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Local Lifeworld and Global Mental Health—Perspectives from Medical Anthropology

VWB

Zum Titelbild/Front picture *Curare* 38(2015)3
The cover picture shows an amulet against the evil eye, a worldwide popular practice to obtain mental health. Here it is an individually created "house blessing" in Modern Hebrew from a market in Jerusalem written on the "Hand of Miriam" (or hamesh hand). In similar way the "Hand of Fatima" (Hamsa hand) as a protective symbol is used in folk beliefs in Arabic Muslim societies in North Africa and the Near East (see fig. 1 in Schreier M. 2014. "Guter und böser Blick bei Immigranten in der Schweiz." *Curare* 35,4: 247–250).

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Ethnic Targeting in the Netherlands: Interrelating Migration, Religion, and Mental Health Care

Amber Gemmeke

Abstract The Dutch mental health care sector is of specific interest in the study of interrelations between migration, religion and mental health care for two reasons: a history of ethnic targeting in policymaking and an absence of a debate on colonialism or racism. Local policymaking has a long tradition of ethnic targeting that is, recently, stimulated by "ethnic entrepreneurship." National policymaking, by contrast, is increasingly concerned with (the perceived loss of) national Dutch identity and Dutch culture in the face of globalization and regards (migrant) religion as a lack of integration. Both local and national discourses on mental health care, religion, and migrants reflect, however, cultural objectification. In this paper, I outline the contrast and divergences between national and local developments in Dutch mental health care policies targeted at migrants. The work of a Surinamese "Winti advisor" will serve as an example of the struggles with notions of "religion" and "culture" in the Dutch mental health care sector.

Keywords mental health care – ethnic targeting – Winti – pillarization – The Netherlands

"Ethnic Targeting" in den Niederlanden: Zusammenhänge zwischen Migration, Religion und Seelischer Gesundheit

Zusammenfassung Der Bereich des Seelischen Gesundheit ist im holländischen Gesundheitswesen für ein Studium der Zusammenhänge zwischen Migration, Religion und seelischer Gesundheit besonders aufschlussreich: In der Politik gibt es eine Entwicklung, die ethnische Herkunft zunehmend zu kennzeichnen, und es fehlt die Debatte zu Kolonialismus und zu Rassismus. Im lokalen Bereich wurde diese Entwicklung durch eine ambivalente Debatte um „ethnisches Unternehmertum“ angeheizt. Die nationale Politik hingegen zeigt Tendenzen, auch unter dem Eindruck zunehmender Globalisierungsprozesse, sich um den Erhalt von nationalen Identität und Kultur zu bemühen und gibt dabei Integrationsproblematiken bei Migranten ein Übergewicht. Die lokalen und nationalen Diskurse spiegeln sich besonders in den Bereichen der Seelischen Gesundheit, der Religion und um den Status der Zuwanderer wider. In dem Aufsatz versuche ich, diese Entwicklung an Hand der Ethnisierung in den Bereichen der Seelischen Gesundheit aufzuzeigen. Dazu dient eine Fallstudie zu einer „Winti“-Gesundheitsberaterin, in der der Einfluss von „Religion“ und „Kultur“ verdeutlicht wird.

Schlagwörter Seelische Gesundheit – Ethnisierung – Winti – ethnisches Entrepreneurship – Integration vs. Abgrenzung – Verzuiling (Versäulung) – Niederlande

Introduction

Mental health care, committed to the treatment of migrants, refugees, and torture victims finds itself in a highly politicized terrain, since the relationship between immigrants and receiving countries is articulated through cultural and religious differences (Giordano 2008: 230). In a number of European countries such as notably France and Italy, ethnopsychiatry and transcultural psychiatry positions itself explicitly in opposition to colonial psychiatry and stands as a critique of the institutional structure of health care. Mental health care in the Netherlands, by contrast, is marked by an absence of a debate on colonialism and racism; ethnopsychiatry is a term hardly ever used. In the Netherlands, contrary to other European countries, the largest groups of immigrants (Moroccans and Turks) do not originate from former colonies. The origins and position of migrants who do originate from former Dutch colonies, however, such as Surinamese, Antilleans, and Moluccans, are not debated either.[1] Migrants' religious backgrounds are, accordingly, largely disregarded. *Winti*, for example, "an Afro American religion which centers round the belief in personified supernatural beings" (Wooding 1979: 35), was banned by Dutch law from 1874 until as late as 1971. Today, though Surinamese form the largest migrant group using mental health care in the Netherlands, Winti is still unknown to the vast majority of caretakers. Non-Dutch interpretations of illness or suffering,

including its religious aspects, is a "blind spot" for many caretakers - even though 30 % of their patients has a non-Dutch background, as Bas Kuiper, project manager at the Amsterdam based mental health care institution Arkin remarks (personal communication 23 November 2012).

The Dutch health care system is strongly influenced by a biomedical, evidence based model, in which little place is given to religious aspects in the treatment of mental illness and suffering. It is, however, of specific interest in the study of interrelations between migration, religion and mental health care for two reasons: the absence of a debate on colonialism and racism, as well as a long tradition of top-down ethnic classification in policymaking. National policy concerning migrant's mental health care of migrants was mainly restricted to incidentally facilitating local initiatives and funding (until 2012) interpreter services. The content of mental health care directed at migrants was explicitly relegated to local organizations and their employees. In the 1990s, due to a shift from focus on socio-economic integration to cultural, linguistic, and religious integration, several nationally coordinated health programs for migrants are established.

