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Diasporic Muslims, Mental Health, and Subjectivity: Perspectives and Experiences of Mental Health Care Professionals in Ghent

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Abstract

The mental health of Muslims with a migration background in Belgium seems to be particularly at risk. Inspired by the work of Nikolas Rose on the question of subjectivity, our sociological research analyses processes of subjectification that occur within existing mental health services, and the subsequent "proper" subject of mental health that is created along the way. We focus on how mental health care professionals approach and construct diasporic Muslims in Ghent, a middle-sized city in the north of Belgium. The article consists of three sections. We first lay out how our study is grounded in the work of Rose and his attention to subjectivity. The second section presents our methodology, and the empirical material that grounds our analysis. In the third section, we apply Rose's approach to subjectivity to our empirical data. Our study challenged us to illustrate and discuss different aspects of the subjectivity dimension as explained by Rose, and to enlarge our analytical approach and identify a logic of cultural difference by relying on the work of Edward Said. We come to the conclusion that the work of Rose and Said allows a critical deconstruction of this binary dialectic between ontologically different categories of Self and Other, yet does not enable us to go beyond a negative appreciation of professionals in mental health care and to (re-)imagine a non-deterministic and non-dualistic framing of the human subject formation of diasporic Muslims.

Keywords

mental health (care), Muslim migrants, Rose, qualitative interviews, subjectivity

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The mental health of Muslims with a migration background in Belgium seems to be particularly at risk (Buytaert, Vandedrink, & Lemmens, 2009; Colaço Belmonte, 1976; Hilderink, Van 't Land, & Smits, 2009; Hoffer, 2009; Inhorn & Serour, 2011), as a result of intersecting power relations that shape the position of many diasporic Muslims in Belgium.[1] Diasporic Muslims are considered ethnic-religious minorities, who are positioned in particular intersections with class and gender relations (see Rondelez, Bracke, Roets, & Bracke, 2016), and who are systematically confronted with the racism and social exclusion that characterise Belgian society and that potentially impact their mental health. As studies in the United States and Europe show, racism and social exclusion can result in mental health problems (Brown, 2003; Chakraborty, Mckenzie, Hajat, & Stansfeld, 2010; Karlsen, Nazroo, Mckenzie, Bhui, & Weich, 2005). Diasporic Muslims are nevertheless largely underrepresented in or even absent from mental health care institutions in Belgium (Doornbos, Zandee, Degroot, & Warpinski, 2013; ZorgnetVlaanderen, 2011).

This leaves us with somewhat of a conundrum, which we have started to explore and unpack from the perspective of the question of subjectivity (Rondelez et al., 2016). This approach is inspired by the work of Nikolas Rose (1998, 1999), and his study of the ways in which the self has been shaped by prevailing ways of thinking. Rose has extensively examined the regimes of knowledge whereby individuals have come to identify themselves as certain beings, the regulations and tactics that are interconnected with these knowledge regimes, and the relationships that individuals have developed with themselves in considering themselves as subjects. Rose's work is particularly relevant for our study as he further elaborates a Foucaultian approach to subjectivity within a sociological framework, that includes empirical research. Moreover, he specifically attends to the role of the psy-disciplines (psychology, psychotherapy, and psychiatry) in the construction of the modern self.

It goes without saying that the question of underrepresentation can be approached in a variety of ways. It might be considered from the perspective of the material and cultural factors that render access to health care more difficult for ethnic-religious minorities, or from the perspective of existing mental health practices within ethnic-religious minority groups that reduce the need of minorities to rely on the established mental health services. More concretely, the focus might be on epidemiological data (Kluge, Bogic, Deville, Greacen, Dauvrin, Dias, Gaddini, Koitzsch Jensen, Ioannidi-Kapolou, Mertaniemi, Pucipinos, Riera, Sandhu, Saravry, Soares, Stankunas, Straβmayr, Weibel, Heinz, & Priebe, 2012; Lodewyckx, Janssens, Ysabie, & Timmerman, 2005), the unequal distribution of mental health

1 The concept of "diaspora" is used as an analytical interpretive frame for the cultural, economic, and political ways of historical particular "genealogies" of migrancy and for the examination of the relations between different migrancies across fields of social relations, subjectivity, and identity. What regimes of power inscribe the formation of a specific diaspora? The concept of "diaspora" also critiques discourses of fixed origins, because not every diaspora goes with an ideology of return. Diasporas often exist out of different journeys to different parts of the world, each with their own history and particularities. The notion of "diaspora" focuses on formations of power which distinguish diasporas internally as well as situate them in relation to each other. These different migrancies can come together in one journey through the convergence of narratives that are individually as well as collectively (re-)lived, (re-)produced, remembered, and transformed. By consequence, the identity of the diasporic imagined community is not pre-given (Brah, 1996).

