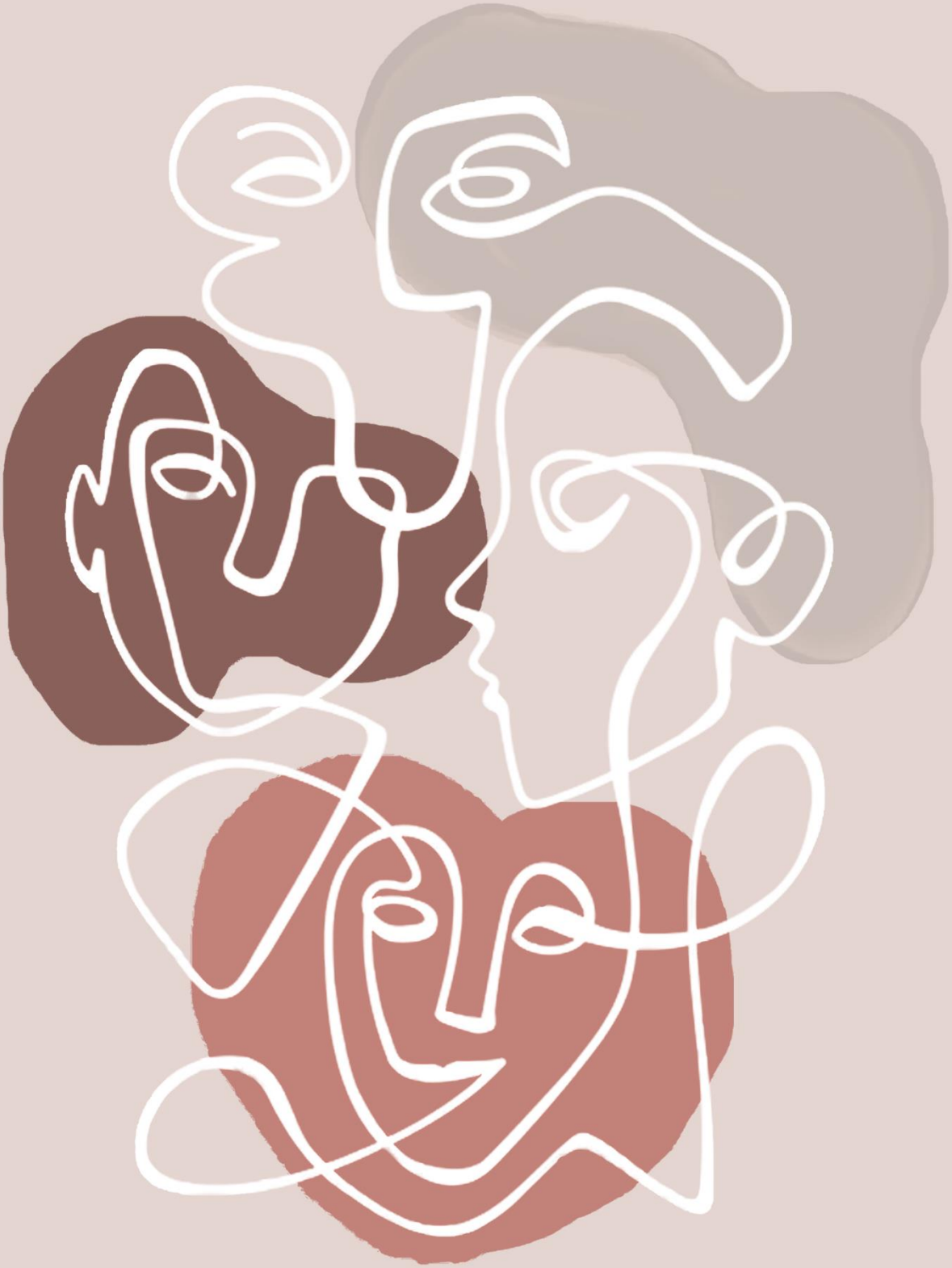
NEVER THE TWAIN SHALL MEET?



UNDERSTANDING HOW DIFFERENT NOTIONS OF MENTAL HEALTH AND TREATMENT SHAPE THE ACCULTURATION PROCESS OF SYRIAN REFUGEES IN THE NETHERLANDS

LAURE ANDRIESSE

Title + Image FrontPage [1]

[1] The title refers to the winged phrase "East is east and west is west, and never the twain shall meet" from the poem *The Ballad of East and West* by the British poet Rudyard Kipling. The image on the frontpage is designed by my sister, Roos Andriesse. Date: 27-07-2020, Amsterdam.

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Master Thesis, Cultural Anthropology: Sustainable Citizenship 2019-2020

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ACKNOWLEDGEMENTS

Anthropologists with experience in the field probably all know the struggle of the first few weeks of doing fieldwork: you feel overwhelmed, lonely, under-prepared; you just feel very lost. However, after some time you start to accept or even expect the unexpected, adjust to your field and build more and more valuable research relations. It is this moment where it feels like things finally begin to roll, that the research you were preparing for so long finally started. It was at this exact moment when the ongoing pandemic of COVID-19 was spreading, became the centre of attention worldwide and started to affect the lives of people all over the world in many different ways. While being thankful and feeling privileged of living in a society where health care quality is very high, the government provides different forms of support, and finding myself in a place where I can safely distance myself from being infected by the virus, the crisis certainly altered my personal and social life and affected my research. And even though instability seems the one thing stable about ethnography and most anthropologists are not only resigned to the fact of instability but even revel in its possibilities, the instability that the current crisis entails is of a totally different scale. Considering the context and timeframe in which the research and writing process were conducted, I am even more proud of the final result of this thesis.

However, this would not have been the case without the help of many people. First, I would like to thank all my participants. My Syrian participants, for their warm welcomes, for trusting me, taking time for me, and sharing their stories with me. I admire their strength, their motivation and resilience and feel honoured to have been able to meet them and learn so much from them. Unfortunately, corona interrupted the face-to-face encounters, but I cannot wait to visit them again to properly thank them while enjoying the most delicious local delicacies they always made for me. Furthermore, I would like to thank my Dutch participants for being so enthusiastic and helpful, and providing me with a lot of interesting data. I have a lot of respect for the work they do. Last but not least, I would like to thank my supervisor, Joost Haagsma, who has guided me with much devotion and enthusiasm through the whole process. Since I have been through some difficult times with my family this year, which made it quite hard to focus on my studies at times, I also want to thank him for being so flexible and understanding. His trust and critical feedback contributed a lot to the final result of this thesis.

1.

INTRODUCTION

The ongoing war in Syria has caused the largest refugee displacement crisis of our time. Since March 2011, nearly half of the population has been displaced and had to seek safety in countries elsewhere, including the Netherlands (UNHCR 2019). Conflict-affected populations are at an increased risk of mental disorders due to frequent exposure to potentially traumatic events, multiple losses, breakdown of supportive social networks and accumulation of daily life stressors related to refugee life (Miller and Rasmussen 2010; Silove et al. 2016; Steel et al. 1999). In response, the provision of appropriate and specialized mental health care for the victims of organized violence has become a major focus of concern. These developments appear very ethical in nature: what could be more right and proper then offering help and treatment to those who have suffered so terribly at the hands of their fellow men? The fact that care should be provided is, fortunately, increasingly accepted, but considerable controversy has arisen about the kind of care that is necessary and needed (Ingleby 2005; Kleinman and Benson 2006; Bracken, Giller and Summerfield 1997; Pupavac 2001).

"Western" assumptions, models and approaches which initially informed mental health care provision for displaced persons, refugees and asylum seekers have been the subject of a sustained and growing critique. Much of this critique has focused on the way in which Western psychiatric categories have been ascribed to refugee populations in ways which pay little attention to the personal, social, cultural, political and economic factors that play a central role in refugees' experience. Rather than portraying refugees as 'passive victims' suffering from mental health problems, critics have argued that attention should be given to the resistance and strength of refugees and the ways in which they interpret and respond to situations, challenging the external forces bearing upon them (Ingleby 2005; Kleinman and Benson 2006; Bracken, Giller and Summerfield 1997; Pupavac 2001). Also the development of so called culturally sensitive mental health intervention or cultural competency, which is intended towards developing a greater sensitivity to culture in general and a deeper understanding of particular cultural groups and their values, norms, social practices, health beliefs, and health practices, has received a lot of criticism, both in the social and academic field.

In addition, recent studies provide evidence that refugees, and Syrian refugees

specifically, are less likely to seek professional care, exhibit higher rates of drop out and lower rates of compliance to treatment compared to their native counterparts (Cetrez and Balkir 2017). Such treatment gap might be partially due to the fact that individuals from Middle-Eastern cultural backgrounds often have different conceptualizations and understandings of mental illness and appropriate healing strategies, as defined by their own social and cultural context, which can be different from those found in European and Western societies (Vignoles et al. 2016; Cetrez and Balkir 2017; Hassan 2015; Ashy 1999). Other reasons for this treatment gap might be due to socio-cultural problems, such as language barriers, discrimination, feelings of shame or taboo, difficulties making the cultural adjustment but can also be the result of a lack of social support, a low socioeconomic status, uncertainty about the future, etc (Neftçi and Çetrez 2017; Hassan 2015). Nevertheless, in order to heal from the past, live a safe, balanced and content life, being able to build healthy relationships and participate in society, one's mental condition is of great importance, which indicates the interrelatedness between mental health and the acculturation process, generally defined as the way people adapt to living in a new cultural environment (Berry 2005, 2015).

However, acculturation can be conceptualised in different ways. Acculturation can be seen as a unidimensional construct, with more cultural adaptation indicating less cultural maintenance (Gordon 1964; Ryder et al. 2000), but also as a bidimensional construct, evaluating cultural adaptation and cultural maintenance as two comparatively independent dimensions. From this perspective, acculturation can be conceptualised in terms of four acculturation strategies: integration, separation, assimilation and marginalization (Berry 2005; Berry & Sabatier, 2011). However, since both my fieldwork and literature expressed that levels of acculturation can vary over life domains/aspects, which can be subdivided into participation in the new society (skills, language, social integration) and cultural maintenance of the culture of origin (traditions, religion, norms/values), this research will consider acculturation as a multidimensional construct, which is in line with the definition of Berry et al. (2005) stating that acculturation can be considered as "the multidimensional process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (698).

Drawing on different studies researching the connection between mental health care, migration and the degree of acculturation, mainly arguing that the well-being of refugees may be affected by policies of the national state, including areas of public health care, this research aims to understand how the interaction between the Dutch mental health care system and traumatized Syrian refugees is (re)shaping their personal and social-wellbeing, which is

inextricably linked to the development of their acculturation process in the new society. Linking this to the discussion on how different systems of knowledge, belief and practice determine what makes up the person (the self) and the world, and thereby affect conceptualizations and understandings of the processes of mental illness and healing, led to the following main research questions of this thesis:

> *"How do differences between the perception of Dutch psychosocial practitioners and displaced Syrian adults about belief systems and practices of mental health affect the acculturation process of Syrian refugees in the Netherlands?"*

In order to answer this question I placed the societal debate, which is discussed above, in a more academic perspective and explored the concepts of mental health and trauma (related to forced displacement) in relationship to the concepts of 'identity' and 'self', concepts that tend to be approached separately in anthropological discourse. This interest derived from examining the meaning of the concept of trauma and its relatedness to the mental condition/wellbeing of my research population: Syrian refugees in the Netherlands. Researching trauma from an anthropological perspective, Sztompka (2000) makes a valuable contribution by stating that trauma is both a collective and cultural phenomenon and thereby a 'social fact', since it involves cultural interpretation of potentially traumatizing events or situations experienced by a group, community, or society. So, if we think of 'trauma' as a relational injury, as a social and cultural construct, rather than a purely intrapsychic or structural one, we can see that through human relationships, a traumatized person can reconnect to the world. Although this way of approaching the complex and multi sided concept of trauma turned out to be valuable during my fieldwork, the idea of trauma being a collective experience, on the other hand, can increase the sense of 'otherness' and affect how refugees are being identified and self-identify with regards to their past. As a result, individuals' status as a traumatized, damaged refugee oftentimes becomes the defining characteristic, over and above other important aspects of personhood, identity, agency, and action.

Understanding how to transform mental distress into mental wellbeing is part of the personal adaptation process for refugees, just as understanding immigrants' diverse conceptualizations and mental health needs should be part of the social adaptation process for health care practitioners and institutions. Little available research provides insights into transformative social processes underlying immigrant mental health and adaptation however, as most research focuses on measurable risk factors instead. Also anthropological interest in forced displacement has seldom focused specifically on mental health, but instead has explored

social and cultural determinants of mental health, such as identity formation and citizenship (Ong 1996) or political experiences of conflict and trauma among refugees (Simich, Maiter and Ochocka 2009; Muecke 1992). Growing academic interest in transnationalism has enhanced appreciation for the ambiguous and the contradictory, often alienating, processes through which migrants cope with changing social and cultural environments and identities (Daniel 1997; Foxen 2007, 18), but rarely aim to uncover qualitative refugee 'illness experiences', understandings, or subjective responses to mental distress.

Always being fascinated by the phenomenon of forced migration and impressed by the resilience and strength of people who have to build a new life entirely from scratch, my need to hear the stories of those fleeing themselves grew and resulted in choosing this research population for my research. Something I was aware of before starting this research, but which became only confirmed and strengthened during my fieldwork is the fact that refugees are often seen as a homogenous mass and made out to be somebody they are not. Since there is so much discussion going on in our daily social and political lives concerning refugees, asylum procedures, residence permits, integration policies, and so on, but rarely hear from those fleeing themselves, this research aimed to give voice to those people, to genuinely listen to their stories; to see the person in the refugee. With regards to the theoretical debate, the meaning of the concepts of identity and the self within the context of this research will be examined and connected to the notions of belonging and citizenship. The concept of belonging offers a way to ground the relationship between (forced) migration and identity and stretches, as this thesis will present, across place and time. In the case of migration, citizenship can be seen as a marker of belonging, but at the same time raises questions about how immigrants' experience of attachment to the host nation is affected by the host country's approach to citizenship (of which the mental health profession is part). All concepts, which will be conceptualized and discussed throughout all chapters of this thesis, contribute in answering the main research question.

This thesis consists of several empirical chapters (chapter 3, 4 and 5), in which the theoretical framework and empirical data will be presented. The first chapter researches, without stereotyping individuals and defining and constraining their behaviours and belief systems according to their cultures, how Syrian refugees in the Netherlands determine what makes up the person (the self) and how they explain and make sense of their mental condition, including how their condition affects them and their social environment, and what they believe is appropriate treatment. By taking a closer look at cultural and religious systems of knowledge, belief and practice, which provide explanatory frameworks for illness that include ideas about causality, course and appropriate treatment, the chapter aims to create a better understanding of

the perspective of this Syrian group of people when it comes to mental health and in turn, will present where and how this perspective differs from the understandings of Dutch approaches and explanatory models of mental health and psychosocial wellbeing. Subsequently, de second chapter will focus more on the 'special' approaches and programmes providing mental health care for refugees and victims of violence. Before addressing underlying fundamental issues, there are some very practical limitations help seeking patients are facing, such as finding a way and understanding the complex and multi-layered structure of the Dutch health care system, stigmatization and the structure of expectations about the therapeutic interaction. Besides, the chapter will discuss the notion of cultural competency and represent how being portrayed as part of culturally homogeneous categories, a victim or a traumatized person influences how people (re)shape their understandings of selfhood, identity, and notions of belonging. Finally, the last chapter will examine the multidimensional and complicated relationship between mental health and acculturation, demonstrating that refugees are in a position to reconstruct their social identities and reinvent their notions of the self, but at the same time are restricted by the parameters of opportunities, services and attitudes of the new social context, including sites and settings of mental health care. In the concluding remarks I have integrated my research findings and connected these to the most important theories and debates, while also parallels and deviations are discussed, followed by the answer on the main research question.