As of the 2000s, however, Dutch secularism is increasingly presented on a national level, in both left and right political rhetoric, as a defining feature of Dutch identity; a pillar of a unified, transparent Dutch nationality in the face of globalization and the influx of, specifically, Muslim migrants (Lentin & Titley 2012: 130). References to religious diversity become, in this context, an obstacle to this commonality and viewed as a lack of civilization, integration – and even, as Fiselier *et al.* note, as a lack of intelligence and independence (2006). The shift from a "multiculturalist" policy to an "assimilist" policy with a specific aversion to (Muslim) religion marked mental health care policy in recent years. All nationally coordinated programs catering to migrants set up in the 1990s where discontinued as of the 2000s. Local initiatives focusing on migrants' mental health, by contrast, are increasing as of the 2000s.

Local policymaking in the Netherlands has a long tradition of top-down ethnic classification (*cf.* Duyvendak & Scholten 2011). Unlike similar systems of refined ethnic classifications in other liberal democracies, the Dutch ethnic category system is used in a strictly top-down fashion: membership in ethnic groups is unilaterally defined by the state on the basis of descent (De Zwart 2012: 303). Within the (mental) health care sector, ethnic targeting includes providing information on the Dutch, biomedical health care system to migrants, providing services such as translation and halal food, and subsidizing institutions such as "Surinamese," "Chinese" and "Islamic" nursing homes. Commercialization of the health care sector as of 2004, resulting in "ethnic entrepreneurship" has further increased local initiatives focusing on migrants.

In this paper, I outline the contrast between national and local developments in Dutch mental health care policies targeted at migrants. In the first part of the paper, I describe the ways in which national mental health care policies struggle with notions of religion and culture from the 1960s until today. In the second part I explore a local initiative in dealing with religion and culture, taking the work of a "Winti advisor" as an example. The paper is based on statistical data, interviews with eight (mental) health care specialists in 2012 and 2013, and policy papers.

Mental health care and religion in the Netherlands

Dutch Mental Health Care Institutions (*Geestelijke Gezondheidszorg Instellingen*, GGZ) had been set up in the 1930s by protestant and catholic churches respectively in a highly political-denominationally segregated society. From the beginning of the 20th century until the 1960s the Netherlands was, together with Belgium, one of the most segregated countries of Europe. Dutch society was divided into "vertically" organized segments; hierarchically organized religious and socialist subcultures called "pillars" or *zuilen*, such as a catholic pillar, a protestant pillar, and a social-democratic pillar (Kennedy 1995). All segments had their own social institutions: their own newspapers, broadcasting organizations, political parties, trade unions and farmers' associations, banks, schools, hospitals, universities, scouting organizations and sports clubs (Lijphart 1968).[2]

In the 1960s, de-pillarization (*ontzuiling*) as well as secularization were experienced and interpreted as a break from oppressive, paternalistic, and authoritarian structures (*cf.* Duyvendak 1999, Tonkens 1999, Verkaaik 2009). In the 1960s, in little more than one generation, the Netherlands thus transformed from one of the most Christian societies in Western Europe to one of the most secular and

liberal. Alongside strong de-churching, a significant new element in the religious landscape emerged in the Netherlands in the 1970s: "spirituality" (BECKER & DE HART 2006). Like in other European countries, such as notably Germany, Austria, and Switzerland, visits to "alternative healers" increased in the Netherlands. From 1980 to 1994 the percentage of the Dutch population, which had visited at least one alternative healer, doubled from 8 to 16 (BECKER *et al.* 1997: 161). This general trend of increasing visits to alternative healers is stimulated by health insurance companies: as part of the sale of "additional insurance packages," they increased their refunds of alternative treatments with 50% from 2005 until 2010, totaling 150 million Euros in 2009, according to a television broadcasting of *Zembla* in 2010.

Most Dutch mental health care institutions lost their religious background with their institutionalization in the 1960s.[3] In its effort to be taken serious as a "proper" science, psychiatry distanced itself from any association with religion and alternative healthcare since the 1960s (ACHARRAT-STITIOU 2009: 112). Dutch care institutions are, nonetheless, legally obliged to provide spiritual care for their patients. Based on the principle of "parity" defined as the equal treatment by the state of all religious groups or denominations, Islamic and Jewish "chaplains" in mental health care institutions, hospitals, prisons and the armed forces are funded by the state under the same conditions applying to Protestant and Catholic chaplains. Most mental health care institutions in urban areas (like the above mentioned Arkin) employ imams.

As of the 1990s a resurgence of interest in religion and spirituality within psychiatry and psychology emerged. In the Netherlands as elsewhere in Europe and the United States, publications and seminars on "spirituality and mental health care" increased (WEAVER *et al.* 2006). In a discussion on spirituality in the health care sector spread out over three articles published in the *Journal of Health Sciences*, DE JAGER-MEEZENBROEK *et al.* state that the amount of articles on spirituality and health multiplied in the last ten years six times (2008: 15). Most of these studies focus on the protective and empowering qualities of religion for patients with psychiatric ailments—seeing religion as a coping strategy (see for example BRAAM *et al.* 2003).