problems (Aichberger, Bromand, Heredia Montesinos, Temur-Erman, Mundt, Heinz, Rapp, & Schouler-Ocak, 2012; Kleinman, 2012; Siller, Renner, & Juen, 2015; Vardar, Kluge, & Penka, 2012), institutional dynamics and implicit biases (Heinz & Kluge, 2012; Kluge et al., 2012; Rechel, Mladovsky, Ingleby, Mackenbach, & Mckee, 2013; Vardar et al., 2012) or the socio-culturally constructed character of mental health problems (Bäärnhielm & Mösko, 2012; Crammond & Carey, 2016; Heinz & Kluge, 2012; Kapilashrami, Hill, & Meer, 2015; Kluge et al., 2012; Vardar et al., 2012). A focus on subjectivity offers another kind of contribution to this discussion. It enables us to trace processes of subjectification that occur within existing mental health services, and the subsequent "proper" subject of mental health that is created along the way. The "proper" subject of the established mental health services might indeed be shaped in such a way that renders both the access of diasporic Muslims and their trajectory through established mental health services more difficult. This is indeed a central assumption of our study, which offers additional insight into the understudied interactions between mental health care professionals and diasporic Muslims (Buytaert et al., 2009; Hilderink et al., 2009; Hoffer, 2009; Inhorn & Serour, 2011).

This article is part of a larger study, in which we consider different aspects of the processes of subjectification that are involved in those interactions. Here we focus on mental health care professionals, and how they perceive their work with Muslims with a migration background. More precisely, we ask: how do mental health care workers in Ghent, a middle-sized city in Belgium, approach and construct diasporic Muslims as subjects and service users of mental health care? The article consists of three sections. We first lay out how our study is grounded in the work of Rose and his attention to subjectivity. The second section presents our methodology and the empirical material that grounds our analysis. In the third section, we apply Rose's approach to subjectivity to our empirical data.

The Subject of Mental Health

Rose's sociological interest in subjectivity builds on the Foucaultian insight that "the ethics of subjectivity are inextricably locked into the procedures of power" (Rose, 1998, pp. 78-79). Modern power, Foucault famously argued, does not function by repression and domination alone, but is productive: it actively produces certain subjects, shapes psyches, and fabricates persons with certain desires (Rose, 1998). This shaping of the subject occurs through particular discourses, which should be considered in their particularity. The critical impulse propelling Rose's analysis can be summarized as follows: "Where, how, and by whom are aspects of the human being rendered problematic, according to what systems of judgment and in relation to what concerns?" (Rose, 1998, pp. 25-26). This critical impulse, moreover, leads him to examine those regimes of knowledge and expertise that are focused on the subject's psychology and mental health: the psy-disciplines.

In *Governing the Soul* (1999 [1989]) and *Inventing Ourselves* (1998), Rose offers an account of the rise of psychology in modern society. Since the end of the nineteenth century, Rose argues, the development of psychological intellectual and practical technologies is related to developments in the political structures in present-day European and North-American liberal democracies, and to changes in prevailing conceptions of personhood (Rose, 1998). More precisely, the regulatory component of psychology, i.e. the way in which humans regulate others and themselves, is connected, according to Rose, to the (re)organization of political powers and government.[2] Psychology, in other words, is particularly well-suited for the administration and social control that modern governmentality requires (Rose, 1998).

The work of Rose demonstrates how the exercise of modern political power has become fundamentally connected to the knowledge of human subjectivity (Rose, 1998). As Rose asserts, "to address the relations between subjectivity, psychology, and society from this perspective is to examine those fields in which the conduct of the self and its powers have been linked to ethics and morality, to politics and administration, and to truth and knowledge" (1998, pp. 48-49). Advanced liberal democratic states, in sum, are confronted with some particular problems to which psy-disciplines propose solutions—an alignment that, at least partly, resides in a shared individualism (Rose, 1998). More specifically, modern democratic rule can be considered as a government through freedom, choices, and solidarities. In a liberal democracy, humans are understood as individual, autonomous selves with self-responsibility and choice, equipped with a psychology aspiring to self-fulfilment, running their lives as enterprises (Rose, 1998). This implies, first, that democratic government requires an extensive knowledge about its subjects, and second, that its rule is partly indirect. The psy-disciplines help to chart the terrain of the subject's choices and their rationale, which enables subsequent governmental interventions. Take, for instance, the domain of health: the health of its subjects is vital to the national successes of the democratic state, which equally constructs and affirms many health-related decisions as "private" and individual choices. The most efficient way to govern such "private" domains, Rose insists, is through autonomy and responsibility (Rose, 1998).