The research is based on extensive literature research and ethnographic fieldwork conducted in the Netherlands from the last week of January (2020) until the second week of May (2020). However, due to the unexpected and rapid outbreak of the COVID-19 virus at the end of February, the circumstances under which the fieldwork and the thesis writing process have been conducted are very different from previous years of fieldwork projects as part of this Master's program. However, even though it took quite some effort, imagination and flexibility to customize the research project in such a way to stay close to the original research aim and questions, this thesis proves that I have been able to continue and finish the research. The next chapter of this thesis will elaborate more on how the virus affected the research and which alternatives were found to complete the process. My research population consists of displaced Syrian adults living in the Netherlands for at least one year, but ranging from age, gender and social, economic, religious, and political background. This wide variety of characteristics can be considered as a limitation for this research, but on the other hand supports one of the arguments I want to make with this thesis, namely that notions of cultures, groups of people and identities are dynamic, heterogeneous, and with blurred boundaries. Since my research focusses on the differences between 'Syrian' and Dutch belief systems and practices of mental

health (and its consequences for the acculturation process), other agents that were part of my research population consists of Dutch psychosocial practitioners working with refugees.

2.

RESEARCH METHODS: DOING FIELDWORK IN TIMES OF COVID-19

The outbreak of COVID-19, also known as the coronavirus, has been at the centre of attention worldwide and has been affecting the lives of people all over the world in many different ways, including the way scientists are working. Also the discipline of anthropology did not escape the current crisis unscathed. The kinds of field methods for which anthropology is so famous have become largely impossible and the relevance of the kinds of questions I and my fellow students were in the midst of asking have been cast into doubt. Running like a thread through these quandaries are questions of ethics: given the scale of the crisis, and its impact on those who participate in our research, what is the point of anthropological work? The first weeks after the first confirmed positive test for the virus in the Netherlands and all measures taken afterwards, I was struggling with the situation a lot. Since I really wanted to continue my research and actually was not yet aware of the impact and the magnitude of the crisis that awaited us, I was still making appointments with all kind of different people within my research field. A bunch of interesting appointments were scheduled, but when the importance of the social distancing approach became increasingly clear, I, and other people with me, realized that we had to take another direction. We found, and still find ourselves in very different circumstances, and this requires flexibility and the ability to adapt and come up with creative solutions when it comes to our researches.

Ethnographic research is traditionally known for its in-depth analysis, for the 'deep hanging out' (Geertz 1998) and the 'thick description' (Geertz 1973) it provides. Ethnography has changed overtime, and its methods adapted to new circumstances too. The meanings and boundaries of the field have transformed, especially with the development of new technology, allowing the researcher to 'being there' without necessarily 'being there' (Craith and Hill 2015). As 21st century ethnographers we are hardly expected to move and live with 'unknown' communities for a prolonged time, as in the traditional ethnographic framework inherited from Boas and Malinowski, just to cite two. Alternative methodologies, such as multi-sited 'netnography' (Kozinets 2006) 'yo-yo fieldwork'(Wulff 2002) are becoming more popular among ethnographers. Virtual interviewing, emails, video conferences and the likes seem to be

the new frontier of ethnographic research methods and became even more relevant in times of corona where much of the world's population are advised to avoid face to face contact with other people. Continuing my research, after using several qualitative research methods such as participant observation, hanging out, informal conversations and several types of interviewing in the 'offline' world, I mostly used virtual interviewing and WhatsApp to stay in contact with my participants during the 'intelligent' lockdown. Regarding those methods I have mixed feelings and experiences. Even though I had some very interesting interviews through Skype and Zoom and I received a lot of valuable data through mail and WhatsApp, I have to admit that it definitely is not my type of doing research. As I was getting more involved in my fieldwork, I became more and more enthusiastic about the whole range of sensations which I was experiencing in my ethnographic encounters. I was received so warmly and kind, by so many people, informants invited me for traditional family dinners, entrusted me their most intimate and painful life stories and showed me the enormous resilience that people can have after experiencing such traumatic events as they had been trough. With time, the relationships with my participants grew and developed and thereby enriched my fieldwork data. Gaining trust and building a relationship with people who are exposed to incredibly stressful and traumatizing experiences and have difficulty with expressing themselves in Dutch or English, really requires an approach of time, attention, and trust. In my view, those aspects are more difficult, if not impossible to reach without a physical encounter. Besides, some of my participants did not even want to participant in the research anymore (both offline and online), because they experienced (and still experience) increased stress because of the outbreak of the virus. Some of them because they worry about family living in refugee camps or other places where the virus is hard to control , others because the strict measures put in place to fight the COVID-19 pandemic, including social distancing and self-isolation, caused significant emotional distress and triggered memories of traumatic events of the past. Observing those sentiments, made me feel uncomfortable and even a bit embarrassed about my research. So instead of pushing through certain interview questions, I tried to comfort and listen to what my participants wanted to share when they reached out to me. Even though I collected fewer specific data with regards to my research topic because of this approach, it felt like the most ethical and right thing to do at that time.

On the other side, the virtual interviews with the Dutch psychosocial practitioners appeared to be very effective, given that we shared the same language and discussed very concrete (and less intimate/sensitive) topics and were not distracted by outside factors. In this case my interview guide included a list of questions and prompts in order to increase the likelihood that

all topics were covered in each interview in more or less the same way (O'Reilly 2014, 148). However, I still believe that a significant part of the data we collect during our fieldwork comes from contextual sides. It is not only interviews and conversations helping us to answer our research questions, there is so much information 'hidden' in body language, the way people interact with their environment, how houses are decorated, what people eat and drink, and so on. This type of doing research, with the aim of generating a range of experiences, views and/or responses, also emphasises the notion of how people react to something in interaction; how meaning is created in groups (O'Reilly 2014, 134). When it was not appropriate anymore to physically meet my participants, I noticed that the data I gathered online felt less 'lively' and dynamic, especially with regards to my Syrian research population. Even though those new methods of doing research also have their advantages and taught me a lot about how to approach people and how to prepare and structure interviews in a different way, it still feels like a loss for my research. For me, anthropology is nothing without ethnography and ethnography feels like an empty practice without the researcher participating in the setting or with the people being studied.

To conclude, this research, that is conducted in very turbulent and uncertain times, is based on both face-to-face and more remote, desk-based fieldwork, including different methods and techniques. Since it was not an option to visit and participate in for example psycho-social education programs at several refugee centres, therapy sessions, meetings of Syrian people in community centres, and so on, an extensive literature study was needed to complement and continue the research. Besides, although my Syrian participants provided me with a lot of valuable data regarding their understandings, perceptions and opinions about the Dutch mental health care system, none of them actually participated in long term mental health care interventions. Therefore, when reading this thesis, it is important to realize that it was not the aim of the research to make statements about the direct effect of mental health care on the acculturation process of Syrian refugees. Instead, it investigates how differences between the perception of Dutch psychosocial practitioners (which are also represented and radiated by wider societal levels within the Dutch community) and displaced Syrian adults about belief systems and practices of mental health, affect their acculturation process. Ultimately, this research is based on 11 qualitative interviews, with 11 different informants (7 Syrian informants and 4 Dutch psychosocial practitioners working with refugees), numerous informal conversations (face to face, on WhatsApp and by phone calls) and extensive literature research. Four of the qualitative interviews were conducted online, by means of Zoom and Skype. All those sources combined, enough qualitative and relevant data is generalized in order to properly

answer the main research question of this thesis. However, is must be said that the outcomes, scope and meaning of this research are certainly shaped by the COVID-19 outbreak.

3.

"MY SOUL IS CRYING": MAKING SENSE OF EXPERIENCE THROUGH CULTURAL FRAMEWORKS OF MENTAL HEALTH AND COPING MENCHANISMS

From its early roots to its current political instability and the Civil War, the region that is now called Syria was populated by people from very diverse ethnic and religious backgrounds, and has served as a haven for a diversity of groups fleeing persecution and conflict all around the world (Chatty 2010). Between 1850 and 1950, Syria received several million forced migrants from borderlands with the Imperial Russian and Ottoman Empires. As World War One came to an end as many as half a million Armenians found shelter in Syria among their fellow religionists. Then, when in 1923 the modern, secularist Republic of Turkey was established, about ten thousand Kurds fled to Syria and in the late 1940s, Syria provided safe haven for over hundred thousand Palestinians fleeing the 'Nakba' and the creation of the state of Israel. During World War II, British and French troops occupied Syria, but shortly after the war ended, Syria officially became an independent nation and became a place where hundreds of thousands, if not millions ethno-religious minorities uprooted from their homelands as a result of war found refuge. Even in the early 21st century, Syria admitted over several million refugees from Iraq, Afghanistan, Sudan, Somalia, and Eritrea (Chatty, 2010; Chatty, 2017). Then, a decade into the 21st century, Syria experiences extreme violence because of the civil war that grew out of a wider wave of the 2011 Arab Spring protests. This ongoing multi-sided war fought between the Ba'athist Syrian Arab Republic led by Syrian President Bashar al-Assad and various domestic and foreign forces combating both the Syrian government and each other, triggered a displacement crisis of a massive scale. The speed with which nearly 20% of Syrian population left the country shocked the world and left humanitarian aid regimes struggling to react to the displacement crisis on Syria's borders and elsewhere around the world (Hassan et al. 2015).

Given Syria's complex and tumultuous history, which experienced massive displacement of all kind of groups, it is very difficult to determine the ethnic and religious composition of the current Syrian population, and thus of the Syrian refugee population based in the Netherlands. Before starting this research I had no idea about the wide diversity of social, socioeconomic, ethnic, and religious backgrounds among the Syrian refugee population, but

my informants showed me, in all kind of different ways, how history, context and cultural, social, political and religious backgrounds differ, matter and how they influence, besides many other aspect of life, explanatory models of mental distress, coping mechanisms, and help-seeking behaviour. This data reflects the anti-essentialist paradigm of culture, which is said to "appeal to the view that cultures are discrete, frozen in time, impervious to external influences, homogenous and without internal dissent: that people of certain family, ethnic or geographical origins are always to be defined by them and indeed are supposed to be behaviourally determined by them" (Modood 1998, 379). This chapter represents the broad variety of data my participants provided me with, but at the same time focusses on the remarkable similarities they share, specifically in terms of how one's mental representation of his or her own person and personality is part of the repertoire of declarative knowledge on which one draws to guide his or her appearance, characteristic beliefs, motives, values, attitudes and behaviours, and their social interactions with other people. So without stereotyping individuals and defining and constraining their behaviours and belief systems according to their cultures, this chapter aims to create a better understanding of how Syrian refugees determine what makes up the person (the self) and how they explain and make sense of their mental condition, including how their condition affects them and their social environment, and what they believe is relevant and effective treatment. By doing this, this chapter deals with the question of how to get closer to the perspective of this group of people, which will allow better communication and positive development of mental health and psychosocial support for Syrian refugees in the Netherlands.

3.1 "SYRIAN" CONCEPTS OF THE PERSON

As discussed above, historical, religious, ethnic and social dynamics all contribute to shaping Syrian identity and views of the person and the relationship of the person to the world. Concepts of the person shape how people experience and express suffering, how they explain illness and misfortune, and how they seek help. In order to understand how experiences regarding those topics are understood, it is important to explore the relationship between the concepts of "identity" and "self". The concept of "identity" has undergone a paradigmatic shift in recent decades and was in anthropology mostly used in the context of "ethnic identity" (Sökefeld 1999). Here identity points to the sameness of the self with others, or in other words, to a consciousness of sharing certain characteristics (place, language, culture, etc.) within a group. This consciousness made up a group's identity. As described by Madsen and van Nearssen (2003), these understandings were complementary rather than contradictory and fitted well

together, as the group to which a person belonged formed an important part of the social environment in which and through which personal identity was formed. Today, this conceptualization of identity in the sense of a social, shared sameness is often discussed with reference to a process of drawing difference, of distinguishing oneself from others (Brettell and Sargent 2006). Cross-border migration or, as in the context of this research, forced displacement, is in many ways related to those processes of dialogical identity formation, since borders ideally delineate and signify different identities on both sides of those borders and the projection of countries as significant cornerstones of identities (Tseng 1999). Over time, refugees undergo a complicated process of identity reformulation and occupy multiple subject positions, some of which they define for themselves and some of which are defined for them. In a classis article on culture and the self, Markus and Kitayama (1991) call for the establishment of a closer connection between the concepts of "identity" and "self", arguing that the traditional anthropological approach write easily about the identity of those they study in the sense of something shared with others, but seem to have more difficulty in attributing a self to the people they are studying. Debating the relations between identity, the self and culture, Sökefeld (1999, 424) contributes to this understanding by considering this denial "a result of the absence of Western attributes of the self among the non-western subjects and the assignment to them of an identity, a shared self, instead of individual selves." Sökefeld is of the opinion that the concept of self has emerged as an important element of culture and identity in the post-structuralist deconstruction phase, in which identity is no longer shared but plural. In this sense, to understand the actions of individuals with a plurality of identities we have to understand the self (Sökefeld 1999). My fieldwork taught me that culture, identity and self are complementary concepts that have to be understood in relation to one another in order to avoid the reification of one or the other. Besides, my research shows the struggle to act and to present oneself as a consistent self in a situation and context of plural and contradicting identities, but at the same time states that we must study the self if we want to study a cultural identity (in this case the 'Syrian' one), an approach that appeared to be particularly relevant when studying the sensitive and 'personal' topic of mental health.

Where the concepts of identity and the self tend to be approached as one and the same in "Western" discourse, pointing to the basic meaning of identity that can refer to both collective identification and self-identification of individuals, my participants presented a different and more separate image of how they construe themselves. The following quote of one of my

participants clearly shows how the distinction between the concepts of identity and the self is perceived, hereby nicely capturing the overall sentiments that many of my participants share[2]:

> *"Identity is the part we cannot change, for example that my name is Nisa, that I am 26-year-old women and that I am from Syria. But Nafs (the self) is a variable factor, it determines what makes you you, it is about the things you love, but also about the things you fear, about how you interact with everything and everyone in the outside world."*[3]

This concept of *Nafs* interacts with the mind (*Aql*), the body (*Jism*), the soul/spirit (*Ruh*) and the word (*Kalimah*) and together compose the existence of a human being. Despite one's religious and socio-cultural background, a harmonious relationship between these different parts is generally deemed necessary in order to maintain healthy, both psychically and mentally (Ashy 1999; Hassan et al. 2016).[4] This idea of an interdependent relationship between the mind, the body, the soul, the self and the world, which directly affect each other and cannot be separated, is very different from the Western mind-body dualism. The core or the point of union between the above concepts and the *Nafs* is the *Qalb*: the heart, which is a non-material principle and the essence of the self. Since the heart is seen as the core of the self, the heart has its diseases too*: "The heart can be surrounded by layers so light cannot pass it, it can be locked or blocked, separated from the truth, the world and from others"*[5]. The heart is the place of extreme terror, but also the site of love and the place of understanding. Emotional distress is considered located in the heart, rather than the head, and the heart is perceived at the essence of human psychosomatic health. Therefore, imbalance, disharmony or conflict in the heart is often intertwined with mental illness, a belief that is mostly religious in nature.