As elsewhere in Europe and the United States, religion-based therapies, such as mourning rituals and Mindfulness (with Buddhist origins) become commonplace in public cognitive behavioral therapy as of the 1990s (KRAMER 2010: 161). Integrative medicine is another recent development in public mental health care, using methods from alternative healing such as a focus on the whole person (ROMME & ESSCHER 1999, HOENDERS *et al.* 2008). In 2010, psychiatrist Hoenders of the *Centrum Integrale Psychiatrie* (CIP, Centre for Integrative Psychiatry) published a "protocol for complementary and alternative healthcare," which he legitimized by stating that 40% of Dutch psychiatric patients use complementary or alternative health care. In the protocol, mental health care takers are advised to, under certain conditions; refer their patients to alternative healers. Hoenders' attempts to regulate alternative healing as biomedical treatments evoked debates and critique, as published by, among others, KUIPERS & GIJSMAN (2006) and VAN DEN BERG & HENGEVELD (2010).

In 1993, in line with an increased interest in alternative healing, the Dutch state lifted restrictions on the use of the title *genezer*, "healer:" not only doctors but anyone now could, un-evaluated, start a practice carrying the title of healer. Since 1993, however, the uncontrolled mushrooming of alternative treatments in the private sector has led to several debates in the parliament and renewed attempts to regulate the "alternative" healthcare sector. Debates have especially been brought forth in 2001 by the death of actress Sylvia Millecam who attended "alternative" practitioners contradicting the diagnosis of breast cancer and offering her instead the prospect of a cure with "unfounded methods" (SHELDON 2004: 185). While before 2001, non-biomedical practitioners were not prosecuted by the Health-care Inspectorate unless in case of malpractice, the inspectorate instated legal procedures against the healer who treated the actress, and attempts to change the law to ensure the registration of all practitioners and greater supervision of alternative practitioners (FISHER & WARD 1994: 110). In 2008 and in 2010, new parliamentary debates on alternative healing arose after documentaries on deaths caused by alternative healers were televised (Netwerk 20/10/2008 and Zembla 17/1/2010).

Dutch debates on alternative healing are often sparked by the "Organization against Quackery" (*Vereniging tegen de Kwakzalverij,* VtdK) and the "Foundation Scepsis" (*Stichting Skepsis,* SS). Advocating evidence based medicine they have an active media presence, publish magazines, organize

conferences, and regularly prosecute "quacks." Both organizations took, for example, legal steps forcing the prosecutor to continue Sylvia Millecam's case after it was initially dropped. In 2009 the case concluded with a guilty verdict against two alternative healers. In 2005, Stichting Skepsis unmasked Robbert van den Broeke, a self-proclaimed psychic with numerous appearances on Dutch television, as a fraud, causing his show to be discontinued. The Organization against Quackery, founded in 1880, is the oldest of its kind worldwide.[4] Notwithstanding the increasing attention for spirituality and alternative care within public mental health care institutions and general psychiatric research, then, this trend develops alongside an increased focus on evidence based medicine, at times clashing in fierce opposition, keenly mediatized by both individuals and organizations.

Ethnic targeting

Another significant new element in the Dutch religious landscape as of the 1990s, besides spirituality, is a new and renewed interest in immigrants' religions. The number of orthodox churches increased, as well as the number of African based Pentecostal churches (Becker & De Hart 2006: 53). Furthermore, between 1990 and 2005 the number of Muslims increased considerably, from 458.000 in 1990 to 944.000 in 2004 (*ibid.* 53). In a few decades, the Muslim part of the total population of the Netherlands has increased to almost 6%, which is the second-highest percentage in Western Europe after France.

As in Austria, Belgium and Germany, the Dutch government expected migrants from the Mediterranean, Turkey, and Morocco, recruited for hard manual labor in the 1960s and 1970s, to return to their country of origin within a few years. An active policy of "integration with preservation of own identity" (*integratie met behoud van eigen identiteit*, later labelled "multiculturalism") would facilitate that return (Entzinger 1984: 87–88). Some scholars described the accommodating "multicultural" Dutch integration policies since the 1970s as Dutch pillarisation being continued, now extending to Muslims and Hindus (Carle 2006, Doomernik 2005, Entzinger 2003). In line with other scholars I regard, however, Dutch integration policies to be pragmatic, rather than ideological (De Zwart 2012, Rath *et al.* 1999, Vink 2007). The violent Moluccan crisis of 1970s and the following Moluccan Report of 1978 were highly influential in this line of policy. In the early 1950s, Indonesia, a former Dutch colony, was fighting the separatist movement that had declared the Republic of the South Moluccas. Moluccan military men serving the Dutch army and their families, totaling about 125,000 persons, where abruptly relocated to the Netherlands. The Moluccans were, upon arrival in the Netherlands, demised from the colonial army and placed in "temporary" camps and discouraged to participate in Dutch society. In 1968, still 80% of the Moluccans was stateless. Feeling betrayed in their loyalty to the Dutch Crown and by the Dutch lack of support for the Moluccan State, Moluccan activists engaged in a series of violent actions throughout the 1970s. In 1977, a group of Moluccan youth hijacked a train and a primary school class, during which eight people lost their lives (see Herman & Van der Laan Bouma 1980). Following this violent crisis, the 1978 Moluccan Report (*De Problematiek van de Molukkers in Nederland*), insists that the Dutch government should not support an independent South Moluccan state, but instead issue a series of welfare measures (and a generous budget) targeted at Moluccan employment, health, education, housing, a variety of cultural and social programs, and stresses "integration with maintenance of culture." The report stands as a landmark in Dutch migration policy of quick and efficient redistribution among designated ethnic groups for the purpose of pacification, applied to all other "temporary" migrants in the Netherlands as well (De Zwart 2012: 304).