Besides Rose's detailed discussion of the rise and significance of the psy-disciplines in relation to established democratic rule, he also draws attention to new forms of government as they developed in the post-welfare states in the West at the end of the twentieth century. These forms of government, which we can call neoliberal, depend even more on the properties of their subjects, to the extent that it would be impossible to understand them without incorporating a new understanding and enacting of ourselves and others as "free and choosing" selves (Rose, 1998). In the context of the emergence of such neoliberal forms of governmental-

2 Following Foucault, government is to be understood in a broad sense as "all those more or less rationalized programs, strategies, and tactics for 'the conduct of conduct', for acting upon the actions of others in order to achieve certain ends" (Rose, 1998, pp. 11-12). Government, for Rose (1998, p. 29), thus refers to a "certain perspective from which one might make intelligible the diversity of attempts by authorities of different sorts to act upon the actions of others in relation to objectives", such as, notably, health.

ity, we are particularly interested in the recovery paradigm, which scholars, policymakers, and practitioners in the last decades have considered as a promising framework for mental health care services, both internationally and in Belgium (see Deegan, 2003; Slade, 2012). In recovery-oriented practice, an attempt is made to "reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event" (Ridgeway, 2001, p. 335), and priority is given to embracing strengths rather than weaknesses, hope rather than despair, and engagement and active participation in life rather than withdrawal and isolation (Secker, Membrey, Grove, & Seebohm, 2002; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). We argue, however, that it is necessary to theorize underlying notions of the human subject when studying how service users are approached in recovery-oriented mental health care (see Vandekinderen, Roets, Roose, & Van Hove, 2012). When people with mental health problems are expected to become self-responsible citizens, the responsibility for leading a fulfilling life is individualized (Craig, 2008). As Vandekinderen et al. (2012, p. 3) argue, it becomes particularly tricky and even impossible to provide high-quality mental health care "when this ideology of individual choice and opportunity denies the fact that some citizens have few available choices and resources". Unsurprisingly, the recovery paradigm has been critiqued, with an increasing number of authors arguing for a truly social approach to recovery, in which people with mental health problems and professionals have an alliance and share responsibility in shaping care and support practices in a continuous dialogue (Beresford & Croft, 2004; Vandekinderen et al., 2012).

Mental Health Care Professionals in Ghent

Our exploration of the question of subjectivity in the realm of mental health services and ethnic-religious minorities focuses on how mental health care workers approach and construct these minorities as subjects and service users. Our empirical case study is situated in Belgium, where the conundrum that we alluded to in the introduction remains unaccounted for.[3] Most Muslims in Belgium are of Turkish and Moroccan descent, which is the result of labour migration, structured by bi-lateral agreements between Belgium and Turkey and between Belgium and Morocco in the 1960s, and subsequent family reunions and marriages (Fadil, Asri, & Bracke, 2015). By "diasporic Muslims" we understand those Muslims with a migration experience in their own life, or in the lives of their (grand)parents. Turks and Moroccans are the largest groups of migrants in Belgium and they have a particular work-related or

3 There have been studies in other national contexts that offer some insights into the conundrum. A Dutch study shows that ethnic minority groups have more police referrals, crisis contacts, and compulsory admissions (see de Wit, Tuinebreijer, Van Brussel, & Selten, 2012; Fassaert, Heijnen, de Wit, Peen, Beekman, & Dekker, 2016). In the United States studies show that diasporic migrants have more trouble accessing (mental) health care (Tabb, Larrison, Choi, & Huang, 2016) for a variety of reasons such as discomfort to talk to someone about personal problems, fear that someone would find out, trouble to get an appointment, a desire to solve their problems on their own, bad experiences with treatment, different conceptions of the nature, causes or cure of mental illnesses, and language difficulties (see Cai & Robst, 2016; Leong & Kalibatseva, 2011; Sorkin, Murphy, Nguyen, & Biegler, 2016).

family-related migration history. This motivates our choice to begin this preliminary research with those groups. An additional reason why we focus on these particular groups is that, as Muslims, they are, according to Said (2005), considered the Other. Mental health professionals, who are often not diasporic Muslims, might be expected to make a distinction between "us" and "them", thus influencing mental health care. In the city of Ghent, where our case study is situated, most Muslims with a migration background are of Turkish and, to a lesser extent, Moroccan descent. A first analysis of our data shows that Muslims of Turkish descent more often go to counsellors than those of Moroccan descent, but it is not clear why.