During my fieldwork, religious value systems turned out to play a significant role in the understanding and the manifestation of the person. According to the World Factbook (2019), 87% of Syrians are Muslim, of which the majority is Sunni Muslims (74%). A further 13% are Shi'a Muslims, following the Alawite (11%), Ismaili (1%) or Twelver Imami (0.5%) sects. Christians constitute an additional 10% of the population with the remaining 3% being a combination of Druze, Jews and atheists. Even though Syrians are often categorised according

[2] Anouar, informal conversation 17-02-2020; Isra, informal conversation 16-04-2020; Yusur, interview 19-02-2020; Yarah, informal conversation 20-02-2020 + interview 28-02-2020; Safae, interview 06-03-2020; Hajar, interview 11-03-2020; Imran, interview 10-03-2020

[3] Nisa, interview 24-02-2020

[4] Anouar, informal conversation 17-02-2020; Isra, informal conversation 16-04-2020; Yusur, interview 19-02-2020; Yarah, informal conversation 20-02-2020 + interview 28-02-2020; Safae, interview 06-03-2020; Hajar, interview 11-03-2020; Imran, interview 10-03-2020

[5] Yarah, informal conversation 20-02-2020

to their religious affiliation, this does not necessarily mean an individual is devoutly religious, or an active practitioner. However, meeting all kinds of people with all kinds of different backgrounds and beliefs, I found a threat in how most of them conceptualize the concept of the person, in which religion plays a significant role. Bringing together and analysing the data I received from my Syrian participants, the concept of the person can be characterised as 'sociocentric' and 'cosmocentric', meaning that each individual can be seen as linked to every other creature created by God, including the more spiritual world of angels and other souls. This connection is symbolised by the double dimension of every individual: a universal dimension that is governed by the will of God and a social dimension governed by social rules of conduct and coexistence (Hassan 2015; Ashy 1999).[6] This universal dimension that is governed by the will of God has different meanings and can be found in every aspect of life. So, what most of my participants believe is that God not only created man, but also determines one's fate and destiny:

> "*That's how God works. He has plans, and He would love for us to follow His plan exactly, but sometimes we make the wrong choices. That is what consequences are for. They help bring us back to the path God wants us to be on — if we are receptive to it."*[7]

However, an interesting insight here is that, unlike the Christian religion where the weight is on a preordained set of events already set in stone, the Muslim idea of fate takes the form of destiny, where active individuals have a particular role to play: *"Allah has given us every means to follow the right path ánd the freedom to act and choose freely, but then it is up to you to make the right decisions"*[8]. As it turns out, adherents of Muslim fate are constantly under a test to control their level of willingness to obey to Allah. In the context of this test, and within one's environment, the life of man, and what he turns out to be in the future is subject to one's own decisions but is also created with predestination (a doctrine that is also important in many other religions); whichever paths a person follows leads to a destined end befitting decision. This religious understanding of the human self, its purpose and functions has a great effect on many 'Syrian' understandings of themselves and the world around them.

Another very important aspect that affects how many Syrian people construe themselves can be found in their interdependent, connected and collectivist worldview:

[6] Imran, interview 10-03-2020; Safae, informal conversation 06-04-2020; Yusur, interview 19-02-2020; Nisa, informal conversation 28-03-2020, Yarah, informal conversation 18-04-2020
[7] Yarah, interview 28-02-2020
[8] Safae, interview 06-03-2020

> *"In Damascus we lived like bees, an individual has no value, but the family means everything to us. It serves its purpose, but sometimes it makes me feel so stuck. In the Netherlands people live as gazelles, every man for himself, even when they are together. It makes you lonely, but you are also free to try something new."*[9]

Also scholars have documented the prevailing power of family and community life in the Middle East context (Rassam 2001; Dahlgren 2010; Joseph 1999; Rabo 2008), highlighting that, within this region, family and community form 'the bedrock of an individual's identity'(Rabo 2008). Where the data regarding the negative feelings and thoughts about my informants' backgrounds was very diverse, literally all my participants gave kind of the same answer when I asked them about the things they value and are proud of as to their cultural identity. All answers roughly included the following: instead of living in a tightly organised society, daily activity is approached at a relaxed pace where time and attention is devoted to personal interactions. In Syria, people often know their community and neighbours intimately and visit their friends and family every day. This people-focused lifestyle gives individuals a sense of belonging and social support. Syrians always attempt to help their friends and family, to always look after each other. In return for their efforts, they trust and expect that the person will reciprocate the favour in the future when they request it. Hospitality is extremely important, or even taken for granted. Connections with one's extended family are deeply valued and serve as crucial emotionally, financially and socially support system. All my encounters with Syrian participants made me realize how the way people in the Netherlands generally interact with their social environment are extremely different from what my participants are used of. Sentiments regarding this topic are in line with Markus and Kitayama (1991), proposing that people in different parts of the world tend to construe themselves in two fundamentally different ways. They argued that Western cultures are exceptional in promoting an independent view of the self as stable, bounded, unitary, and more isolated from the social context, whereas cultures in other parts of the world emphasize an interdependent view of the self as closely connected to others, fluid, and contextually embedded (Markus and Kitayama 1991). Building on their work, one could say that people with independent self-construals would strive for self-expression, uniqueness, and self-actualization, basing their actions on personal thoughts, feelings, and life goals (Vignoles et al. 2016). In contrast, people with interdependent self-construals would strive to fit in and maintain social harmony, basing their behaviours on situationally determined norms and expectations. In the context of migration, the

[9] Hajar, interview 11-03-2020

interdependent nature of relations are key elements towards individuals being recognised and understood as being members of a wider collective, or as Warner (1994, 165) said: "It is the relations with other people that ground man in his existence, and not the physical grounding of the individual and group within a given space." As my research taught me, feelings of belonging are complex, intricate, and multifaceted, especially in the case of forced migrants since the new living conditions may not have been a matter of choice for them:

> *"It is not like I wanted to leave Syria, I had no choice. And now I am trying to make the best of it, to build a new life and to understand how everything is working here in this country. I really try so hard to adapt and get 'your' way of living, but it feels like nobody tries to get or see my story, everyone seems so busy with themselves."*[10]

Both the fact that displacement and the dynamics of conflict challenge and disrupt social structures, which are of immense importance for most Syrian people, and arriving in a society where people value independence and self-reliance and advocate that interests of the individual should be considered more urgent than the interests of the state or a social group, has a profound influence on how people relate to their new 'homes' and experience notions of belonging and citizenship, thereby determining their acculturation process.

3.2 EXPLANATORY MODELS OF MENTAL ILLNESS AND PSYCHOSOCIAL PROBLEMS & COPING MECHANISMS

Notions of the person influence how people experience and express suffering, how they explain illness and sorrow, and how they seek help. In order to understand why Syrian people are less likely to seek professional care, show higher rates of drop out and lower rates of compliance to treatment (Cetrez & Balkir 2017), we have to take a closer look at their cultural systems of knowledge, belief and practice, because they provide explanatory models for illness that include ideas about causality, course, suitable treatment and plausible outcome. A better understanding of people's attitudes and ways of giving meaning to mental health and how it is managed, will allow better communication which can improve the quality of service delivery for refugees (Cetrez & Balkir 2017; Hassan 2015). In addition, by strengthening refugees' resilience and well-being, through well-organised, well-fitting, and sustainable (mental) health practices, the assoiated acculturation process will be affected as well. However, it is important to realise that people may use several explanatory models to explain dimensions of their suffering at different

[10] Isra, informal conversation 09-03-2020

moments in time, depending on the context, question and concern. Moreover, while explanatory models can be valuable in the medical encounter, they should not be used in restrictive or over-generalising ways (for example: 'Syrian man think X of X') as such explanatory models vary between people and over time. Another problem is that cultural factors are not always central or relevant to a case and might actually obstruct or complicate more practical understandings of an episode.

As religious value systems turned out to play a significant role in the conceptualizations and manifestations of the person, they also play a significant role in the perception and understanding of psychological problems, and the methods of treatment. During my research, religion (mainly Islam, but also others) turned out to be central to the meaning systems of many of my participants, although its centrality varies greatly from person to person. Regardless of whether religion arises specifically out of the need for meaning or helps people who embrace religion for other reasons, religion can be characterized as a belief system that provides ways to understand suffering and loss (Park 2005). However, the same event can be viewed quite differently depending on individual's specific religious views: *"Some of my friends believe that they are punished or deserted by God, but I believe that God is trying to communicate something important through the terrible events I have experienced, that I can learn and get better from difficult times."*[11] This is in line with another participant saying: *"God is testing people with good times and bad times and you have to trust him, because God will not put you through things if he knows you could not pass it."*[12] As a result, for many Syrians difficulties in life can be viewed as an opportunity to strengthen faith and to prove oneself, or at least are understood as normal, inevitable parts of life. Besides, when a person does suffer from mental distress, religion offers ways to cope with this distress by prayer, reading the Koran or the Bible, making religious vows or attending religious ceremonies. From this perspective religion can be considered a protective factor by strengthening each individual's resilience. However, as a result people tend to believe that medical or psychiatric intervention is not needed, except in severe and debilitating forms. According to some of my participants, persons with serious mental disorders and disabilities are often described as 'crazy', 'mad' or 'insane', for which they use the word *majnoon* and only those majnoon people seek out mental health services.[13] Probably this is one of the reasons why mental health care is in short supply in Syria, or at least

[11] Yarah, interview 28-02-2020
[12] Nisa, informal conversation/hanging out 02-03-2020
[13] Imran, interview 10-03-2020; Safae, informal conversation 06-04-2020; Yusur, interview 19-02-2020; Nisa, informal conversation 28-03-2020

was in short supply. Prior to the conflict there was not really existing a mental health infrastructure in Syria and 21 million people were served by only 70 psychiatrists (WHO 2020). This affects the attitude of Syrian people towards mental healthcare services in the Netherlands, in most cases it is unknown territory for them.

Even though religion and social standards are deeply intertwined in Syria (Hassan 2015; Rabo 2008; Chatty 2017), some are important to discuss because they have important implications for coping, help seeking behaviour, treatment expectations and stigmatisation. Syrian norms about behaviour, also with regards to mental distress and coping, are largely influenced by a cultural perception of honour. Conservative behaviour is the norm and people generally act in accordance to social expectations as they do not want to stand out or risk doing something that is considered to be shameful or contrary to their religious beliefs.[14] Through utilization of terminology such as 'crazy' and 'mad' to describe persons with mental disorders or high levels of psychosocial distress, stigma is created and is likely to lead to considerable shame, fear and embarrassment, and thus serve as considerable obstacles to help-seeking behaviours. With the protection of both their personal and family honour in mind, instead of acknowledging that they are in a difficult situation, many Syrians may try to convince themselves that they do not have an issue. In addition, strong cultural norms surrounding masculinity exist, often leading to the perception that men should not publicly express emotions for fear of being perceived and portrayed as weak:

> *"It is a difference in culture. We were brought up to be strong. You should not cry, because as a man you have to be strong. When you fall you should get up, you should not lie down, because old women do. So, you have to keep going, instead of wasting time and whine about your problems."*[15]

This can lead to an increased risk that men will not engage in social networks that would usually support and promote positive coping. Syrian refugee men's coping mechanisms, therefore, appear to be primarily individual. Another core concept that is very important for many of my Syrian participants, and one that appeared to have a great influence on the structure of expectations about the therapeutic interaction, is the concept of hierarchy. Although subject to change because of the new environment, person's age, wealth, education, and profession are the biggest class indicators and determines the grading of respect in social interactions. In

[14] Yarah, several informal conversations + interview 28-02-2020; 07-02-2020; Nisa, interview 24-02-2020 + informal conversation 02-03-2020; Isra, informal conversation 09-03-2020 + interview 14-02-2020; Maya, informal conversation 18-02-2020; Yusur, several informal conversations + interview 19-02-2020

[15] Anouar, informal conversation 17-02-2020

general, trade professions or jobs that require physical labour are viewed as low-status positions where more respect is shown to those people who have received university degrees and work in professions that require an advanced education.[16] This system of organizing people into different ranks or levels of importance affects how many Syrian people position themselves towards for example doctors, psychologists, and other psychosocial practitioners, and it contains implicit ideas about the purpose of an interaction, the role of the parties involved and the rules and agreements determining the interaction. Drawing from both literature research and empirical data, most Syrian people expect a 'doctor' to be proactive and direct with regards to what is 'wrong' with them and what to do about it (van der Boor & White 2020; International Medical Corps, 2017; Hassan, 2015) . This more traditional and authoritarian model of care and medicine, is in contrast with the more modern practices of most Dutch mental health care services, which can lead to diverge interpretations and expectations, unsuccessful interactions and even higher rates of drop out and lower rates of compliance to treatment:

> *"When I went to the doctor and told him about my problems, he asked me what I needed, what I thought would be the best approach for getting better. So, I asked him: who is the doctor here? I have no idea about what is even going on with me, it took a lot of effort and courage to come here and now I have to decide about my own treatment while I did not even study for it?"*[17]

As discussed by Bracken et al. (1997), the system underlying most modern Western forms of therapy is firmly based on norms of self-expression, individualism, fostering autonomy, and tolerance. Instead of the doctor being proactive and the patient reactive, the roles are more equal. For many Syrian people, who expect a therapist to be in a more commanding and expert role (Llácer, Zunzunegui, del Amo, Mazarrasa, & Bolumar 2007), such encounters can be confusing and result in feelings of not being heard, feeling put off and treated badly. Additionally, for many migrants it is especially important to have clear affirmation of their sickness because this justifies their inability to meet social responsibilities, which again has to do with feelings of honour, status and gender roles.

In a more general sense, social coping mechanisms appear to be more highly prioritized than coping strategies at the individual level. As shared by some of my participants, culturally, gathering as a community, and maintaining strong links with extended families and friends are

[16] Imran, interview 10-03-2020; Safae, informal conversation 06-04-2020; Yusur, interview 19-02-2020; Nisa, informal conversation 28-03-2020
[17] Yusur, interview 19-02-2020

an essential component of maintaining a healthy life balance and to help support positive coping. Hassan et al. (2015) noted that when positive and healthy coping mechanisms are unavailable or fallen apart, individuals may resort to more unhealthy and unhelpful methods of coping. Due to this strong link between positive coping and community engagement, stimulating the capacity of Syrian persons to engage in community-level activities is of great importance because it can promote resilience and a sense of community and belonging. Drawing from conversations with my participants this aspect of togetherness and daily gathering with friends and family is perceived as one of the most important coping mechanisms:

> *"Because we are around our loved ones all the time, talk for hours, listen and take care of each other, we immediately notice if something is going on with someone, if someone is feeling sad, angry, or just confused. We are each other's psychologists, haha."*[18]

However, given the above-mentioned stigma associated with mental distress, it seems like most people tend to only vent and share emotions, thoughts and struggles that are manageable, easier to 'solve' or more 'superficial', because they do not want to bother people with their psycho-social distress when it has a more complex and long-lasting nature. Besides, it must be noted that the concept of talking about 'what is going on inside', can be expressed in various ways and is also defined by one's social and cultural context. For example, Syrian people with psychological or mental problems often first present their physical complaints, before addressing the psychological, relational, or spiritual dimensions of their difficult situation (Hassan et al 2015). Most Arabic and Syrian idioms of distress do not separate somatic experience and psychological symptoms, because body and soul are connected in explanatory models of illness, including mental distress. When not acting from the mind-body dualism perspective, it makes sense that people express their psychological discomfort in physical metaphors. Therefore, it is not likely they come up with psychological metaphors for explaining their psychological problems, or to use is as a strategy of psychological symptom presentation, it is just seen as one and the same (Ashy 1999). Most of my participants perceive the interconnectedness of the body and the mind as something taken for granted, something that cannot really be seen as two separated things: *"You cannot have a healthy body when your mind is not healthy, so when we have physical complains it is often linked to our mental state of being"*[19]. Due to the identification of the deep interconnectedness of physical and psychological suffering, many of the common expressions and idioms of mental distress in Syrian Arabic are

[18] Safae, interview 20-02-2020
[19] Isra, informal conversation 14-02-2020

very physical in nature: such as: "I have a squeezed heart" or "I have a fatigued self/soul" (Hassan 2015; Scarry 1985; Ingleby 2005)[20]. As a researcher I really struggled with my participants' ways of talking about their internal feelings and struggles, because at the beginning I got the impression that the use of everyday expressions and proverbs or metaphors to express distress might have been as 'resistance' to direct communication. Where I expected or even assumed my participants would tell me that they were feeling sad and helpless, they said things like *"sometimes I feel like my soul is going out"*[21] or "*my body feels so heavy all the time"*[22]. With time, I got to realize that we were talking about the same things, but just using another form of expression. Within mental health care, the distinction between somatic and mental symptoms is particularly unfortunate for refugees as labelling problems as 'somatisation' (with the assumption that the 'real' problem is psychological) is usually not helpful.