As in Germany, it became clear at the end of the 1970s that most immigrants, whether recruited for labor, or coming from the former colonies, were not returning home. At the end of the 1970s, doctors and mental health workers in the urban centers of the Netherlands realized that the needs of this group were acute and not adequately met by the existing services. Since the end of the 1970s, local initiatives to improve the (mental) health of migrants were temporarily funded, often as a result of the charismatic involvement of individuals (Ingleby 2006: 3). Nationally coordinated policies did not focus on migrants' mental health care, however, until as late the 1990s. During the 1980s, the Dutch policy pertaining to ethnic immigrant minorities was focused on ethnic identity as a source of empowerment, emancipation and integration of migrants (WRR

Policy paper "Allochtonenadvies"—*Advise on Allochtones*—of 1989 in BLOK 2004: 37). Assuming that improvement of socio-economic integration (specifically housing issues and employment rates) automatically improves health, the health care sector is not a specific focus of minorities' policies (SBITI & BOEDJARATH 2009: 74).

In the 1990s, however, the general political debate shifted from the necessity of socio-economic integration to the necessity of cultural, linguistic, and religious integration (PRINS 2004, SUNIER 2005). Accordingly, several mental health care institutions create departments for "transcultural care." The Free University of Amsterdam establishes in 1989 the chair of Health Care and Culture and in 1992 the chair of Mental Health Care and Culture. Pharos, a national center for the development and spread of knowledge on (refugee) migrants and mental health, is founded in 1992. The influential 2000 report of the Council for Public Health and Health Care (Raad voor Volksgezondheid en Zorg, RVZ) on the *Interculturalisatie van de gezondheidszorg* (Interculturalization of the Health Care Sector), stated that in view of the increasing number of migrants and in view of the poorer health of migrants as compared to the Dutch population, structural and centrally coordinated changes should be made. The RVZ recommended, most notably, integrating knowledge on different experiences of illness (other than the Dutch) in educational programs. A direct result of the report was the establishment of Mikado, a national knowledge center for intercultural care, in 2001. Mikado publishes since 2004 the scientific journal *Cultuur Migratie Gezondheid* (Culture Migration Health). Also, from 2001 until 2004, more than thirty nationally coordinated projects are implemented including research, mental health care programs, and the hiring of migrant caretakers and managers in health care institutions in order to overcome cultural, linguistic and religious differences.

Assimilation

The debate on cultural, religious and linguistic integration of immigrants in the Netherlands intensifies in the 2000s. Its focus, however, changed from integration to assimilation. On a national level, this shift dramatically influenced mental health care targeted at migrants. As of the 2000s, Dutch government measurements are largely informed by the assumption that migrants "just do not want to integrate" (HOOGSTEDER 2012). Specific care needed by immigrants with different cultural and religious backgrounds is now considered a lack of integration and not the governments' responsibility (KRAMER 2010: 192). Sociologist Professor Paul Schnabel, for example, states at a conference on migration and mental health in 2000 that "it is almost impossible to effect research on mental health issues of ethnic minorities and to understand their backgrounds, there are just too many ethnic groups. We have no choice but to focus, even more than in the past, on integration" (BOGAARD & CAN 2000: 22, translation from Dutch: AG). All centrally coordinated mental health care projects focusing on migrants are cancelled after 2004. Mikado's subsidy ceased in 2007, after which the center continued on contracts made with individual institutions. As of 1 January 2012, the government stopped reimbursing interpreter's services in the health care system. The discontinuation of this service, operating since 1978, met with much resistance on the part of health caretakers, resulting in letters to the parliament, petitions, opinion pieces in newspapers and an Internet forum, which had no result.

This drastic departure from the former migrant policies emerged in the aftermath of 9/11 and with the meteoric rise of the charismatic Pim Fortuyn in the Dutch political arena (VELLENGA 2008b: 455). The Netherlands adopted one of the most Muslim immigrant-hostile rhetorics in Europe. Anti-Islamic discourse has become a staple of political discourse in the Netherlands: Pim Fortuyn had openly criticized Islam in inflammatory terms (and had published in 1997 *Tegen de islamisering van onze cultuur: Nederlandse identiteit als fundament* "Against the Islamization of Our Culture: Dutch Identity as Foundation") prior to his assassination in 2002, and his party continued to run on a platform of tougher measures against "non-assimilating" immigrants after his death. In media representations and in political rhetoric in the Netherlands, categories of immigrant and Muslim now overlap and are increasingly associated with terrorism.

Long before 2000, however, as early as the 1980s, some policymakers declared that the multiculturalist society had failed, especially in terms of education and health (PENNINX 1996). An airplane crash in 1992 in an Amsterdam outskirt densely populated with immigrants, *The Bijlmer*, made the

existence of undocumented immigrants (especially Ghanaians and Nigerians) suddenly visible. In the elections of 1994, anti-immigrant parties won elections in urban areas and mainstream politicians copied the vote-winning anti-immigrant and anti-Islamic rhetoric (*ibid*. 17). Then in 2000, an essay by Paul Scheffer sparked a debate on integration and immigration in the Netherlands, which was, for the first time, dominated by pro-assimilist voices. Paul Scheffer, professor in urban sociology at the University of Amsterdam and a prominent member of the social democratic party PvdA, published *Het multiculturele drama* (The Multicultural Drama) in the newspaper *NRC Handelsblad*. This essay stated that Dutch pillarization and a "soft" government had resulted in failed integration as shown by the relatively high criminality among second generation Moroccan boys, the fact that many (older) migrants were still not able to speak Dutch, and that imams were preaching in mosques against "Dutch" values such as equality of homosexuals and abortion.