We set up a qualitative interpretative study and engaged with local network analysis (Turrini, Christofoli, Frosini, & Nasi, 2009). This allowed us to make a "cartography"[4] of social problem constructions in the field of mental health care in Ghent. We selected and recruited 24 local actors in mental health care in Ghent, such as socio-cultural workers, psychologists, psychiatrists, therapists, community (health) professionals, welfare professionals, nurses, and general practitioners, based on their experience with diasporic Muslims with mental health problems or the expectation that they would be able to formulate a well-founded opinion about the possible issues in this field. We began by contacting local actors who were related to a few umbrella organizations. We then dug deeper in the field of mental health care organizations. Following a snowball sampling strategy (Esterberg, 2002), all respondents were asked if they knew other interesting contacts for our study. Biomedical professionals ended up being underrepresented in our sample, as many of them responded to our request to participate by pointing out that they did not have enough Muslims in their institutions to be of interest to the study. This seems to indicate that diasporic Muslims are most underrepresented on the institutional and biomedical side of the spectrum of mental health care. It also implies that biomedical views are underrepresented in our analysis. On the other hand, community care centres and system therapists are overrepresented. This can explain the focus on culturally sensitive ways of treating patients and the dominance of the family in the conducted interviews. Snowball sampling runs the risk of taking respondents out of the same pool of respondents, which can result in too much similarity between respondents. Both factors influenced the results of the analysis.

We used qualitative, semi-structured interviews to explore the personal meanings that our respondents gave to their experiences with diasporic Muslims. The interviews were semi-structured to allow the respondents enough space to articulate their own insights. The duration of the interviews varied from 45 minutes to slightly over 2 hours. All interviews were recorded with a voice recorder and fully transcribed.

We subsequently sought to relate our data to the theory of Rose and Rose's theory to our data. Instead of focusing on a specific theoretical framework or theorist,

4 We decided to call this a "cartography" because of two important characteristics. The first one is that it is politically normative: selecting is also always appreciating. The second one has to do with its link with subjectivity, our main focus of research (Braidotti, 2002).

Jackson and Mazzei (2012) argue that researchers can rely on particular concepts, which are part of an assemblage of "texts" that constitute one another and create something new. As such, analytical questions become possible by referring to, and hence activating, a specific theoretical concept. Although Rose (1999, p. xi) is reluctant to turn his Foucaultian commitment to studying power, knowledge, and the subject into a formal methodology, he does discern four dimensions in an analysis focused on subjectivity: an ontological, epistemological, ethical, and technical dimension.

Shedding Light on Emerging Insights

We now turn to our empirical material, and analyse and discuss the narratives of mental health care practitioners through the lens of these four aspects.

1. Ontological Aspects

The first aspect Rose discerns when it comes to subjectivity is the ontological one, that is, the views on the nature of being of subjects, in this case diasporic Muslims with mental health issues. Here we found that, most of the time, our respondents considered the subjects to be lacking knowledge about themselves. Many expert professionals seem to consider diasporic Muslims as largely unknowing about their health, bodies, and mind.[5] This is notably reflected in how they are seen to frame mental health problems as psychosomatic complaints.

> The intercultural counsellor is sometimes called in. But most often when we try to deal with people with a migration background... Why? Because . . . they often know little about their own body. We grow up with knowledge about our body, as a result of which we know how everything works . . . how many times do you learn about this, you learn about it in secondary education, you learn about it in elementary school . . . we really grow up with that. Over there, there are a lot of people who know little or almost nothing about the way their body functions, and as a result it might be supportive to explain a bit so they do not panic when something happens. We also notice that in healthcare in general, especially for people with children, when the children have a fever, we do not have a problem with that, . . . but the people here can sometimes totally panic because "once there was someone with a high fever and he died". People are completely panicking, they do not know . . . so you see that as a result of the lack of, or little knowledge of the way their own body functions etcetera, there is a lot of concern ... we sometimes have

5 Some of the respondents make a distinction between the older and the younger generations. The younger generations generally grew up in Belgium and incorporated the prevailing system of knowledge.

> the feeling that people get into a panic mode . . . because of things that are quite trivial to us. So we try to impart some knowledge, some knowledge about the body, also some knowledge about how our health system functions. We call that, without being condescending, our educational task (interview 8, coordinator, community health care centre).

In the scholarship on Western mental health care, a distinction is made between lay knowledge and expert knowledge: mental health service users are often ascribed experiential knowledge about their own body and experiences, but they are seen as lacking knowledge about disease processes or the process of diagnosis that only medically trained people have (Prior, 2003). In this excerpt we see how modern normalization processes are premised on, and further construct, a binary dialectic of Self and Other, as Said (2005) has analysed in detail. The Other is considered as different and inferior, whereby everything that diasporic Muslims with (mental) health problems say or do is considered as "non-sense" instead of meaningful. "Unknowing", moreover, seems to mean unknowing of Western medicine. This also implies a devaluing of the knowledge the Other might have—this is not the "right" kind of knowledge.