3.3 SHIFTING EXPLANATORY MODELS

Numerous of my participants working with refugees from Syria noted that explanatory models of mental distress and attitudes to mental health and psychosocial support services are rapidly changing as a result of the shared experiences of violence, loss and displacement, which tends to lessen the stigma surrounding mental health problems.[23] This shows how collective traumatic experiences affect cultural systems of knowledge, belief, and practice, which is in line with Sztompka (2000) arguing that trauma affects culture, because it touches the cultural tissue of society. As part of this cultural tissue, the immense violence and injustices of the current conflict also have an impact on the role of religion within the personal and social life of people from Syria; leading some people to turn more strongly to their religious beliefs as a source of hope and meaning making, while others are left ambiguous or re-evaluating their religious beliefs, struggling with existential questions such as: "How can God accept this happening to my family?"

Over time, refugees undergo a complicated inner process of identity and self (re)formulation as a result of displacement, which is interconnected with the external process

[20] See appendix 1: Table 1 gives a brief overview of common expressions and idioms of distress in Syrian Arabic, used by Syrian people with problems related to mental health, psychological wellbeing, social problems, and corresponding physical symptoms. I was provided with this table by one of my participants: Diederick.
[21] Hajar, WhatsApp conversation 23-02-2020
[22] Mother of Yarah, informal conversation 20-02-2020
[23] Imran, interview 10-03-2020; Safae, informal conversation 06-04-2020; Yusur, interview 19-02-2020; Nisa, informal conversation 28-03-2020; Marieke, informal conversation 01-04-2020 + interview 18-04-2020; Diederick, interview 05-03-2020; Liselotte, interview 24-03-2020; Markus, interview 21-02-2020

concerning questions of citizenship and belonging in the host society. As my research taught me, feelings of belonging are complex, intricate, and multifaceted, especially in the case of forced migrants. Belonging, in any way whatsoever can be seen as a human need and the satisfaction of this human need can lead to individual and social well-being. On the other hand, denial or not feeling to belong anywhere or to anyone can cause (mental) suffering and social disorder. What is difficult in this case, is that the social, dominant perception of civic society could differ dramatically from the individual's sense of self and belonging, which can lead to issues of identity and the struggle for belonging. This process, in which someone is deemed socially to belong or not belong, is related to the interplay between 'sameness' and 'difference' (Ralph 2012; Yuval-Davis 2011; Madsen and van Naerssen 2003). Politics of belonging are dependent on a constant negotiation between two sides: the side which claims belonging and the side that has the power of 'granting' belonging, occurring either at an individual or collecti ve scale. Negotiations of belongingness are thus part of wider everyday and structural expressions of inclusion and exclusion that determine belonging or non-belonging to wider geo-political collectives (Croucher 2004; Yuval-Davis 2006). Actors in this field are the state, which establishes the criteria of belonging within a national population and corresponding territory based on the concept of citizenship, but also all other elements of society where migrants interact with other people, for example their neighbourhood, the job market, naturalization institutions, school, etc. All those actors allow one to feel, or not feel part of a wider collective through social bonds which capture 'emotional bonds with others and to place' (Madsen and van Naerssen 2003). This process affects the acculturation process, defined by Berry et al. (2005, 698) as "the multidimensional process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members."

As part of this process, understandings of the concept of the self, including the ways people experience and express mental suffering, how they explain illness, and how they seek help, become highly challenged. The Netherlands has a culture where psychological care is commonly seen as something normal and beneficial, resulting in the possibility that people will gradually adopt another point of view:

> *"First I felt so 'naked' and even a bit ashamed when my Dutch friends asked me about the most intimate things, but after a while I started to realize that it really helped me. And if you do not have friends of family who can help you, I really understand that someone would go to a psychologist."*[24]

So, when being confronted with different perspectives and opportunities, it is likely that people will reconsider their own perceptions regarding mental health and ways of dealing with it. However, although the level of acculturation presumably influences the types of explanatory models that people hold, the maintenance of a connection or even embodiment with people's country and cultural background in many cases remains of important value. Cultural traits and identities have proven to be strong, which also applies to the ways that people explain and make sense of their mental distress. However, the role of the self must be considered here as well. Even though many Syrians share a collective identity that is in this case based on both nationality (citizenship) and the experience of horrendous events that leaves permanent scars upon their group consciousness, marking their memories forever and changing their future identity in fundamental and indelible ways, the understanding of the self indicates a more layered insight in how individuals give meaning and deal with mental distress as a result of traumatic experiences. As for the concept of collective identity, the personal construction of the self can be seen as 'a product of change', as dynamic, context-dependent and as the result of a dialectical process involving internal and external processes and perceptions (Croucher 2004; Golubovic 2011). Although the concepts of identity, self and belonging are conceptualized like this in general and every human being experience shifts and changes regarding those processes, they are particularly present in the lives of displaced people. When people find themselves in the grip of a new culture, or when the socialized, internalized culture that they carry 'in their heads' or in their semi-automatic 'habits of the heart' clashed with the cultural environment in which they find themselves, understandings of identity, the self, belonging and citizenship can be highly challenged.

CONCLUDING NOTES

As demonstrated in this chapter, it is clear that culture does matter in the context of mental health. Cultural factors shape health-related beliefs, behaviors, and values, since cultural processes include the embodiment of meaning in psychophysiological reactions, the development of personal and interpersonal relationships, the serious performance of religious

[24] Nisa, informal conversation/hanging out 02-03-2020

practices, common-sense interpretations, and the establishment of collective and individual identity. As shown in this chapter, cultural systems of knowledge, belief and practice can provide explanatory models for mental distress, that include ideas about causality, course and appropriate treatment. While the Netherlands has a culture where psychological care is commonly seen as something normal and beneficial, it should be understood that this is not the case for refugees from Syria. In a country with only very few psychiatrists, admitting having mental problems carries a strong stigma of being crazy and negative attitudes and beliefs that stimulate the general public to fear, reject, avoid, or discriminate against people with mental illness. Besides, when a Syrian person overcomes this stigma and decides to seek help, the structure of expectations about the therapeutic interaction between the patient and the 'doctor' often differs a lot and can complicate the treatment process. Other significant components for making sense of mental distress and healing can be found in ideas about the interdependent relationship between the mind, the body, the soul, the self, the social context and the world, which, according to my participants directly affect each other and cannot be separated. This understanding of what makes up the human self, in which religious value systems and a collectivists worldview appeared to play a significant role, are very different from 'Western', including Dutch, ideas and understandings about the concepts of identity and the self.

The ways that people explain and make sense of what makes up the person and the world, including ideas and theories of the processes of illness and healing can have important implications for coping, help-seeking behaviour, treatment expectations, and stigmatisation and therefore explanatory models can be crucial to diagnosis, treatment, and care. However, this chapter showed how cultural processes are not static and homogenous but frequently differ within the same ethnic or social group because of differences in age, gender, political affiliation, background, class, religion, ethnicity, and even personality. This is especially true for people living in between two worlds (in this case the Dutch and the Syrian one), when people undergo a complicated process of identity and self (re)formulation as a result of displacement. Therefore, even though culture is perceived as inseparable from psychological conditions, culture and explanatory models should not be used in a restrictive or over-generalizing way or materialized as a kind of substance or measurement skill. Instead of understanding culture as a set of already-known factors, a practitioner in this field, as an anthropologists of sorts, should engage with what really matters, what really is at stake for a specific person, by empathizing with the lived experience of the patient's distress, and try to understand the illness from the eyes of the patient.

4.

BEYOND VICTIMHOOD: RETHINKING THE MENTAL HEALTH CARE FOR REFUGEES AND DISPLACED PERSONS

As unfortunate as it is forced migration seems to be part of human history. However, in our time, it has become one of the world's biggest concerns. If one's expectation was that two world wars would be followed by a long period of peace and stability, this turned out quite differently. Uncountable conflicts, both within and between nations, has created vast numbers of asylum seekers, refugees and displaced persons (WHO 1996; Ingleby 2005; Berry 2015). As a response to this, there has been an increase in the involvement of professional care workers and agencies, both governmental and non-governmental. In the last two decades, a major point of attention, also in the Netherlands, has been how to provide appropriate mental health care for the victims of organized violence (Ingleby and Watters 2005; Bala 2005; Bloemen and Gastel 2020; Verhoeven and van Dijk Chairgroup 2016). That care should be provided is, fortunately, increasingly accepted. However, that does not mean that there is consensus about the kind of care that is necessary. Related to this, the assumptions and models which initially informed mental health care provision for displaced persons, refugees and asylum seekers have come under scrutiny (Carpenter-Song, Nordquest Schwallie, and Longhofer 2007; Lammers and Arentsen 2017; Kleinman and Benson 2006; Gregg and Saha 2006). Even though programmes established to offer psychological help for refugees and victims of wartime violence with culturally different backgrounds appear very ethical in nature, the appearance of such programmes and special centres has had a number of largely unanticipated effects (Lammers and Arentsen 2017). Some of those effects, the ones that appeared most relevant during my fieldwork, will be discussed in this chapter. After briefly outlining the policies and structures with regards to mental health care for refugees in the Netherlands, the concept of culturally sensitive (mental) health care will be examined. Subsequently, the chapter will discuss how the past experiences of refugees are being framed, defined and even medicalized by mental health care institutions and the the wider society. Where the first chapter discussed several differences between 'Western' (including the Dutch) and 'Syrian' conceptualizations and understandings of mental illness and the best healing strategies, as defined by their own social, political, and cultural context, this chapter goes beyond exploring how those differences affect the mental

health care encounter, and argues that the appearance and/or participation of special programmes for the psychological treatment of refugees affects the way refugees see themselves, and (indirectly) influences the interaction between Dutch citizens and Syrian refugees.

4.1 THE ORGANIZATION OF THE MENTAL HEALTH CARE SYSTEM FOR REFUGEES IN THE NETHERLANDS

Every society influences mental health treatment by how it organizes, delivers, and finances such services. In the Netherlands, these are provided by a great number of practitioners in a diverse and broad array of settings, and sectors. Settings range from home and community to institutions, and sectors include public or private primary care and specialty care (Verhoeven and van Dijk Chairgroup 2016). In principle, refugees in the Netherlands have the same rights as Dutch citizens regarding access to and provision of mental health care services, but research shows that a large number of this group do not seem to seek or receive any care or treatment (Bloemen & Gastel 2020; Sijbrandij et al. 2017). Besides many other reasons, some of which were discussed in the previous chapter, this is partly due to the fact that refugees are often unfamiliar with the possibilities of care provision in the Netherlands or do not understand how the system works, which is very understandable given its multi-layered and complex dimensions (Donnelly et al. 2011; van der Boor and White 2020).[25]

With regards to health care services for asylum seekers and refugees, in 2000 the Council for Public Health and Care published an advisory report on multicultural health care in the Netherlands (Wiese and Burhorst 2008). As input for this report, a study had been done to understand better the adequacy of care provisions for ethnic and cultural minorities. The Council concluded that the process of 'interculturalising' Dutch health care had taken place too much on a temporary, noncommittal base (Watters and Ingleby 2002) (Verhoeven and van Dijk

[25] The Dutch health system has four layers. Zero-line health care consists of disease prevention such as immunisation. First-line or primary health care consists of health care provided by general practitioners, dentists, and home care. The general practitioner is the gatekeeper that determines access to more specialized services. Second-line health care is acute hospital care and long-term care means psychiatric hospital care, care for mental illnesses, disabled or nursing homes. However, over the last years these layers have become blurred as professionals and organizations have integrated and merged more of their services. When discussing this topic with my Syrian participants, I realized that I even find it hard to understand how the system actually works myself, let alone how complicated it must be for them.

Chairgroup 2016). The report concluded that a more effective and coherent policy is needed to structurally, integrally and on a permanent basis address the deficiencies in care provision for migrants, including education of professionals. The Council's advice stated that the role of the general practitioner/family doctor is of great importance, as migrants more often visit their GP than autochthonous Dutch people. The GP is crucial as he/she informs and guides them further into the health care system. However, both literature and my fieldwork indicate that this gatekeeper role is not always working well: *"I don't understand how the system works so I also don't know where to go with my problems. I went to the GP here in the village again, but he only advised me to have more patience, that it is logic that I feel sad and depressed, but that time will heal. So now I don't know what to do actually."*[26] During my research I have mainly been in contact with practitioners and institutions who are specialized in multicultural care provision and care for refugees. Therefore, I was not able to gather empirical data from GP's, who certainly also face a lot of challenges in the encounters with refugees. Besides the GP's there are many other actors involved. An important organization is the Dutch Council for Refugees (VluchtelingenWerk Nederland), an independent NGO that defends the rights of refugees and asylum seekers and represent their interests from arrival until integration in society (funded by ministries of the government). The Central Agency for the Reception of Asylum Seekers (COA) is also an important actor. They are an independent administrative agency responsible for housing and basic needs of refugees. Their responsibilities are established in the COA-act and are under the responsibility of the ministry of security and justice (COA, 2016a). Two other important actors, that I have also been in contact with during my fieldwork are Pharos and ARQ Centrum'45. Pharos is the Dutch Centre of Expertise on Health Disparities and ARQ Centrum'45 is the Dutch national centre for specialist diagnostics and treatment of people with complex psychotraumatic complaints. Both institutions aim to improve quality and access to care and reduce disparities between groups by insisting on culturally sensitive care. One big part focusses on refugees. They do this by supporting national and local organizations with providing knowledge and trainings.[27]

Given all actors involved, the Dutch mental health system is highly institutionalized and complex in nature. This is partly due to the enormously increased demand for health services of all kinds. Governments and insurance companies that finance these services are in urgent

[26] Maya, informal conversation 18-02-2020

[27] The information presented in this paragraph is based on interviews with my Dutch participants working in the field of mental health care for refugees. They taught me, in brought lines, how the system is organized and who the main actors are within this system.

need to find ways to control costs and increase efficiency, which led to what David Ingleby (2005) calls the phenomenon of 'managed care'. However, undermining the assumption that the principles of good management are universal, this type of managing the field of mental health care has major consequences for the quality of care and shows how mental health care providers working with refugees are part of wider power structures.