The present anti-migrant and anti-Muslim social and political climate in the Netherlands is often depicted as a clear (and surprising) break with its previous multicultural tolerance. Until about 2000, the Netherlands used to be seen by foreign and Dutch observers alike as Europe's forerunner of "multicultural" tolerance (De Zwart 2012). Now, it is leading Europe in its anti-migrant and anti-Muslim rhetoric. Rather than a radical shift from multicultural to assimilist approaches towards migrants and religion, however, national policies increasingly focused on the religious, social and linguistic assimilation of (especially Muslim) migrants while, on a local level, continuing ethnic targeting continued. Within mental health care, an emphasis on ethnic minorities is amplified by the commercialization of the sector.

Ethnic entrepreneurship and the efficacy of the *migrant healer*

While centrally coordinated mental health care programs targeting migrants thus were discontinued after 2000, local initiatives, by contrast, increased. A major factor in this development is the commercialization of health care in the Netherlands. In 2004-2005, the government opened the health care sector up to the market. Commercialization would, it was hoped, reduce government costs. "Interculturalization" projects were, accordingly, left to individual health care agents. This new policy lead to "ethnic entrepreneurship" in mental health care and the establishment of mental health care institutions focused specifically Turkish and Moroccan patients and, to a lesser extent, on Surinamese and other ethnic minorities. The National Organization for Allochtone Mental Health Care (NOAGG), for example, was established in 2005. Although the institution went bankrupt within one and a half year, it was taken over by another health care institution, Altrecht, and continued in 2007 with its original name. Now, it has branches in Utrecht, Gouda, Zeist and The Hague. The Rotterdam and The Hague branches of NOAGG were taken over by health care institution Parnassia and continued under the name i-Psy in Rotterdam, The Hague, Amsterdam, Alkmaar, Tilburg, Almere, Lelystad, Eindhoven and Utrecht. Within a few years, thus, mental health care institutions for immigrants spread from the urban centers to more provincial areas. NOAGG and i-Psy promise to provide care in "the own language and culture and to take migratory backgrounds into account."[5]

At the same as the increase in ethnic entrepreneurship, national preoccupation with the integration of migrants, and specifically of Muslim migrants, intensifies. The 2012 work plan of the Health Council (*Gezondheidsraad*), for example, positions the alarming rate of mental health care problems among immigrant youth at the top of her list of current issues (*actuele onderwerpen*). The plan furthers scientific research into the discrepancy between the high rate of problems and the low rates of participation in mental health care programs (p. 15). Especially Moroccan, and to a lesser extent Surinam and Antillean men of the second generation experience more often schizophrenia and psychosis than native Dutch (Veling *et al*. 2006). Most studies suggest that the reshaping of identities within confusing and at times clashing socio-cultural frameworks causes this distress.[6] Specifically Muslim migrants would be, due to the anti-Muslim sentiments in Dutch society, be subject to increasing marginalization, exclusion and discrimination (Hoffer 2009: 250). Another important factor for the above mentioned discrepancy, psychiatrist Veling remarked, is "miscommunication" (*ibid*. 2006). Recently, an increasing number of psychological studies attribute the high rates of schizophrenia and psychosis among migrants to differences in perceptions of symptoms and illness between patients and caretakers. Zandi *et al*. (2010) state, that "first contact incidence of schizophre-

nia among Moroccans was no longer significantly higher than among ethnic Dutch people when a cultural sensitive diagnostic procedure was applied." ADEPONLE *et al.* (2012) affirm that "misdiagnosis of psychotic disorders occurs with patients of all ethnocultural backgrounds when a cultural competence model is not used."[7]

Ideally, awareness of cultural contexts would help translate the patients' voice where language falls short. The positioning of a patient toward his culture does have, however, important implications for the diagnosis and it's kind of treatment chosen (GIORDANO 2008: 598). Magical and religious believes, for example, risk being assimilated by therapists into a generic understanding of the patients "culture," disregarding different social, educational and regional differences and migratory backgrounds of non-Western patients (*ibid.* 599). It also tends to disregard the influence of the caretakers' own cultural and religious viewpoints, relegating "culture" and "religion" exclusively to the cultural objectification of the "other."

Cultural objectification surfaces, for example, in one of the current debates within Dutch mental health care: whether or not caretakers should refer their migrant patients to religious healers (ATALAY *et al.* 2010). It is estimated that about 30% of Dutch patients visit, alongside formal health care, religious healers. This is the same percentage as for non-Dutch patients (HOFFER 2011, HOENDERS 2010). Well-known examples of Dutch religious healers are the Catholic psychologist Roelof Tichelaar and the Protestant psychologists Jan Minderhoud, who both published books on psychology and religion. The debate on religious healers centers, however, exclusively on migrants, and on whether or not to refer them to migrant healers such as an Islamic magical-religious expert or a Surinamese *bonuman*, an expert in Winti. Some mental health caretakers are against referring (migrant) patients to religious healers, on the grounds that "the efficiency and trustworthiness of the healer cannot be evaluated and often family members of the patient know better ways to find healers" (MAY in ATALAY *et al.* 2010: 14). Others do advocate this approach, claiming that "family members not always can or want to be involved," and "that if care really is patient-centered, religious care should be included" (HAMAN in ATALAY *et al.* 2010: 16). At the moment, public mental health care institutions do not have general guidelines, and approaches towards (migrant) religious beliefs depend largely on the attitude of individual caretakers.