Research has also indicated that stereotype endorsement is stronger among those who grew up in (rural) towns or regions than those who grew up in (urban) cities. Their attitudes towards, for example, schizophrenia are also more negative and rejectionist. This is supposedly due to the fact that inhabitants of towns are more loyal to their culture, values, and the judgements of their communities (Gur & Kucuk, 2016; Sarıkoç & Öz, 2016). Another study shows that stigmatization most often takes the form of a paternalistic and benevolent view of the persons with mental health problems (Gur & Kucuk, 2016). In Ghent, Muslims came mostly from the Turkish rural town Emirdağ or from the urban Arabic regions in North-Morocco and the Berber regions of the Rif mountains (Fadil et al., 2015; Verhaeghe, Van der Bracht, & Van de Putte, 2012). It is known that individuals living in rural areas, or those with lower socio-economic status, are less likely to seek help (Gur & Kucuk, 2016). There is, moreover, a link between the level of education and stigmatization. How lower the education level and income, how higher the internalized stigmatization (Gur & Kucuk, 2016; Sarıkoç & Öz, 2016). The inverse relationship, however, has also been found: educated people or the higher economic classes have more negative attitudes toward persons with mental health problems (Gur & Kucuk, 2016).

The narratives of our respondents were profoundly shaped by orientalist tendencies. These have typically cast the scientific, modern West in opposition to a childish, magical, Oriental Other, in need of education (Said, 2005). Counsellors then see it as their task to educate clients, and turn them into autonomous citizens. Within a neoliberal view, clients without such knowledge are not considered as deserving, autonomous clients and are rejected (Wiebe, 2009). Yet the depth of the distinctions that the community health worker here

establishes cannot be understood without recognizing the operation of a logic of cultural difference that profoundly culturalizes both the distinction between knowing professional versus unknowing patient, as well as good (autonomous) client versus bad client.

Modern, Western knowledge, moreover, has special bearing in this context on the biomedical approach, which does not recognize its own "cultural" or situated dimensions but rather considers these as "universal" (Gailly, 1988). Some mental health professionals explicitly take this approach to Muslim clients, we found, while others do take cultural aspects into consideration and follow a more "culturally sensitive" approach (cf. infra). We found the latter to be rather widespread among the professionals we interviewed. And while in some respects this might be an improvement in relation to a logic that universalizes its own cultural bearings, very often culturally sensitive approaches continue to be marked by a logic of cultural difference which is premised on an "us"-"them" separation as well as the presentation of the Other as superstitious and unknowing. The latter characterization, moreover, amplifies the construction of a "bad" or problematic subject for Western (mental) health care within a neoliberal logic (Wiebe, 2009).

> I do not want to draw a caricature but, for example, last year we heard a couple of times about exorcism in the news. One also finds other solutions for a problem that one wants to solve in the community itself. These are of course really extreme examples, but they exist. And they will probably still be present. While we, Western health care practitioners, think about other solutions than devil exorcism. But, those are things that... I believe one looks for other kinds of solutions than you and I would look for if we would have problems. So yes, many problems (interview 3, coordinators, consultative body).

> There is also too little knowledge about the body. Too little knowledge about the notion of depression etcetera . . . Even in our society this is a taboo. Let alone in the Turkish, Moroccan community. It is also a taboo. You are rejected. No, that is too extreme. I am telling it in terms of prejudices . . . Because that is to fall short of God etcetera. Yes (interview 11, general practitioner, community health centre).

A Turkish general practitioner, however, when asked if he saw a difference in the way diasporic Muslims perceive mental health, responded:

> No, no. I think that has all changed. I would say that it is also seen as normal, mental health care. So the approach to mental health problems used to be more: "yes, is this one possessed?" or something similar. And they need to go to someone else than a doctor. But we see now that it becomes more and more accepted as an illness. And that they want to be treated.

> Sure, sure. It is an evolution, it is changing. So people see things, are reading, are following things and nowadays it is all with social media et-cetera . . . (interview 20, general practitioner, private practice).

Or as another respondent, a psychologist in a private practice, said:

> I think that by bringing mental health care in the public sphere through the announcement of days such as "too insane" days and the day of mental health care and the way that centres of mental healthcare come out with their assistance nowadays. And that much more figures in the media, in different programmes—not only in *Libelle* [a lifestyle magazine]—, on different aspects of psychiatric problems. Nowadays, there is something on television about mental health care every day, and ten years ago that was not the case. But also the generations of Turkish people change-; in a sense, they become more and more integrated in our way of thinking about mental health care. And the current generations are informed of how it works. In the past—twenty, thirty years ago—that was not the case, because, the people were not in Belgium as long as is now the case and they had no need to or insight in how it all functions. I notice that is a big difference (interview 24, psychologist, private practice).