4.2 CULTURE AS CURE?

As discussed in the previous chapter, concepts of the person, which are inextricably rooted in a cultural context, influence how people experience and express suffering, how they explain illness and misfortune, and how they seek help. Considering cultural factors as relevant, defining components in mental health intervention is perceived as something very important by all of my participants, among which a psychiatrist who comes from Syria himself. He studied medicine in Ukraine when, during a family visit, he was arrested by the Syrian police for his involvement in a Kurdish human rights organization. He came to the Netherlands as a refugee in 1999 and now helps people with similar backgrounds: *"We know that psychosocial problems are universal, but the approach must be different: an approach based on language and culture. If we don't understand the meaning of their words and their emotions and if we don't understand their culture, we cannot help them."*[28] However, this perspective contrasts with the psychiatric model of pathogenicity, in which biology is presumed to 'determine' the cause and structure of disorder (Kleinman 1978). The anthropological perspective suggests an alternative model, arguing that biological and cultural factors dialectically interact (Kleinman 1987; Young 1976; Seligman 2010; Park 2005; Scarry 1985). At times one may become a more powerful determinant of outcome, at other times the other, but most of the time it is the interaction between the two which is more important than either alone as a source of (mental) illness. This notion of illness as a social construct, based on the social constructionist's idea stating that individuals and groups produce their own conceptions of reality, and that knowledge itself is the product of social dynamics, is particularly embedded with cultural meaning. Therefore, the concept of culture has become an important term in mental health and psychosocial support, especially for refugees. In addition, a very important concept for cross-cultural studies of medicine (including mental health care) is a radical appreciation that in all societies health care activities are more or less interrelated. Therefore, they need to be studied in a holistic manner as socially organized responses to illness that constitute a special cultural system: the health

[28] Imran, interview 10-03-2020

care system (Langdon and Wiik 2010). In the same sense in which we speak of religion, language, kinship and illness as cultural systems, we can view medicine as a cultural system. In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all interconnected. The totality of these interrelationships is the health care system. A very strong example of how legal, institutional and cultural differences can define a certain event that can have a great influence on a person's mental state, was illustrated by one of my participants who is an anthropologists and psychiatrist: *"In too many countries in the world, marital rape is not included in the criminal code or prosecuted. For example, in Kenya sex is considered as the man's right. Or in Ghana where conservative politicians blocked legislation to criminalize marital rape."*[29] So, if martial rape either remains legal, or is illegal but widely tolerated and accepted as a husband's prerogative, women may experience or react to the phenomenon, that is grounded in the interplay of individual, family, community and socio-cultural factors, in a different way than for example Dutch women. In this sense, the way women perceive, experience and cope with the phenomenon and consequences of rape in marriage is governed by wider social, political, and cultural rules.

As a response to the growing understanding of the cultural meaning of mental distress, medicine and the health professions have begun to implement the idea of cultural competency (Kleinman and Benson 2006; Slobodin, Ghane, and De Jong 2018; Kramer 2005). With the aim to develop a greater sensitivity to culture in general and a deeper understanding of particular cultural groups and their values, norms, social practices, health beliefs practices, such cultural competence strives to prepare health practitioners for their interaction with culturally diverse and minority patient populations, mitigating possible issues that might otherwise arise (Beagan and Kumas-Tan 2009; Turner 2005). Based on the explicit acknowledgment that the usual "one-size-fits-all health care" model is not able to sufficiently meet needs that may vary by race, ethnicity, gender, sexual orientation, or language proficiency, the development of culturally sensitive services is seen as a way to overcome barriers between professionals and refugee clients and provide methods of therapeutic intervention, which are meaningful and effective to refugees (WHO 1996). However, even though health providers of such programs are well-meaning, the pressure to 'do something' or 'fix' patients in practice can mean that 'cultural sensitivity' is used in a limited, strategic way to win patients' cooperation, facilitate diagnosis and support the doctors' authority, instead of emphasizing and engaging with others and with the practices they undertake in their local worlds (Ong 1995). In their research on culturally

[29] Dierderick, interview 05-03-2020

sensitive health care Kleinman and Benson (2006) reveal the problem of cultural competency by stating that this method suggests that culture can be reduced to a technical skill for which clinicians can be trained. This problem stems from how culture is defined in medicine and health care, which contrasts very much with its current use in anthropology.

Rethinking the concept of 'culture' from about 1995 onwards, new developments have occurred in the field of multicultural care which challenge the notion of 'culture' previously assumed by transcultural psychiatrists. These developments concern emerging views within anthropology. Firstly, Geertz (1973) argued for the substitution of the static, monolithic concept of 'culture' for an approach that recognizes the heterogeneous and dynamic nature of real cultures. Quite different from treating culture as a categorical variable on which each individual can be assigned a single value, many people position themselves simultaneously within two or more cultures, something which is especially the case for migrants. This is in line with many other anthropologists arguing that culture cannot be perceived as a 'fixed' clearly delineated, separable entity that guides individuals' behaviour in linear ways and therefore cannot be simplified to "competence" (Gregg and Saha 2006; Kirmayer 2012; Hall 1980; Sökefeld 1999). Rather, they understand culture as the shared symbols and meanings that people create and develop in the process of social interaction, as a continuous process that defines how people understand and engage in their world. In addition to this, not only do individuals belong to multiple cultures, but those cultures are neither coherent, nor static, nor do they always join together seamlessly (Gregg and Saha 2006). Culture itself has no objective existence but is a social construct as well: cultural properties are actually 'ethnic markers', used when strategic considerations make them necessary (Barth 2010; Modood 1998). With this in mind, attempts to put culture on the agenda of health care may have led practitioners into the wrong direction. 'Cultural sensitivity' has often been interpreted as adapting service delivery to the cultural peculiarities of different racial or ethnic groups. However, whether these groups (Asians, Moroccans, Arabs, Blacks, Hispanics, etc.) actually exist as culturally homogeneous categories is highly questionable. The effect of using these distinctions may have merely been to reinforce existing myths and stereotypes and actually widen the distance between service providers and users. It equates the concept of culture with an unchanging ethnic and racialized Other (Beagan and Kumas-Tan 2009). An empirical example that illustrates how the approach of cultural competency sometimes overlooks the heterogeneous nature of a culture is the situation of one of my male Syrian participants, living in the Netherlands for about two years now. After being moved between different asylum seekers centres, the Dutch Council for Refugees in a small village in the Netherlands assigned him a home. However, without any consultation, the council

decided to place three other Syrian man in the house as well, an approach that could have worked out well, but it did not:

> *"Those people from Vluchtelingenwerk do not even know who we are, where we come from and what our backgrounds are. They think we are all the same and do the right thing by bringing us together, but now I am stuck in a house with people who judge me for my beliefs and tell me what to do and what not to do. I fled to the Netherlands because I had to escape that, but now it still feels like a warzone, in my own house!"*[30]

The danger of narrow and simplistic conceptualizations of culture is that they may actually reinforce generalized cultural stereotypes and thus increase instead of reduce cross-cultural misunderstanding (Beagan and Kumas-Tan 2009; Gregg and Saha 2006; Turner 2005). Such understandings may also inadvertently put the blame on a patient's culture, rendering it "both a source of problematic behaviour and the solution to all the difficulties encountered" (Carpenter-Song, Nordquest Schwallie, and Longhofer 2007, 1364) with minority populations. However, critiquing the concept of culturally sensitive care is quite an easy thing to do if you are not a practitioner in the mental health sector yourself, something I noticed when I introduced the topic to my participants. One of them, who is an anthropologist and psychiatrist as well said:

> *"Studying the concept of culture is something fundamentally different from practicing it. Anthropologists have the luxury to extensively research the concept, which is also important, but they do not have to heal people. We are not scientists doing idealistic fieldwork, we do not have the time to participate or map someone's cultural context and ways of giving meaning. If we only see someone one hour a week or less, so we have to make compromises."*[31]

A statement that is in line with this view comes from another participant, who is a medical anthropologist specialized in transcultural psychiatry:

[30] Yusur, informal conversation 04-02-2020
[31] Markus, interview 21-02-2020

"The approach brings along many challenges and pitfalls, but I have a lot of respect for all practitioners who try to incorporate the concept of culture within their treatment, because it is not easy at all. I think the secret is in assessing what cultural and religious identity and practices mean for an individual. It is about seeing the person in the patient, and that is something most psychiatrists are very good at."[32]

However, besides the controversy surrounding the concept of culturally sensitive care, the increase in the number of programmes providing psychological help for refugees and victims of wartime violence in particular has sparked another discussion, one that was strongly present during my fieldwork and will be discussed in the following paragraph.

4.3 THE MEDICALISATION OF SUFFERING: DISEMPOWERMENT AND CONSTRICTION OF THE REFUGEE THROUGH 'TRAUMA STIGMATIZATION' AND VICTIMHOOD

"There is a lot of discussion surrounding immigration and refugees in our daily and political life, but rarely do we hear from, and listen to those fleeing themselves. Rather, refugees are seen as a homogenous mass, often villainized and made out to be somebody they are not."[33]

Even though this research aims to represent the voices of those fleeing themselves, I have to admit that I also made my research population out to be people they are not before I personally met them. While networking and reaching out to potential participants, I acted on the assumption that every Syrian refugee must somehow suffer from what they have experienced in the past. And even though this is true in many cases, this dominating disempowering image about refugees can also overshadow the fact that the majority of refugees make peace with the past and find ways to re-start their disrupted life. For me, the question I constantly asked myself during my fieldwork is not so much how or why individuals became psychosocial 'patients', but how or why the vast majority does not? One of my participants, an incredibly strong and ambitious teenager who has become a good friend of mine, once explained to me:

"Yes, I am traumatized. And yes, I suffer sometimes, but don't all human beings suffer at times? I am so much more than a traumatized girl from Syria, but if society frames it like that that is what people see. So, then it is up to me to show them another image, but that can be quite tiring and challenging."[34]

[32] Liselotte, interview 24-03-2020
[33] Marieke, informal conversation 01-04-2020
[34] Yarah, informal conversation 12-02-2020

This tendency that individuals' status as refugee becomes the defining characteristic, over and above other important aspects of personhood, agency, and action is also discussed by Ong (1996). In her article: Cultural Citizenship as Subject-Making, she argues that becoming a citizen depends on how one is constituted as a subject who exercises or submits to power relations. Refugees occupy multiple subject positions, some of which they define for themselves and some of which are defined for them, or as stated by Croucher (2004); politics of belonging are dependent on a constant negotiation between two sides: the side, which claims belonging and the side that has the power of 'granting' belonging, occurring either at an individual or collective scale. Where other scholars, such as Rosaldo (1994) give the impression that citizenship can be unilaterally constructed and that immigrant or minority groups can escape the cultural inscription of state power and other forms of regulation defining different modalities of belonging, Ong (1996) considers cultural citizenship as a dual process of self-making and being-made within webs of power linked to the nation-state and civil society. In one of her studies (1996, 1243), drawing on influences of Foucault, Ong links the health profession to the normalization of citizenship, by claiming that although biomedicine attends to the health of bodies, it is also embodies social and bureaucratic practices that socialize subjects of the modern welfare state and therefore (intended or unintentionally) remain the standard for controlling integration, shaping identity, and defining notions of belonging and citizenship. Her studies illustrate how refugee care is a mixture of good intentions, the desire to control diseased and deviant populations, and the urgency of limited resources which often favour medicalization.

The appearance of special programmes for the psychological treatment of refugees and other survivors of war and atrocity happened at a time when a ‘culture of victimhood’ has emerged within Western society, which led to an approach of ‘ordering’ the experiences of refugees (Bracken, Giller & Summerfield 1997; Kramer 2005). One of the inherent messages involved in such developments is that suffering of traumatized refugees is of a ‘special nature’ and therefore requires special expertise in caring for such people. However, this ‘special nature’ message can increase the sense of ‘otherness’ and has the tendency to only focus on a single clear-cut traumatic event instead of the often many negative (and even some positive) experiences of war or oppressive societies (Bracken, Giller & Summerfield 1997). Drawing from my fieldwork, I also learned that this way of ordering or capturing the experiences of refugees, even if you have no idea what they have actually been through, creates distance and causes people to not ask about someone’s past because they fear the answer or are insecure about how to respond. My participants shared their sentiments regarding this topic, saying

things like: *"I know that people feel uncomfortable to talk about my past, because they are afraid they cannot relate to it or don't understand what I've been through, but that only makes me feel more lonely. I do not expect people to understand it, I only want them to listen and be there for me."*[35], or *"We maybe experienced inhuman things, but we still have the human need to belong somewhere and we can only reconnect to the world through human interaction."*[36]

The social consequences of being portrayed as a victim or a traumatized person are an illustration of the American sociologist Talcott Parsons' theory of the sick role, stating that such a 'label' does not simply indicate what is going on inside your body: it also redefines your rights and your place in society (Parsons 1975). Besides, as drawn from my fieldwork, it affects one's self-story, self-perception, and self-representation, as shown in several quotes of my participants in this chapter. Apart from the fact that 'their' very existence can promote a sense of victimhood, special programmes also develop and use a knowledge of trauma which is usually firmly rooted within the framework of Western psychology and psychiatry. As discussed in the previous chapter, these disciplines may be constructed on assumptions that are very different from those of the refugee's own culture (Summerfield 2012). Although this understanding of mental health is widely acknowledged by state institutions and non-governmental organizations, some scholars are critical and warn for the risk to immediately label refugees with trauma when they are coping with stress from war and conflict. Many refugees themselves do not perceive their behaviour and feelings as a disorder; they just see it as coping with the situation (Hassan 2015; Verhoeven and van Dijk Chairgroup 2016).[37] Therefore, they may overcome this stress on their own since they are used to this stress feelings and see it as a normal part of their life. Summerfield (2000, 1449) wrote a critical piece on Western assumptions on traumas resulting from war and conflict. His main critique is that there is a tendency to apply Western cultural ideas to refugees which results in the medicalisation of stress and the rise of psychological therapies. This means that social distress has become something bio-psychomedical (for example in the form of PTSD) and thus can be treated in a medical way, which is also called 'medicalization'. This can lead to stigmatization of people, defining them as passive victims who have lost control of their lives. Though the status of 'victim' may help in obtaining political asylum, it can create an extra handicap when it comes

[35] Nisa, informal conversation 02-03-2020
[36] Yusur, interview 14-03-2020
[37] Most of my participants (Yarah, Yusur, Nisa, Safae, Isra, Hajar) do acknowledge that they mentally suffer from pre-migratory, post-migratory factors or things they have experienced during migration itself, but they do not describe it in terms of having a mental disorder. That is in most cases also the reason for not seeking any professional help.

to social integration and self-(re)formation, for example, a refugee referred to such a programme can view him/herself as primarily a victim of torture, requiring special psychological help (Bracken, Giller & Summerfield 1997; Ong 1995; Summerfield 2012). This self-identity can become self-perpetuating. However, even though being part of wider power structures that certainly shape the kind of care that is provided, most of my participants operating in the field seem to actively try to undermine this type of treatment that is part of the victimization of refugees. While emphasizing that psychological help remains very important because many refugees suffer from what they have experienced, many of them also try to call attention to the more 'positive' sight of the story and change the image constructed around refugees. Such images can lead to generalizations that all refugees are traumatized; an image that highly impacts the way refugees perceive and experience their identity, selfhood, and mental distress. One of my participants, working for ARQ Centrum'45, a centre where people are treated who suffer from complex psychotrauma complaints that are the result of persecution, war and violence contributed to this notion by saying:

> "*If we see refugees as damaged people instead of messengers of human right violations for example, we fail to see how strong they are, how they manage to re-discover a meaningful life under extremely difficult condition. So, by placing them in a different light, I immediately can see a shift in how they look at themselves."*[38]

Complementary to this, another participant operating in the field of mental health care for refugees said:

> *"Besides only passing the traumatic events over and over again, I also ask my clients to share their good and beautiful memories, because if nobody does, the difficult and painful memories will eventually overshadow the good ones. I really want them to understand that they are not only victims, but also survivors, and that the help I provide aims to empower them instead of only treating them."*[39]

Therefore, in the context of my research, it seems that it is not so much the practitioners themselves who socialize refugees to a category of newcomers defined as traumatized or dependent upon the civil society. Given my research focus, which did not explore state agencies or other forms of regulation, it is hard to determine where this tendency of portraying and medicalizing refugees as being victimized and traumatized comes from. However, studies from

[38] Marieke, interview 18-04-2020
[39] Imran, interview 24-04-2020

different scholars (Ong et al. 1996; Kramer 2005; Summerfield 2004; 2012; Bracken, Giller & Summerfield 1997) in combination with my empirical data indicate that the attitudes of wider society (which may change over time) influences what individual victims feel has been done to them, and shapes the vocabulary they use to describe this, whether or how they seek help, and their expectations of recovery. The more a society sees a traumatic event as a serious risk to the present or future health and well-being of the 'victim', the more it may turn out to be. In other words, collectively held beliefs about particular negative experiences are not just potent influences but carry an element of self-fulfilling prophecy; individuals will largely organise what they feel, say, do, and expect to fit prevailing expectations and categories.