Winti

One such caretaker is *Ingrid Sporkslede*, a charismatic supporter of the integration of Winti within mainstream, public mental health care. A social psychiatric nurse of Surinamese origin, now in her fifties, Ingrid Sporkslede has been greatly influenced by her mentor Cecilia Pengel, a Surinamese social psychiatric nurse as well, who informed health care students and professionals in seminars, workshops and lectures on Winti. As of 2012, Sporkslede's employer, mental health care institution Mentrum in Amsterdam, agreed to attribute eight hours of her activities to "Winti related" work and presented her in media, on the institute's website, and in leaflets, as a "transcultural worker/Winti advisor" (*transcultureel werker/winticonsulent*). Mrs. Sporkslede's position as a Winti advisor at a public mental health care institution is remarkable. Winti is, even in Surinamese communities, rarely discussed openly. As mentioned in the introduction to this article, Winti was forbidden by Dutch law from 1874 until as late as 1971, until the early 1980s by Surinamese law, and strongly condemned by most churches in Suriname as idolatry (VAN ANDEL *et al.* 2013: 10). Secrecy remains an important aspect of Winti in Suriname as well as among the Surinamese diaspora in the Netherlands, although Winti is now practiced more openly. Since the 1980s, mainly due to the publications of the high-educated such as Winti-expert Henri J.M. Stephen who published extensively on Winti and mental health care, Winti practices and believes became known to a wider public in the Netherlands.

Several authors regard the Afro-Surinamese Winti religion as the most traditional magical-religious system among blacks in the Western Hemisphere, as it preserves more West African religious elements than Vodou, Santería or Candomblé (VAN ANDEL *et al.* 2013, HERSKOVITS 1941, WOODING 1979). In colonial times, Suriname typified the large-scale Caribbean plantation economy. The average number of slaves per plantation and the ratio of Africans to Europeans were higher in Suriname than anywhere else, the system of slavery was harsher and more wasteful of human lives, and violent resistance and communities of maroons (escaped slaves) were more pervasive, persistent, and successful in Suriname than in any other Caribbean slave colony, with the possible

exception of Haiti (Price 1976: 1–39). "Magic," poison and "sorcery" where the few areas in which blacks could manipulate their white masters (Voeks 1993). Their widespread belief in *obia* (magical medicine), and the fear it caused among the whites constituted perhaps their most potent weapon (*ibid.* 1993). Most successful rebel groups were led by religious leaders and skilled herbalists, who consulted the spirits for the best way to escape and provided the enslaved with *obia* that made them invulnerable for their prosecutors (Price 2008). Considered by the authorities as hotbeds of resistance, African dances and rituals were therefore forbidden by the end of the seventeenth century (van Lier 1971).

Winti literally means "wind" but also refers to spirits, invisible energy and the belief itself. Among practitioners, the religion is also known by the terms Komfo (gods), Kulturu (culture) and Obia, which is used to define both healing spirits and supernatural medicines or objects (Thoden van Velzen & Van Wetering 1988, Wooding 1979). (Mental) health problems are often linked to Winti, in particular to disturbances with ancestors and the soul (*kra*). Herbal baths form an important part of treatment for these problems, performed by a *bonuman* (Winti expert). In the last two decades, Winti is gaining popularity among higher educated urban Creoles. Due to the urbanization of Maroons, the growing Surinamese economy, and the improved socioeconomic position of Surinamese migrants in Dutch society, the trade in herbal medicine is, accordingly, expanding (Van Andel *et al.* 2008: 362). They estimate that the total Surinamese medicinal plant trade is worth $1,576,180 per year, of which an estimated 54,600 kg per year with a value of $453,180 is for export, mainly to the Netherlands (*ibid.* 2008: 361).

Unlike migration from former colonies to other European countries such as France and Great Britain, the migration from Surinam, and, to a lesser extent, the Antilles and Aruba, was prompted by panic. In the early 1970s, after the Dutch government announced that the colony of Suriname would become independent in 1975, about one-third of the Surinamese population migrated to the Netherlands. The Surinamese civil war of the 1980s led to a further exodus. In 2014, the amount of Surinamese in the Netherlands is estimated at 350,000 (which is about half of the population of Suriname). They thus form 2% of the total population of the Netherlands.[8] According to the Trimbos Institute for Mental Health Care, in 2006 Surinamese were the largest migrant group in mental health care: 15% of the total of migrant users of mental health care in the Netherlands. Surinamese are reported to suffer more than native Dutch (but comparable to Moroccans and Turks) from schizophrenia, loneliness, and depression. Surinamese form the largest group in the Netherlands suffering from anxiety.[9] Despite the fact that often (though not always) mental health problems are, especially by creole Surinamese, related to Winti, caretakers often do not take religious aspects of their Surinamese patients problems into account.