Here a psy-logic, and the biomedical model it rests on, take the upperhand. The problems are identified as illnesses in need of treatment by a doctor. This general practitioner is also aware that his patients become more and more educated. Lay knowledge is sometimes ambiguous about scientific biomedicine and can consist of intuitive, individuated, and personalized knowledge. Lay knowledge and expert knowledge need to be considered more and more as a continuum and not as polarized positions (McClean & Shaw, 2005).

A second finding is the important role our respondents attributed to the family and community of the subjects.

> The pressure of the family. And being confined to the family, also the taboo on asking for help . . . Not wanting that problems and stuff come out in the public sphere. And that they need to stay within the family, but that is a cultural fact. That has nothing to do with discrimination, exclusion, etcetera. Or... Yes, still also a cultural aspect. I do not want to hyper-culturalize but... (interview 1, counsellor, community health centre).

These narratives almost tend to overrule the individuality of the subjects. Here we can identify the logic of cultural difference that juxtaposes so-called collectivistic cultures to so-called individualistic Western cultures. According to our respondents, collectivistic cultures are characterized by a strong tendency to gossip and the difficulty of keeping secrets. This is supposed to be more the case in the Turkish

community than in the Moroccan community, and older generations are supposed to have more problems with this than younger generations, who are already more individualistic.

> Community. For example, in the Turkish or Moroccan one probably, but especially in Turkish culture, there is an enormous culture of gossip, everything goes around very fast. And there is also a prejudice against people with psychiatric problems, so that is not OK. And I believe that also among Flemish people this is not always OK.... But you notice that there is still more pressure from the community. The belief that we can keep something a secret within our family. I believe that that is much more complicated within other cultural communities, there everything is passed on. And that is also often the fear when you work with interpreters, that they will not keep their mouths shut. And that is also very difficult, I know from the people who work here as cultural interlocutors, as interpreters, that they really are asked questions by their communities. I believe that those people sometimes get into very difficult situations (interview 5, counsellor, psychology service of social services).

> Those were people with an atypical country of origin, so they did not have a community that could see whether he or she had help, while being here in Ghent. For example, among the Turks . . . there are many differences. Islam will also play a role in it, because that is really their religion. Take care of your parents. We also have that, but maybe still a little less than it should be. Or I believe that the pressure is still a little different (interview 10, staff member, community organization).

Another purported characteristic of collectivistic cultures is the pressure to keep the care of family members in the community. Within a cultural logic, this characteristic is most often attributed to "a different culture". That for some minority populations community or family might at least appear to be safer than existing mental health care institutions—notably because of how racism characterizes and shapes existing institutions, including mental health institutions, in Belgian society—is not part of the equation. From a psy-logic, moreover, the tendency to seek help within the community is assumed to be an impediment to care.

It is also important to take the literature on stigma into account. The influence of the community might also be explained by a higher level of anticipated self-stigma. Research has shown that seeking help from general practitioners and psychiatrists, but not from psychologists, is more difficult when self-stigma is more pronounced (Pattyn, Verhaeghe, Sercu, & Bracke, 2014). It also seems to be the case that hospitalization is linked with higher self-stigma (Sarıkoç & Öz, 2016). On the other hand, the fear that the community would gossip can be associated with a higher level of perceived public stigma. In that case, one is afraid of devaluation and social

discrimination by one's social network (Ciftci, Jones, & Corrigan, 2013; Pattyn et al., 2014). This is also the reason why many persons with mental health problems are reluctant to seek treatment (Sarıkoç & Öz, 2016). One can also speak of label avoidance: "instances in which individuals choose to not seek help for mental health problems in order to avoid negative labels" (Ciftci et al., 2013) which could, for example, form an impediment for marriage candidates. So, the bonds with the immediate family improve, but the relation to society gets worse (Sarıkoç & Öz, 2016).

2. Epistemological Aspects

The epistemological aspect of subjectivity revolves around the question: "How can we know the subject?" The more culturally sensitive actors among our respondents emphasized that they wanted to really listen to the stories of people who seek their help, instead of relying on a more traditional consultation model. They offered critiques on organizations that approach mental health problems primarily in a biomedical way, and that prioritize the organizational structures over the well-being of their clients. We encountered mental health practitioners who criticized the neoliberal logic, and sought to work with people on a case-by-case base, instead of being driven by organizational values that value efficiency, time-concerns, and standardization over people.