CONCLUDING NOTES

Fortunately, in the last two decades the idea that mental health care should be provided for traumatized displaced persons, refugees and asylum seekers has become increasingly accepted. However, unfortunately, this does not imply that the traditional Western style of such health care is most suitable for these groups of people. Before addressing underlying fundamental issues, there are some very practical limitations help seeking patients are facing. The first of this is the complex and multi-layered structure of the health system, which for many Syrian people is difficult to understand. Secondly, while the 'point of entrance' is the GP, in practice they are often not properly equipped for dealing with and understanding migrants complicated complaints, ways of communicating and requests for help. Thirdly, refugees from Syria are not that easy convinced to seek professional help in fear of being stigmatised, and once showing such willingness they are used to a top-down approach: the doctor telling them what they have and what they need, which is very different from the Western psychological approach.

Once these issues of a more pragmatical nature have been overcome, more fundamental issues arise. First of all, the notion of cultural competency was questioned for its rendering of culture as a static entity in which medical professionals can be trained to develop expertise, arguing that treating cultural differences as objective phenomena can form inevitable barriers to communication and, in fact, can actually make matters worse. Another effect of the appearance of special programmes for the psychological treatment of refugees and other survivors of war and atrocity is the emergence of the so called 'culture of victimhood', a trauma discourse and as a result the 'medicalisation' of mental distress. Those phenomena led to an approach of 'ordering' the experiences of refugees and the tendency to perceive individuals' status as a traumatized refugee as a defining characteristic. As this chapter has shown, being

portrayed as part of culturally homogeneous categories, a victim or a traumatized person influences how people (re)shape their understandings of selfhood, identity, and notions of belonging. Even though practitioners in the field seem to have the best intentions and certainly contribute to stories of success as well, this chapter illustrates how both clinicians and refugees can be equally caught up in wider power structures involving control and misrepresentation, appropriation and resistance, negotiation and learning, that all constitute and influence the process of change that occurs through prolonged contact or interaction between two or more cultural groups: the acculturation process.

5.

REPAIRING A BROKEN SOCIAL WORLD: ACCULTURATION & MENTAL HEALTH

Always being fascinated and moved by the hardships refugees endured and the resilience they often show in rebuilding their shattered lives, I started thinking about the interplay between someone's personal (mental) and social wellbeing and the process of change that occurs through prolonged contact or interaction between two or more cultural groups, also called acculturation. Soon I realized how complex and contradictory the relationship between those components of mental health and acculturation can be. Previous research has demonstrated that those who participate in the fabric of society are less at risk of maintaining or developing mental distress (Organista, Organista, and Kurasaki 2003). However, the reverse is equally true. If people are to reap these benefits, they must first be 'healthy' enough to engage with their new living conditions. Psychological instability can lead to social isolation, not being able to learn a new language, go to school or to work, aspects that all complicate the acculturation process. Additionally, acculturation may increase stress or conflict between two competing cultures (Koneru et al. 2007), or be associated with a reduction in family support (Gil, Wagner, and Tubman 2004). Not surprisingly, then, empirical findings have been mixed, some studies arguing that the acculturation process itself can be perceived as conflicting and problematic and as a risk factor for mental illness, whereas others demonstrate a favourable relationship or no association at all (Hassan 2015; Vignoles et al. 2016; Bhugra & Becker 2005; Gerritsen et al., 2006). Drawing from the discussion presented in the previous chapter, mental health care and psychosocial support services for refugees can also be considered agents in the acculturation process, since they constitute a site where two cultures meet and where change can occur. This chapter will examine the multidimensional and complicated relationship between mental health and acculturation. By integrating the concepts of identity, the self and belonging, and building on the results of the previous chapters, this chapter will create a better understanding of the construct of acculturation and the importance of this not solely being a one-way street, requiring the refugee to accept 'all that is Dutch' while leaving behind his Syrian roots. It will then present three very real stressors (language, religion and the concept of the self) that complicate the integration process as well as the therapeutic encounter between a clinical and a Syrian refugee.

By creating a better understanding about the relationship between mental health and acculturation, this chapter will contribute in answering the main research question.

5.1 REINVENTING THE SELF: ACCULTURATION, IDENTITY & BELONGING

The term acculturation is generally used to describe the process of adaptation of newcomers to the culture of the host country. De Jong & Van den Berg (1996, 16) define acculturation as: "becoming familiar with a new culture and being able to function in that other culture while retaining the own cultural identity." Such a definition can lead to misunderstandings. Firstly, there is the suggestion that acculturation is a one-sided action: the adaptation by the migrant. Secondly, the authors place too much emphasis on the culture factor and show too little that acculturation, in addition to adaptation to another cultural reality, also implies adaptation to a new personal, social, political, and economic environment. Those factors of identity (re)formulation, the reinvention of the self and notions of belonging with regards to the acculturation process appeared to have a significant meaning during my fieldwork. Therefore, the definition of Berry et al. (2005, 698) is more applicable to this study, considering acculturation as "the multidimensional process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members." In a previous study Berry (1997) presents a conceptual acculturation model which distinguishes four acculturation orientations, explaining the extent to which immigrants maintain the heritage culture and/or adopt to the host culture. Integration (identifying with the host culture while continuing to identify with the culture of origin), assimilation (rejecting the culture of origin), separation (rejecting the host culture) and marginalisation (no sense of belonging to either culture). The latter is the weakest predictor of long-term health and wellbeing, and integration is the strongest (Schmitz, 1992; Berry 1997). A distinction can be made between acculturation on a collective or on an individual level (Sam 2006), but since the notion of the self is of great importance within this research, acculturation in this context will refer to the conceptualization of Berry et al. (2005), complemented by the understanding that psychological acculturation may invoke changes in individual's identities, values, behaviours and attitudes.

Perceived cultural distance, subjectively perceived discrepancies between social and physical aspects of the heritage and host-culture environments are the significant factors impacting acculturation (Galchenko and Van de Vijver 2007; Koneru et al. 2007). Berry (1997) suggests that a large perceived cultural distance can be a challenge to adjustment for migrant groups, as it creates greater conflict in balancing aspects of both cultures and requires the need

for greater culture shedding and culture learning. The greater the gap between immigrants' perceived identity, cultural values and norms, and those typical for the host country, the harder the acculturation process (Berry 1997). In such a period of flux, it is quite logic to assume that individuals experience confusion and distress while adapting their social and personal identities to the new social structure (Smith and Henry 1996). This chapter shows that, if during this process, the norms, values and ideologies of one's own personal, social and cultural identity are sensed as conflicting with those of the host society, reconstructing new social and personal identities may become challenging.

Having had the opportunity to meet a lot of Syrian people, who all carry their own story and try to blend into Dutch society in their own, unique ways, I learned that acculturation is a dynamic, context-dependent, multidimensional process influenced by personal factors as well as the characteristics of the heritage and host countries. The most striking and interesting insight regarding the acculturation process of this group of people is that, despite all of them expressed that they observed the Syrian and Dutch cultures to be entirely different, which indicates large perceived cultural distance, they almost all tried to increase affinity and establish mental similarity with the 'mainstream'. They attempt to present themselves in a manner accepted by the Dutch people or even in contrast with the stereotypical expectations of their in-group and tend to minimize the cultural differences and highlight the similarities with the host culture.[40] In many cases, especially among the young Syrian people I met, I felt a very strong motivation and need to become part of the Dutch society, to participate, create social bonds and build a new and meaningful life. One of my participants, a girl in her twenties who is in in the Netherlands for nearly two years and already speaks fluently Dutch, follows higher professional education, and tries very hard to make Dutch friends once said to me:

> *"I really want to integrate, I speak Dutch, I study, I join fun activities at school and really put a lot of effort in trying to understand how you people see and move in this world. But I often hit a wall. The entire society pressures us to integrate, but if we do so it is not good either. It feels as if my deepest self is being completely ignored, as if I have been considered a lower being. Sometimes it feels like the only way to fit in and feel to*

[40] Anouar, informal conversation 17-02-2020; Isra, informal conversation 16-04-2020; Yusur, interview 19-02-2020; Yarah, informal conversation 20-02-2020 + interview 28-02-2020; Safae, interview 06-03-2020; Hajar, interview 11-03-2020; Imran, interview 10-03-2020

belong in this society is to look, dress, talk and do the exact things that Dutch people do. But I simply cannot because I am not a Dutchman."[41]

As this expression shows, the concept of belonging is not excessively deterministic. Instead, Croucher (2004) claims that the politics of belonging is dependent on a constant negotiation between two sides: the side, which claims belonging and the side that has the power of 'granting' belonging, occurring either at an individual or collective scale. Negotiations of belongingness are thus part of wider every day and structural expressions of inclusion and exclusion that determine belonging or non-belonging to wider geo-political collectives (Croucher 2004; Yuval-Davis 2006). In this sense, refugees are in a position to reconstruct their social identities and reinvent their constructions and notions of the self, but at the same time are limited by the parameters of opportunities, services and framings created by the new social context. In the Netherlands, one of those sides that has the power of 'granting' belonging is the government. Their policies, implementation, and ways of framing topics of migration, multiculturalism, and integration influence how the 'mainstream' understand and deal with those topics in their daily lives. Since many studies (Koneru et al. 2007; Berry 1997; Cetrez and Balkir 2017; Hassan 2015; Kleinman, Eisenberg and Good 1978) indicate that integration is associated with less mental health symptoms in comparison with the other three acculturation strategies as presented by Berry (1997), it is important to get a better understanding of the meaning/conceptualization of integration within Dutch society. Without going into too much detail with regards to Dutch integration policies and laws, a little research on the topic already indicates the strong assimilationist characteristics of the concept of integration. According to the Dutch government, the refugee would need to learn the Dutch language, the country's rules, culture and history and to accept the country's laws and values (4.6 Integratie, Regering, Rijksoverheid.Nl n.d.). This assimilationist characteristic of the governmental normative approach to integration shows that there is little space for the analysis of an individual perspective and that the newcomer's ideas, motivations, expectations, perceptions and feelings of belonging are not part of the national integration policy. This view on what integration should comprise and when it is perceived as successful contrasts strikingly with the meaning that the concept ideally should entail. In the field of integration research, there is a consensus that integration is a two-way process. Numerous scholars explicitly support this by arguing that the achievement of integration does not only depend on the commitments, efforts, and

[41] Yarah, interview 07-02-2020

achievements of immigrants and their offspring but also on the structure and openness of the receiving society (Modood 1998; Strang and Ager 2010; Korteweg 2017; Berry 2005). In line with this, several scholars criticise integration policies, discourses, and fellow researchers for being too 'one-way' oriented: disproportionally emphasising the responsibility of 'people with a migration background' and underestimating the role of the receiving society (Anthias 2013; Klarenbeek 2019; Schinkel 2013). The reason for outlining the integration part of the acculturation process, is because during my research it appeared to be a significant topic that was often brought up by my participants themselves when talking about identity, the self and mental distress. As the previous one, the following quote shows how refugees undergo a complicated process of identity reformulation and occupy multiple subject positions, some of which they define for themselves and some of which are defined for them (which are in turn shaped by wider societal and political power structures):

> *"I think my classmates accept me and do not have any problems with me, but I find it hard to read them. They know that I fled from Syria, but they never ask me about it. They know I am a Muslim, because I wear a hijab, but they never ask me what it is I believe in or what it means to me. I do ask them a lot of questions because I want to learn from them, but conversations always remain a bit superficial, because they seem a bit scared or uncomfortable or something. But I mean, look at me, I cannot be the reason for scaring them, right?"*[42]

Another participant explained in a similar manner how she experiences the interaction with her social environment:

> *"I am often asked: have you adapted to this new reality? I certainly adapted. It was very hard at times, but only by adapting and participating in society you can have peace again and build a future. I speak Dutch, my children go to school, I go to the disco without my husband, I work in a shop here in the village, things are good. But if you ask me if I am integrated? My answer is no. Simply because the adaption from the other side has never started. I am still looking for that dialogue, but I have not found it yet."*[43]

The four acculturation strategies as defined by Berry et al. assume that non-dominant groups and their individual members have the freedom to choose how they want to acculturate. However, as shown in this paragraph this is not automatically the case. If refugees feel that their

[42] Yarah, informal conversation 12-04-2020
[43] Safae, interview 20-02-2020

social and personal identities are not sufficient for interaction in the new context, they will readjust their behaviour or modify projected self-images in line with what is perceived and accepted as suitable by members of the dominant group. Such adaption does not necessarily have to entail an actual change in the understanding of the self, since integration does not require a person to become a totally different person. However, as shown in this paragraph, individuals may feel like they are expected to make such profound adjustments in their social and personal identity domains in order to maintain interaction with their new environment that there is little room left to show 'who they really are' in other terms then what they do, study or where they come from*: "Of course I changed, I have a different identity now, an identity that fits in this society. People accept me and care about me, but in general it feels like people cannot separate me from my cultural and refugee identity markers. I am not my culture, it is part of me, but it is not everything."*[44] This statement indirectly shows how being open and inclusive towards cultural diversity is not naturally an indicator for the improvement of people's personal well-being. A sense of "who you are" is essential to all humans. If individuals do not have a clear sense of self or identity, it will be unlikely that they do have a clear sense of their motives, goals, attitudes, values or set of social roles which are all part of their identity (Ward & Styles 2002). Indeed, according to Erikson (1974, 27) "a sense of identity means a sense of being at one with oneself as one grows and develops a sense of affinity with a community, both in the present and future." Consequently, if a challenge to a person's identity and understanding of the self occurs, a crisis situation is possible. While pre-migration factors are commonly recognized as key predictors of identity struggles, challenged self-concepts and mental distress in refugees, my research called for a focus on the effects of post-migration stressors, which occur in the process of adapting to the host country: the acculturation process. Generally, when acculturation experiences cause problems for the individual, the phenomenon of acculturative stress arises. Given the focus of this research the next paragraph will discuss how acculturative stress can lead to mental distress, which specific acculturation stressors appeared most present in the lives of my participants (also in their encounters with mental health practitioners), and which role the mental health care system can play in (re)shaping the acculturation process.