Ingrid Sporkslede currently is the only "Winti advisor" in the Netherlands working at a public mental health care institution, and uses most of her time to present short overviews of Winti to mental health care takers. Furthermore, she advises caretakers and patients who are confronted with Winti-related issues. Ingrid Sporkslede does not perform Winti treatments herself but collaborates with Surinamese *bonuman* Marvin, a 38 year old former security guard, to whom she occasionally refers Surinamese patients to. "Since half a year, I work together with him," Mrs. Sporkslede said, "I used to work together with an older man, but he began to falter (*vertoonde gebreken*). I really have faith in Marvin." Mrs. Sporkslede cannot refer patients to Marvin if the patient's treating physician does not agree, and even if the physician agrees, the treatments are given separately from the formal care. For as long as a patient undergoes treatment with Marvin, therefore, treatment with a psychologist or a psychiatrist is put on hold. Ingrid Sporkslede gave the example of a psychotic patient who tried to commit suicide by jumping from a window:

> *I managed to convince her psychiatrist that a treatment by a* bonuman *could be helpful in her case, also since she visits* bonumen *anyway. It is very difficult to know whom to trust and she had lost a lot of money and had bad experiences with the* bonumen *she visited. Her psychiatrist now allows a treatment by a* bonuman*, provided she will show improvement quickly. So I am quite nervous about it. (Interview 22 November 2012)*

I later spoke with Marvin, who had been anxious about this case himself, he said:

> *I am very excited. I just did a small thing for this lady and already she is moved to the top of the list of project housing, so soon she will get her own house. At Mentrum [the mental health care*

institution] they tried to sedate her with medicines, which is not necessary. You see how quickly I managed to change her mood. I am surprised and relieved myself. Now, I would like to work on the relationship with her mother. For us, the relationship with the mother is very important. I always involve the family members and often, I am merely a mediator for them, talking with them about their issues. I honestly tell people when Winti does not cause the problem, when they just need to talk things through. (Interview 5, December 2012)

Marvin thus addresses, in contrast to some caretakers in formal health care, the patient's socio-economic circumstances, such as in this case, accommodation. Marvin indicates that formal health care is not always fit to treat patients and critiques the use of "chemical" medicine. Mrs. Sporkslede, on her part, says she meets with critique from caretakers: "I hope that my approach will convince caretakers, eventually. Now, most caretakers are reluctant to have anything to do with Winti," she says. The "Occupational Health and Safety Office" published on its website critique on Mrs. Sporkslede's work and her employer Mentrum stating that Winti is not an evidence based treatment and calling the employment of a Winti-advisor a "worrying development."[10] Mrs. Sporkslede hopes that by informing health caretakers about Winti will change attitudes.

Ingrid Sporkslede was invited to present her views on Winti in November 2012 by a public voluntary in-house accommodation for mentally ill in Amsterdam. I interviewed five of the twenty-five staff members two months after Sporkslede's presentation in a group interview. All staff members agreed that with the new knowledge about Winti, they do understand their patients better. "One of our Surinamese clients always had a sharp tongue towards two of our female Surinamese colleagues," one caretaker explains. "We thought that was because he has a bad relationship with his mother and thus associated our colleagues with his mother. But it appeared he suspected these colleagues to use Winti, with which he had bad experiences. Now, we explained to him that in this house, Winti is not applied." Another staff member tells: "A number of Surinamese patients kept talking about snakes. I thought it was normal they feared snakes since in Surinam there must be a lot of snakes. Now I know snakes have completely different meanings." The caretakers indicated that they had never worked for a mental health care institution that paid specific attention to religion or the spiritual, and that this was the first time (in their sometimes 20 year long career) that Winti issues were addressed. One caretaker said: "A woman suddenly started wearing Surinamese clothes, smoking a cigar, and talking with a deep, manly voice. That did something to me; I thought this was complete madness. Now I do not have to be scared anymore." Another added: "I did not know if she tried to impress us or if this was a psychosis and I had to call for help. Now I know it is not a psychosis and that we are probably better able to help than those who treat a psychosis." Although the five interviewees thus expressed mostly positive attitudes towards Winti and said they are interested and curious, one caretaker expressed negative feelings: "I am raised as a Catholic, I was an acolyte, and I heard so much about heaven and hell, good and bad," he said. "I am scared of it [Winti]. It can be vicious [*kwaadaardig*]. I heard about dead babies. It is good to know about it, but not to know too much about it. I would like to keep my distance, because it affects me."

The effect of the religious world-view (or anti-religious worldview) of caretakers and therapists on treatment has not been subject of much research in the Netherlands. It does affect, however, treatment. Fiselier *et al.* show, in the only (small, qualitative) study to date on this issue, that the Christian-raised Dutch psychiatrists they interviewed attribute negative qualities to religious patients, such as dependent and less intelligent, while, at the same time, they use Christian inspired themes such as hope, faith, and compassion in their treatments (2006).