> It is the organization, and the organization of the system, yes yes. They are creating such barriers for their organization that they say, already on the phone, "yes but they will not get there, they do not know the language well enough, that will not go smoothly. We will not take that one". Systematically, they do not look at the people, not at the needs, they look at the values and norms of their organization. And that is no longer human. And there we will need to change something. And we go back to policy (interview 9, staff members, city service).

In this particular instance a cultural logic, i.e. recognizing that people might not speak the prevalent language within the organization, served to reject neoliberal imperatives and resulted in a constructive and creative culturally sensitive approach. This logic, moreover, was infused by an awareness that prevailing procedures within current Western biomedicine do not suffice.

> So the art is to find entrances in which you, in a culturally sensitive way— to use the word— succeed in digging up the sensitivities and there where you suspect that people are stuck by problems they have to bring them to the surface. This will still require a lot of searching, but I believe that that is indeed the way we will need to go about it. That we can't just copy and paste from the white people so, we are doing that... It will require more skills (interview 2, co-workers, umbrella organization).

These practitioners prefer a way of working that reaches out to clients, uses interpreters, is life-world oriented, and allows for exceptions to the rules.

> We are actually quite used to rely on the consultation model . . . You have a problem, someone sits there, you go to that person, you have a consultation. But this is a quite Western model that we use. The way it happens in other cultures is not at all like that, this is very noticeable. Do not let your clients come to you at consultation, but the other way around. Go to their homes. Travel around yourself. Or go much closer, where the people dwell and live, and into the community (interview 2, co-workers, umbrella organization).

> I believe that you need to work with the time people have, and that means demand-oriented working. And that is what we at the service really try to do. We take liberties with the standard structures, standard rules. That is the general view in the service, through which we also reach those people. In a Community Mental Health centre, I believe, sometimes one attaches more importance to certain guidelines or certain structures, for example, clients need to be motivated, need to be at appointments. If we get a referral and the client is absolutely not motivated, then it is our job to get him motivated for therapy. If the client does not like the sound of coming to the centre, than we go on a house call. So disregarding the origin of the client or the problem, our goal is to take care of those people who otherwise do not get to the psychologist. And I believe that this also implies that we can reach those people with a migration background, because we use those methods in any case. We will not say, when someone with a Russian background does not show up, that we cannot give therapy. Then we are already happy with everything that we can offer at that moment that the client is with us (interview 5, counsellor, psychological service of the social services).

While the last quote represents an exception in this respect, we found a general tendency to hyper-culturalise, while the respondents precisely claimed not to do so. Instead of considering people in their particularity, which of course includes cultural aspects, many practitioners approached "culture" in a homogeneous sense, and operated under the assumption that others are almost completely determined by their culture, and that every individual is a representative of their culture, unmediated by personal or contextual elements. And while this cultural logic functions as a ground of critique in relation to the biomedical and neoliberal logic the practitioners felt pressured by, it did so through fostering a very essentialised view of "us" versus "them"—a view that aligned quite seamlessly with Said's understanding of Orientalism (Said, 2005).

3. Ethical Aspects

A third aspect of subjectivity that Rose highlights is the ethical aspect. Here ethics pertains to the kind of selves that are valued as "good subjects" and to which one should aspire. As already discussed at the outset of this article, Rose's work helps us to understand how neoliberal governmentality relies on the expectation of free, independent, autonomous civilians, and how the psy-disciplines have been instrumental in creating those free subjects that are necessary in a liberal democracy (Rose, 1998).

The most important values and traits of "good subjects" that we were able to identify in our interviews are: recovery, activation, responsibility, and independence. In the last decades, marked by the deinstitutionalization of residential services and the development of community-based services, "recovery" became popular in mental health care in Flanders (Vandekinderen et al., 2012). "Recovery" is defined as "enabling people with mental health problems to 'regain control over their lives, and . . . be responsible for their own individual journey of recovery' (Deegan in Vandekinderen et al., 2012, p. 2)".[6] Recovery was mentioned by our respondents as an important frame of reference, which they understood as clients taking responsibility for their own healing process and formulating their own goals while taking into account their vulnerability.

> But there is also some philosophy behind the concept of recovery: I am the expert of my life. I know what is best for me at this moment and also later I will know what is best. And you caregivers, you have studied for that, help me with that, the route that I am mapping out for myself, help me to walk that way (interview 2, co-workers, umbrella organization).