5.2 ACCULTURATIVE STRESS

Migrants have left their social environment behind, in which they were integrated, still carrying with them those earlier acquired patterns of thinking, feeling, and acting. When stepping into a

[44] Nisa, interview 24-02-2020

new culture, migrants must learn how to deal with a host population showing an unfamiliar programming of the mind and the social world. When there is conflict between learning new aspects of the host culture, and shedding aspects of the culture of origin, the acculturative stress paradigm becomes applicable (Berry, 1997) and coping strategies are needed to deal with physiological and emotional reactions. Acculturative stress is beyond general life stress and includes acculturation-specific issues such as ethnic identity, discrimination, culture competence, cultural values and second-language competence (Jasinskaja-Lahti et al. 2003; Koneru et al. 2007). It follows that when immigration is not a choice, as in the case of refugees who are forced to leave their own cultural base, acculturation may impact to a greater extent on the stress already experienced by virtue of being a refugee. Being exposed to new intercultural contacts, leads to a number of conflicts, with an impact that can range from small to substantial. There are conflicts through the new roles played in the new place of residence, conflicts through change of status, specific practices, beliefs and values, and conflicts through having to manage a new language. All of them may become significant daily stressors. Within the period of my fieldwork, my participants, who all got a residence permit and are not living in reception centres anymore, revealed three main acculturation stressors they are currently dealing with: language acquisition, religious identity and the individualist character of Dutch society. Those stressors can lead to mental distress which in turn affect the course of the acculturation process. Additionally, within the context of mental health care, a system that is devoted to the treatment of mental illnesses and the improvement of people's personal and social well-being, those stressors can complicate the interaction between mental health practitioners and Syrian refugees and form a boundary for meaningful, effective and sustainable care and support. Conversely, when those obstacles can be overcome, treatment can positively influence the acculturation process.

Language and identity

First of all, language is central to acculturation as the means of integration through communicating and understanding in both cultures. Learning, or not learning the dominant language can influence Syrian's identity development as well as facilitate or hinder their integration within Dutch society. As stated by Bourdieu (1993, 164), language, as a practice "is not merely a method of communication, but also a mechanism of power that impacts individual's access to various social networks, their identities and their access to sources and forms of cultural knowledge". Therefore, learning Dutch not only becomes a means of

communicating with others or a tool for building social relationships, but also an entry point into a new way of life that could reflect a new sense of identity and a way of positioning oneself within the larger community (Perice 1995). However, even though all my participants stressed how their lack of Dutch language skills affects their ability to communicate and the feelings of frustration, shame, and anxiety that accompanied such incapability, they also emphasised another significant point of view regarding this topic. While acknowledging that the acquisition of the Dutch language is one of the most important elements toward integration, all of them believed that their linguistic world differs so dramatically from the Dutch one, that some forms of expression will never be possible, not even when being able to fluently speak Dutch. Not per se from grammatical or practical perspectives, but in the underlying meaning that words, expressions, and stories entail: *"What I say often comes close to what I mean, but it never feels like I can say exactly what I want, because Dutch language is so limited and does not have enough words to describe what I mean*."[45] As my research findings indicate, language is a defining feature of a person's identity, contributing to how they perceive, experience, and express themselves. In all conversations about language I could sense some level of pride and strong identification with this important facet of their cultural background:

> *"Arabic is a very rich language; it has different dialects and different calligraphic forms and styles, and its history is as complex as the history of the countries that speak the language. But I think all Syrian people agree that Arabic is a beautiful and poetic language, a veritable form of art and part of who we are. You cannot even compare it to Dutch, it is different form of expression in every sense."*[46]

To get a better understanding of this deep-seated meaning that language has for many of my participants, I started to read a book that one of my participants recommended and is written by the Syrian author Rafik Schami, called: Damascus Nights (2011). Even though I was reading the book in English, I think I was able to taste and grasp a little sense of how my participants feel about their mother tongue. The time of the book is present-day Damascus, where Salim, the city's most famous storyteller, is mysteriously struck dumb. To break the spell, seven friends gather for seven nights to present Salim with seven wonderous 'gifts': seven stories of their own design. While the seven friends swap stories about the magical and the mundane: about djinnis and princesses, about contemporary politics and the difficulties of bargaining in a New York department store, all of Damascus appeared before my eyes, along with a vision of

[45] Nisa, informal conversation 22-04-2020
[46] Husband of Isra, informal conversation 09-03-2020

storytelling and talking as the essence of friendship, of community, of life. When I finished it and shared my praise for the book, my participant had to laugh and said: *"If you already like it in English, image how beautiful it is in Arabic."*[47] Given the intrinsic and important role of language in the lives of most of my participants, I came to realize how much language is intertwined with notions of identity and understandings of the self, which are both subject to change in the process of acculturation, and central topics within the medical encounter. Complementary to this understanding are studies of Muslim scientists, who consider language ability as the highest achievement of the human self (Ashy 1999). They see in it the basis of thinking. Expressing the self accurately is the major function of language in Islamic understanding and Islam, and Muslim scientists also emphasize the importance of avoiding useless speaking. In Islamic tradition, listening has more significance than useless talk and people are 'advised' to talk only for good purposes, to express themselves, and to avoid talking that might be damaging to society, to relationships, or to the self:

> *"I noticed that my Dutch friends speak a lot about other people, that gossiping is really a thing, and even though I have to admit that I also do it sometimes, I think it is a very useless and stupid thing to do. A famous Arabic saying is that Allah gave us two ears and one tongue, so we listen more than we speak."*[48]

A well-known proverb states that a good word is like a seed that grows to be a tree; the roots of this tree are in earth and the branches are in the sky, and it always gives fruit.[49] This understanding of the purpose of language and its consequences has significance in relations among Muslims and in therapy. The diagnosis and treatment of mental distress depend to a large extent on verbal communication between patient and clinician. Both research populations (Dutch psychosocial practitioners and displaced Syrian adults) perceive language as a major obstacle in the medical encounter and argue that translation of emotional, mental, and other relevant terms means more than finding semantic equivalents. Imran, a Syrian man who fled to the Netherlands in 1999 and a psychiatrist by profession said:

[47] Yarah, informal conversation 18-02-2020
[48] Maya, interview 02-04-2020
[49] Explained by Yusur, interview 19-02-2020, originating from the Quran

> *"Language is an equaliser, so besides our expectation of them learning Dutch in order to participate and express themselves in our society, we also have to show some interest and respect regarding their language, especially in the sensitive context of mental health care, if we don't understand the meaning of their words we cannot help them."*[50]

Given his long experience with guiding Syrian people suffering from mental distress, he can state that language is a defining component in 'successful', equivalent and sustainable treatment. He communicates with his clients in Arabic but given the simple fact that there only are a few Syrian/Arabic psychiatrists in the Netherlands, not all Syrian people who need help can be ascribed to a practitioner that speaks the same language. Because many of his clients share the sentiment that communicating with a Dutch practitioner about their complex complaints is perceived as very challenging or even impossible, Imran started to provide methodologies and approaches for professionals in the field in order to improve communication with Syrian people. According to him the responses from the field are often very positive:

> *"Actors in the field often say that when they acknowledge that people not only literally speak another language but also speak another language in terms of how they give meaning, interpret things and perceive the world around them, connection is made so much easier. It is not about translating the exact words they are saying, but about translating why they ask for help and what they need in order to get better. With this approach, we often see that people feel taken seriously and start to open up. And that is where change can start to happen."*[51]

In this sense, mental health care intervention seems to positively affect the acculturation process. However, given the fact that I did not gather first-hand experiences from Syrian people attending mental health care, I cannot make statements about how such interventions effected their lives and course of the acculturation process. Thus, accordingly to my research findings, since language ability is considered so important, not being able to properly express oneself, seems to damage a person's self-esteem and cause feelings of frustration, shame, and stress. Even though learning the Dutch language can facilitate the development of Syrian refugees' identities and enrich their position in Dutch society, it seems like many of my participants still feel like they cannot show their inner selves by means of the Dutch language. This, in turn,

[50] Imran, interview 10-03-2020
[51] Imran, interview 10-03-2020

affects the acculturation process and the interaction between practitioners and 'clients' within the mental health care setting.

Religion: a restraining or supportive element for acculturation?

For Syrian refugees, it is not only a matter of learning a new language and readapting to a completely new way of life but also having to deal with the idea that their religious beliefs usually goes against 'Dutch modernity'. Although my participants differ in how devout 'religious' they are, most of them believe that religion impacts their acculturation experiences as a profound boundary marker. Drawing from my fieldwork data, there can be said that religious boundary impacts their involvement and acceptance in their social life at many different levels. Many of my participants reported difficulty in creating a social network because of religious restrictions and social distance placed by natives in reaction to these restrictions. The quote below shows the links between religious boundary, decreased social involvement and perceived social distance:

> *"My religion is not who I am, but it definitely is part of who I am. I cannot drink alcohol or go swimming or to the disco with my friends, because for me that is haram (forbidden in Islam). But there are so many things I cán do but are not asked for because people assume that I not allowed to do it because of my religion. Therefore, it is just easier to hang out with my Syrian friends, we understand each other better."*[52]

According to Shadid and van Koningsveld (2002), when the West is confronted with a significant number of Muslim immigrants, religion is often used to distinguish between social groups, even though other ethnic, social, and linguistic markers also exist. In the case of Syrian refugees in the Netherlands, religion is also being used to highlight differences and incompatibilities between refugees and the natives. For many of my participants it feels like Islam is publicly condemned in the West, which according to them is the result of the influence of the media painting a negative image of Syrian refugees. They explained that boundaries are instigated by Dutch natives' establishing social distance and limiting contact with Syrian refugees due to prejudice regarding religion, ethnicity and refugee status.[53] Even experiences of refugees who have less religious affiliation or no longer practice Islam at all are not exempts

[52] Nisa, interview 24-02-2020

[53] Anouar, informal conversation 17-02-2020; Isra, informal conversation 16-04-2020; Yusur, interview 19-02-2020; Yarah, informal conversation 20-02-2020 + interview 28-02-2020; Safae, interview 06-03-2020; Hajar, interview 11-03-2020; Imran, interview 10-03-2020

from religious prejudice probably due to the link between ethnic origin and religiosity that seems to be so persistent in the perception of the Dutch:

> *"I try to live without my religion more and more, because of several reasons. But because I am a Syrian, people will assume that I am a Muslim, that I am dangerous and that I never will fit in this society. So, what I am supposed to do then? Stand on the street and shout to people that I don't believe in any religion?"*[54]

This expression echoes the research done by some scholars, stating that the Islam is perceived as culturally distant and contradictory to the Dutch national identity and viewed as a problem for the integration and adaptation process of immigrants (Verkuyten and Aslan 2007; Bender and Yeresyan 2014; Foner and Alba 2008). The impact of religion on acculturation of my Syrian research population is evident and can be explained through religion's vital role in identity and boundary formation, both of which contribute to the creation of perceived cultural distance and influence intergroup relations between Dutch society and Syrian refugees. However, although participants stated that religion impacts their involvement and acceptance in their social life and is a major source of acculturative stress, they also emphasized how religion offers them a way to cope with their distress and concerns. As stated by Kuo (2014) there is an interwoven relationship between coping and acculturation. In fact, major acculturation scholars state that the principles of acculturation theory are based on the broader psychological theory of stress and coping (Berry 1997, Kuo 2014). As individuals undergo acculturation, they manage and cope with the stressors and major life changes caused by migration, cultural transition and being in prolonged contact with a new society. Lazarus and Folkman (1984) define coping as 'the constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person'. Coping strategies denote the range of responses to the stress that an individual has available and can use successfully (Biggs, Brough, and Drummond 2017). Coping is a natural, necessary and inevitable aspect of acculturation for most immigrants and plays an important role in mitigating the effects of acculturative stress (Kuo 2014). As extensively discussed in chapter one, many Syrian refugees highly utilize their religion as coping mechanisms, which is something mental health and psychosocial support practitioners must be aware of.

[54] Hajar, interview 11-03-2020

The self in the social context

Another very important trigger for acculturative stress, which is discussed in the first chapter as well and is affected by and affects the components of language acquisition and religious identity, is the Dutch way of promoting an independent view of the self. For most Syrians, the first source of support is the circle of family and friends. Displacement and the dynamics of the conflict challenge and may disrupt these social support structures, and the search for making new, meaningful social connections can be very stressful in a society where most people place at the centre of their lives, the importance of self-expression, uniqueness, and self-actualization, basing their actions on personal thoughts, feelings, and goals. In my data, a strong relationship between religion and social differences is explicit, they appear to be intertwined. Religiosity encourages a collectivistic lifestyle, which necessitates an increased level of social contact and hospitality compared to a secular context that yields a more individualistic lifestyle, such as the Netherlands (Gebauer, Sedikides, and Neberich 2011). Thus, most Syrian refugees, even those with low/no religious identifications, place much meaning on close and frequent social contact because it is associated with family life, a sense of belonging and acceptance. Most of my Syrian participants expressed an intense desire to recreate a similar collectivistic setting in the Netherlands. Especially in the case of forced migration, when people are sheared off from their expected connections with others, from their perceived social supports and from their basic sense of safety, it is through human relationships a traumatized person can reconnect to the world:

> *"There are only a few Dutch people in my life, but they honestly changed my life. Because of them I feel welcome and not scared anymore. They help me to rebuild my life and become part of the Dutch community. I just don't understand why it is so hard to make contact for so many Dutch people, I know we are different but in the end we are all human beings who long for connection and a meaningful life."*[55]

Lack of frequent social contact with Dutch citizens can cause an increased sense of grief over the loss of family/social life in Syria and a profound sense of rejection and isolation in the Netherlands, which influences the level of acculturation.

Obviously, the above-mentioned stressors do not automatically lead to mental health problems, most migrants are able to successfully adapt to new cultural contexts by managing the tension that those stressors bring about. However, both literature research and my fieldwork

[55] Yusur, informal conversation 08-04-2020

show that many refugees who do suffer from mental distress often connect their problems to difficult acculturative aspects of their lives in the country of reception, rather than to the (traumatic) experiences in their country of origin (Koneru et al. 2007; Şafak-AyvazoĞlu et al. 2020; Galchenko and Van de Vijver 2007; Hassan 2015; Kuo 2014). Where mental health professionals generally attach more value to individual than to structural (social, cultural, political) factors, refugees more often connect their problems to the structural factors they are facing in their daily lives. Some participants expressed their wish that the therapist or doctor would help them solve the practical aspects of their lives, such as finding a job and improving their Dutch. These expectations are sometimes considered by mental health professionals as unrealistic, unethical, conflicting with therapeutic roles or the blurring of provider–client boundaries (Hassan 2015). However, even though admitting that they do not have the capacity and time to practice it themselves, most of my participants working in the field shared the opinion that mental health and psychosocial support for refugees should consist of a multi-layered system of services and supports:

> *"Of course, we have to make sure that we address risks for longer-term mental health consequences, but I have seen so many cases where more practical support would have been more beneficial and effective. Interventions to foster social cohesion and strengthen community support often have the power take away much of the experiences mental distress.*"[56]

This statement indicates the beneficial association between increased acculturation and mental health.

CONCLUDING NOTES

Refugees who want to establish new lives and fit into a new, unfamiliar socio-cultural context should be able to do so in a way that they can harmoniously integrate the values, norms, customs, and practices of their ethnic culture with those of the host (dominant) culture. The acculturation process involves relearning the meanings of symbols; readjusting to a new system of values; experimenting with new roles; and gaining skills and competencies that are necessary for participation in the new society. In such a period of flux, it is not only to be expected but also to be acknowledged, that individuals experience confusion and distress while developing their 'new' identities and evolving understandings of selfhood. This chapter showed that

[56] Liselotte, interview 24-03-2020

reinvention of the self and reconstructions of identity can occur over varying lengths of time for different people. Additionally, the chapter revealed the complex relationship between acculturation and mental health, showing that mutual accommodation is required for integration to be attained. This implies the acceptance by both groups of the right of all groups to live as culturally different peoples. It was also observed that although refugees are in a position to reconstruct their social identities and reinvent their notions of the self, they are at the same time restricted by the parameters of opportunities, services and attitudes of the new social, political and cultural context. Negotiations of belongingness and identity (re)constructions are part of wider every day and structural expressions of inclusion and exclusion that determine belonging or non-belonging to wider geo-political collectives. By emphasising the strong relational character of the acculturation process, this chapter showed how stressors such as language acquisition, religious identity and divergent needs/desires for social contact, can complicate processes of interacting and adapting to the new environment, and, in turn can cause significant mental distress. When those boundaries are overcome, room will be created to build healthy, equal, and valuable relationships, which can help refugees to reconnect to the world and find their place in Dutch society. Last but not least, moving away from considering refugees as threats to 'our' comfort and start accepting, protecting, and empowering them is not only beneficial for the refugees themselves, but also for the country of destination since refugees' life experiences (educational backgrounds, professions, etc.), resilience, cultural backgrounds, and ways of giving meaning to the world can contribute greatly to the enrichment and development of Dutch society.