Mrs. Sporkslede is, through her work, becoming known as the expert in religious and cultural matters. Increasingly, Ingrid Sporkslede says, she is consulted by not only Surinamese, but also African, Moroccan and Turkish patients, sent to her by colleagues. This causes confusion: "Colleagues send me patients having problems with spirits, or with jealousy. Everyone has these issues, regardless of one's background. But it is difficult to help patients I cannot talk to without an interpreter, since a lot is passed on through language, and there are differences as well. Surinamese people, for example, struggle more with inherited problems through their ancestry than with jealousy." Clearly, Mrs. Sporkslede's work is still taking shape, and it remains to be seen if

Mentrum will maintain, expand, or discontinue her position as a Winti advisor. Ingrid Sporkslede's position seems to serve, at times, as a proxy for Surinamese and other migrant patients alike constructed as having other cultural/religious mental health issues. On the one hand, Mrs. Sporkslede's work improves the much-needed understanding of spiritual believes of Surinamese patients. Seen as caretakers sent her patients from other backgrounds as well, such as Africans and Moroccans, her position clearly provides in a need more generally as well. On the other hand, Ingrid Sporkslede's work is met with distrust: not only by those advocating evidence based treatments, but also by those who fear the negative influence of Winti from a religious standpoint.

Conclusion

Unlike in other European countries such as notably France and Italy, the Dutch mental health care sector rarely questions the influence of racism, colonial history (including the Winti-ban) or the religious world-views of mental health caretakers as a factor in diagnosis and treatment. Non-Dutch alternative healing, as for example Winti, is largely unknown. Since the 1990s, in line with worldwide developments, Dutch psychological and psychiatric research interests in the influence of religion and spirituality on mental health (re)emerged and integrated in mainstream therapies. Generally, religion is seen as a coping mechanism. Migrants' spiritual believes, often in contrast to religious beliefs of non-migrants, are frequently viewed as culture specific aspects of migrants' lives, thus relegating religious and magical believes into a generic understanding of the patients "culture."

The disruption of national policies specifically addressing migrant's mental health and religion after 2000 is a reflection of the concern with (the perceived loss of) national Dutch identity and Dutch culture in the face of globalization (*cf.* Duyvendak & Scholten 2011). The continuing ethnic targeting of migrant's mental health care policies on a local level reflects a tradition of top-down ethnic classification. Ethnic targeting within mental health care institutions is a legacy of decades of ethnic classification in Dutch minority policies as such, starting as what was then called a pluralist approach in the 1970s and continuing with ethnic entrepreneurship as a result of commercialization in 2005. Both national and local discourses, despite their at times contrasting approaches to migrant's (mental) health care and religion, reflect cultural objectification. Migrants' mental health is specifically addressed to facilitate access to and information about the Dutch (biomedical) health care system and providing services such as translation and halal food. The mental health care sector does, at the moment, tentatively explore the influence of migrant religion—mostly due to the enthusiastic engagement of individuals, as the work of Winti-advisor Mrs. Sporkslede indicates. Her work does, however, meet at times with harsh criticism. Furthermore, the clustering of migrant patients (of Surinamese backgrounds, but also of completely different religious or linguistic backgrounds) she experiences testify of the general struggle with notions of religion and culture that characterize Dutch policies towards migrants in general and towards the influence of their religious and spiritual beliefs on their mental health in particular. It exemplifies that in facilitating migrant specialists such as Winti-advisor Mrs. Sporkslede, one might exactly run the risk of objectifying migrants "culture." A way out of this apparent inescapability of objectification might be intensified and structural discussions on religion and culture in educational programs for health caretakers. These discussions should, however, not take the form of a debate on the perceived efficacy of traditional versus biomedical medicine, a discussion Van der Geest has called a "dialogue des sourds" (2012). They should, rather, focus on the history of ethnic targeting in Dutch policymaking, on colonial history and the absence of a debate on colonialism or racism in Dutch (mental) health care, on the socio-economic position of migrants in Dutch society, and on the dialogue between migrant and caretaker as influenced by both the migrant's and the caretaker's religious and cultural backgrounds.

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Notes

1. The current national debate on *Zwarte Piet* (Black Peter), the black faced sidekick of St. Nicholas celebrated on and before the 5th of December, stirred by Surinamese legislators, Antillean and Ghanaian artists, and Dutch Human Rights organizations, is a remarkable exception. The discussion on Black Peter's colonial origins and reference to slavery led to court hearings, death threats, and investigations by the United Na-

tions Human Rights Council in 2013 and continues to be hotly debated in 2014.

2. Remnants of this segmented society are surviving today: public television is still divided in several organizations, the Netherlands has both public and religious schools, and some communities such as the Reformed Churches still have their own (primary and secondary) schools, national newspaper, labor union and political party. Increasingly, Muslim immigrants in the Netherlands are using the legal possibilities created for the pillarized society to set up their own schools.
3. A few exceptions are Jewish mental health care institutions, as well as new Protestant-Christian mental health institutions established as a reaction to de-pillarization (such as GLIAGG, Eleos, and De Hoop).
4. Similar organizations have been established in 1982 (VoF, Sweden) in 1987 (Skepsis, Finland; GWUP, Germany) and in 1997 (ASKE, UK), with each around 2,000 members.
5. http://www.ipsy.nl/ and http://www.noagg.nl/ last consulted July 30, 2014
6. Although some studies, like Selten 2002, suggest genetic weaknesses and excessive use of cannabis to be the cause of the elevated schizophrenia rates.
7. The "cultural competence interview" gained popularity as of 2,000. It is a model for psychiatric classification to improve the diagnosis of non-western patients based upon the Cultural Formulation of Diagnosis of DSM-IV, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders,* published in 1994, revised in 2000.
8. cbs.nl, last consulted July 10, 2014.
9. trimbos.nl, last consulted September 30, 2014.
10. http://www.arbodienst-preventix.nl/nieuws/artikel/7/.

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