6.

CONCLUSION AND DISCUSSION

Before fleeing Syria and during the journey to the Netherlands, many Syrians have witnessed or experienced the death of loved ones, physical harm, violence, and terrifying situations. The psychological impact of conflict-related violence combined with the ongoing daily stressors as a result of displacement can have a significant impact on the mental health and psychosocial well-being of Syrian refugees (Hassan et al. 2015; Cetrez & Balkir, 2017; Silove, Ventevogel, & Rees, 2017; Ingleby & Watters, 2005). With the aim of mobilising individual and collective strength and resilience of refugees, thereby enhancing mental and social wellbeing, mental health care for refugees in the Netherlands is being acknowledged as something that must get high priority (Health Council 2016). However, there are several major challenges to providing suitable mental health care to refugees, the extent of which varies depending on a range of factors. In addition to this, considerable controversy has arisen about the kind of care that is provided. The assumptions and approaches which initially defined mental health care provision for displaced persons have come under scrutiny. Not only the practitioners working in the field, but also Syrian refugees face numerous challenges when approaching the mental health care sector. Given the scale of the influx of Syrian refugees and the expected levels of mental distress among them, research concerning the topic of mental health care for refugees is deemed very important. After all, refugees' mental condition, their state of well-being, is not only determining and shaping their own lives, but also affects the environment they live in.

This anthropological research focussed on Syrian conceptualizations of the person, in order to get a better understanding of how they experience and express suffering, how they explain mental distress, cope with their situation, and how they seek help. By doing this it became clear that cultural worlds may differ so dramatically that translation of emotional terms, cognitive processes or recovery approaches means more than finding semantic equivalents. Referencing Kleinman and Good (Good & Kleinman 1985, 246), they asserted that "describing how it feels to be aggrieved or melancholic in another society leads directly into an analysis of a radically different way of being a person." Therefore, when helping people to recover from traumatic pasts or profound mental distress as a result of post-migratory stressors and challenges, it is very important to understand 'the construction of self' and the way that people

give meaning to their life's. This entails recognizing self and personhood and the relationship between self, family, and others in a sociocultural context, as ideas and their environment co-evolve and interact together. This process of co-evolvement, interaction and adaption can be referred to as the acculturation process, which in this thesis was researched in relationship to mental health. Not only the connection between one's psychological condition and the level of acculturation was discussed, but also the way in which mental health care and psychosocial support services for refugees can be considered agents in the acculturation process, since they constitute a site where two cultures meet and where change can occur. In these concluding remarks I will integrate my research findings of the previous chapters and answer the main research question:

"How do differences between the perception of Dutch psychosocial practitioners and displaced Syrian adults about belief systems and practices of mental health affect the acculturation process of Syrian refugees in the Netherlands?"

As discussed in chapter one, underpinning the constructs of "mental health" or "trauma" is the concept of a person, embodying questions such as how much or what kind of adversity someone can endure, when acceptance or resignation is appropriate or when a sense of grievance, what suitable behaviour is at a time of crisis, including how mental distress should be expressed and help sought, and whether healing is due. Views of the person and the relationship of the person to the world are, as extensively discussed in this thesis, being shaped by historical, religious, ethnic and social dynamics and influence how people experience and express suffering, how they explain illness and misfortune, and how they seek help. As represented in the first chapter, the 'Syrian' concept of the person, in which the self is largely interpersonal and consensual, more orientated to key roles and relationships than to what is deeply private, is very different from the 'Western' understanding of personhood. Western personhood gives emphasis to a concept of the self as a rather independent entity, less influenced by its surroundings and society. Besides, many of my Syrian participants perceive the mind, the body, the soul, the self, and the social context as interdependent entities, which directly affect each other and cannot be separated. Therefore, it is likely they will describe the experience of their mental distress in physical, somatic terms. As a common thread throughout different components of this thesis, chapter one also discussed how religious value systems play a significant role in the perception and understanding of the self and the world, including their psychological problems and methods of coping and treatment. When social connectedness and religious affiliation, not personal depth, is the measure of the moral value of the self and when the harmony of the family

or group matters more than the autonomy of the individual, who is not conceived of as a free-standing unit, the individualistic and internalizing framework of Western psychology may have a number of implications for refugees attending in mental health care programs. The explanatory models described in chapter one can be useful for informing and designing culturally appropriate programs and mental health care. However, even though explanatory models can be crucial to diagnosis, treatment, and care, it is critical to view this information as one of many tools that may be utilized within the clinical encounter with a refugee. This is because cultural processes do not stand still, they are not static and homogenous but frequently differ within the same ethnic or social group because of differences in age, gender, political association, background, class, religion, ethnicity, and even personality. This is especially true for most of my Syrian participants, which come from a country that can be seen as the product of not just Islam but also of Western nation state making and, more importantly, massive waves of forced migration. In addition, Syrian refugees undergo a complicated process of identity reformulation and occupy multiple subject positions and contradicting identities as a result of displacement, some of which they define for themselves and some of which are defined for them.

Chapter two of this thesis focussed more on this phenomenon of how the wider network of welfare bureaucracy, of which mental health care facilities for refugees are a part, affect the attitudes of wider society with regard to refugees and shape how Syrian individuals see themselves. An analysis of the Dutch mental health care system, its approaches, methods and ways of interpreting and making sense of a refugee's story, provided valuable insights in how the system and its actors try to develop a greater sensitivity to culture in general and a more comprehensive understanding of particular cultural groups and their values, norms, social practices, health beliefs, and health practices. Even though such culturally sensitive or trauma specific care is only intended to do good, this research showed how special programmes established to provide psychological help for refugees and victims of wartime violence with culturally different backgrounds have a number of largely unanticipated effects. Even though chapter one discussed how culture is perceived as inseparable from psychological conditions, the danger of narrow and simplistic conceptualizations of culture is that they may actually reinforce generalized cultural stereotypes and thus can contribute to, rather than reduce, cross-cultural misunderstanding and increases the sense of 'otherness'. Another phenomenon that has the power of imposing certain identities on Syrian refugees and affect their self-stories, self-perceptions and self-representations is the tendency of defining and portraying them as victims, as traumatized persons requiring special psychological help. Such labelling and ordering of

refugees' experiences, which in most cases happens in an indirect and unconscious way, is part of what Ong (1996) calls the 'dual process of self-making and being-made' within webs of power linked to Dutch nation state and civil society, which also influences notions of belonging and citizenship. While acknowledging that mental health care can certainly attend to the health of individuals, chapter two discussed how the mental health care system is much more than a construct of care provision. It argues that, in the same sense in which we speak of religion, language, kinship or illness as cultural systems, mental health care can also be viewed as a cultural system, including patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially legitimated statuses, roles, power dynamics, interactions settings, and institutions. In this sense, practitioners working in the field are not only grounded in the world of the patient, but also in their own personal and societal context, and in the professional but socially and culturally constructed world of mental health care for refugees. Being able to unpack the formative effect that the culture of mental health care for refugees and institutions have on clinical practices but also on the wider image that is represented through their acts (including bias, inappropriate and excessive use of advanced technology interventions, and stereotyping), could help practitioners in the field to critically self-reflect and acknowledge how they are part of wider social and bureaucratic practices that in some sense socialize subjects of the modern welfare state. In other words, chapter two discussed how societally and culturally constructed ideas about refugees, integration, trauma, mental distress and outcomes, which include the explanations of the mental health field, carry a degree of self-fulfilling prophecy and determine how Syrian refugees identify, relate and adapt to the new Dutch environment. However, it must be said that the psychosocial practitioners I have met genuinely seem to focus on the patient as an individual, not a stereotype, as a human being facing anxiety and uncertainty, not solely a case, as an opportunity to engage in an important moral task, not an issue in cost-accounting. Probably this can be explained by the fact that most of them are familiar with the discipline of anthropology, are not Dutch or experienced forced displacement themselves, providing them with the tool of critical self-reflection that comes from the unsettling but at times enlightening experience of being between different social and cultural worlds. Therefore, the arguments made in the second chapter of this thesis are mainly build on sentiments and experiences of my Syrian participants, opinions of Dutch psychosocial practitioners about the wider field and practices of mental health care for refugees, and extensive literature research.

Eventually, the relationship between mental health and the acculturation process was discussed, arguing that acculturation is a dynamic, context-dependent, multidimensional

process influenced by personal factors as well as the characteristics of the heritage and host countries. After placing the concept in the academic debate and discussing how the process of acculturation is dependent of wider every day and structural expressions of inclusion and exclusion that determine belonging or non-belonging to wider social collectives, the chapter revealed that refugees suffering from mental distress often connect their problems to difficult acculturative aspects of their new lives in the country of reception, rather than to the experiences in their country of origin or during migration itself. The main acculturative stressors shared by my Syrian participants were language acquisition, religion and the concept of the self, which not only form an barrier to integration within Dutch society, but are also perceived as main reasons for not seeking or not succeeding mental health care. First of all, given the intrinsic and important role of language in the lives of most of my participants, this chapter showed how much language is intertwined with notions of identity and understandings of the self. Even though all my participants are able to express themselves in Dutch, they still believed that their linguistic world differs so dramatically from the Dutch one, that some forms of expression will never be possible, not even when being able to fluently speak Dutch. The deployment of more Arabic speaking practitioners in the mental health care sector, the use of specialized, professional translators, or at least the effort of trying to gain a better understanding of the linguistic meaning worlds of Syrian 'clients', could bridge a significant part of the treatment gap. Secondly, as throughout the entire thesis, religion appeared an important determinant for acculturative stress, contributing to the creation of perceived cultural distance and influencing intergroup relations between Dutch society and Syrian refugees. In relationship towards religiosity, the concept of the self as positioned in and related to a social cultural context was discussed, again demonstrating how differences in understandings of what makes up the person determines how people perceive, relate to and move in this world. The following quote beautifully captures this reasoning and at the same time comprises the broad lines of the answer to the main question of this research:

"*I do believe that there are so many people out there who can help me with my pain, but the kind of care they give does not fit. You know what the thing is, my mind, my body and my heart are programmed in a different way than yours, but that does not mean we cannot connect. But for connection to happen, you always need two sides, two parties, we cannot do it on our own. We need people to not only tolerate us but to see us as more then damaged or threatening refugees. We are just normal people trying to rebuild our lives in the best possible ways we can. And just like you, we need social connection, safety and future perspective to survive and build a meaningful life."*[57]

Integrating all concluding notes of this chapter and combining it with the above quote, it can be said that there exists a certain 'mismatch' between Dutch mental health and psychosocial support for refugees, and that what is needed by Syrian persons. As a consequence of this mismatch, the acculturation process of Syrian refugees, as difficult as it already is, is further complicated and challenged, mainly through trauma-focussed (hereby objectifying and ordering 'suffering' as an entity apart), internalizing and individualistic approaches and a different conceptualization and understanding of the self. Given the embodied and essential meaning of the person as being closely connected to others and contextually embedded, it is precise the lack of this feature of social connection creating feelings of isolation, neglection and non- belongingness among Syrian refugees. Putting a lot of effort in reinventing and reconstructing their notions of personhood and identity in order to adapt in such a way to connect to and participate in Dutch society, many of my Syrian participants feel bounded and restricted by the parameters and attitudes of the Dutch social, political and cultural context, of which mental health care institutions are a part. While this conclusion is worrisome, it should specifically be mentioned that all of the described hurdles, once properly identified, can be overcome. From the interaction I had with Syrian refugees, I can only draw the very positive conclusion that they are willing to put a lot of effort in adapting to the new social and cultural context. If this is combined with more suitable services from the mental health care sector, based on the competence and commitment of its professionals, which as shown by my Dutch participants is already happening on a small but growing scale, one may assume that positive steps will follow, thus contributing to a more successful integration process.

[57] Yusur, interview 14-03-2020

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APPENDIX 1

Arabic term or phrase	Transcription	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
متضايق كتير هالفترة حاسس حالي متضايق ضايج نفسي مخنوقة	- Meddayyek ketir hal fatra - Haassess haalii meddayyek - Dayej - Nafsi makhnouka	- I am very annoyed these days - I feel annoyed - To be cramped - My psyche is suffocating	- Rumination tiredness, physical aches, constriction in the chest, repeated sighing - Unpleasant feelings in the chest, hopelessness, boredom
حاسس روحي عم تطلع	- Hassess rouhi 'am tetla'	- I feel my soul is going out	- Dysphoric mood, sadness - Inability to cope, being fed up - Worry, being pessimistic
قلبي- مقبوض انعمى على قلبي	- Qalb maqboud - In'ama 'ala kalbi	- Squeezed heart - Blindness got to my heart[1]	- Dysphoria - Sadness - Worry, being pessimistic
تعبان نفسياً- حاسس حالي تعبان- حالتي تعبانة- نفس تعبانه	- Taeban nafseyan - Hassess halii ta3ban - Halti taebaneh - Nafs ta'bana	- Fatigued self/soul	- Undifferentiated anxiety and depression symptoms, tiredness, fatigue
-ما قادر اتحمل الضغط علي كتير- مو قادر ركز من الضغوطات -	- Ma ader athammel - El daght 'alayy ketiir - Mou kaader rakkezz men el doghoutaat	- Can't bear it anymore - The pressure on me is too much - Can't concentrate because of the pressure	- Feelings of being under extreme stress or extreme pressure - Helplessness
فرطت-	- Faratit	- I am in pieces	- General state of stress, sadness, extreme tiredness, inability to open up and to control oneself, or to hold oneself together
و الله مو شايف قدامي-	- Wallah mou shayef oddaamii	- By God, I can't see in front of me	- General state of stress, feelings of loss of options, loss of ability to project into the future, - Confusion, hopelessness
-حاسس الدنيا مسكرة بوشي - ما في شي عم يزبط معي	- Hases eddenia msakkra bwishi - Ma fi shi 'am yizbat ma'i	- I feel the world is closing in front of my face - Nothing is working as planned with me	- Hopelessness, helplessness, state of despair
- شو بدي إحكي...الشكوى لغير الله مذله - الحمد لله	- Sho baddi 'ehki… el shakwa le gher allah mazalleh -Al hamdullillah	- What am I supposed to say… it is humiliating to complain to someone other than God. - Praise be to God.	- Reference to shame in asking for help - State of despair, surrender
ما بعرف شو بدي إعمل بحالي	- Maa ba'ref shou beddi a'mel be halii	- I don't know what I am going to do with myself	- General state of distress - Feeling upset, edgy, helplessness -Hopelessness, lack of options
متوتر	- Mitwatter	- I feel tense	- Nervousness, tension
خيفان حاسس بالخوف مرعوب	- Khayfan - Hases bil khof Mar'oub	- I am afraid - I feel fear - Frightened, horrified	- Fear, anxiety - Worry - Extreme fear
مُعَصَّب	M3asseb	- I feel angry	- Anger, aggressiveness - Nervousness