This approach to "recovery" is simultaneously marked by the psy-logic and the logic of neoliberalism. To be a good citizen means being a healthy autonomous individual. The figure of the autonomous individual emerges from both a neoliberal and a therapeutic discourse, as a consequence of the "responsibilisation" and the "autonomisation" of the self (Brunila, 2014).[7] The concept of recovery is thus also linked with the emergence of a set of new ideas about citizenship, based on the assumption that people with mental health problems have the right to live their life *in* society just as everybody else does (Vandekinderen et al., 2012). The value of activation and responsibility is stressed while the importance attached to the learning process included within counselling is also emphasized. It is through subjectification processes that occur within these conversations that one is supposed to learn how to behave at work and in society at large (Rose, 1999).

6 In the literature we can find two different approaches to recovery: an individual and a social one. Both are linked to different notions of citizenship. The individual notion of recovery is connected to a normative perspective on citizenship and the social notion of recovery is connected to a relational and inclusive notion of citizenship (Vandekinderen et al., 2012).

7 The therapeutic ethos is formed by the permeation of the language of disorder, addiction, vulnerability, and dysfunction together with associated practices from different branches of therapy in popular culture as well as in political systems (Brunila, 2014).

> Showing or not showing up is an item in counselling. Because it is also about the activation of people, about acquiring responsibility, about the development of an identity. I am someone, and I am someone who keeps his or her appointments, I am someone. That is something that we find very important, so not showing up or showing up is an item as such in counselling. You also have people who are always half an hour late. Good, I am glad you are here. In that case you do not speak about that half hour. Do you notice that it is because it does not bother them to be on time? Then you discuss that and you notice if there is a problem or not. If people had to summon up all their courage to get here, yeah, then they are half an hour late. But then you can say when they are a little bit earlier the next time "ah I see that you are a little bit earlier, that you managed." You work with that. So we do a lot to let the clients come to us, but we also expect that they take responsibility, there is a line, there is a difference between meeting people where they are and patronizing. Some responsibility remains with the client, and when you have a longer trajectory with people, then you work towards that. That is the ultimate goal, that they come to counselling, without you having to phone them, without missing an appointment, that they are on time, that they call when they are not able to come. That is a goal, because those attitudes are also needed in society, they also need them when they go to work, when they have to go to their children's schools. You just need them. I believe that sometimes this is also due to cultural stuff, keeping appointments (interview 5, counsellor, psychology service of social service).

For some of our interlocutors, the values of recovery, self-responsibility, and independence seem to be the most important objectives of the counselling process, almost more important than the client's mental health. These values are central in our contemporary neoliberal society. The dominant discourse implies that citizens have the responsibility, the social obligation, to realize those values (Rose, 1998; 1999; Vandekinderen et al., 2012).

4. Technical Aspects

Finally, Rose (1999) draws attention to the technical aspect of subjectivity, which revolves around the question: "What do subjects need to do to change or improve themselves?" In the answers to this question we can observe that, in line with a predominant neoliberal spirit, the responsibility for the recovery process is the client's.

> I work very systemically, circularly. And I very often get people who perceive their problem as linear. See, that is the cause, that need to get over it and be done with it, that need to be fixed. You have to do it for me.

> They see me as an expert, while I consider myself as someone next to the person who is the expert of his or her own life (interview 7, psychologist, community health centre).

According to our respondents, clients have to prove that they are good citizens by curing themselves, and when necessary they can appeal to the psy-disciplines for help. The underlying assumption seems to be that good and full citizens are autonomous, rational, healthy, and economically independent (Rose, 1998; 1999; Vandekinderen et al., 2012). Rose calls this pressure to "do it yourself" the "therapeutic imperative" (Rose, 1998; 1999). Nowadays, this therapeutic imperative combines a psy-logic and a neoliberal logic.

> Recovery refers to the idea that people with psychiatric problems have to formulate goals for themselves. I have, here and now, these kinds of problems. And these are the kinds of solutions, or those are the problems I want a solution for. And caregivers help me with solving it or guide me in the search for solutions for those kinds of problems (interview 2, co-workers, umbrella organization).

> That has to do with capacity and mental capacity. There are people whom it does not bother and there are people who simply drown. That does not make it okay that such things happen, but it is still the responsibility of the people with a migration background themselves with a certain issue to deal with it in a certain way. It is not because you are wronged that you have no responsibility. Your responsibility is to deal with it in a good way. And then I believe you can support people to make them more resilient. It does not make things right, but it is what it is in this context, people have to live in it. And then I believe it is the job of the caregivers to be aware of the fact that people live in it and to help them to find tools to deal with that (interview 5, counsellor, psychology service of social service).

Throughout this approach to recovery, there is a strong tendency to neglect social and cultural circumstances and structural inequalities that hinder people with mental health problems (Vandekinderen et al., 2012). In the case of diasporic Muslims with mental health problems, we can speak of a double stigma, which results from their ethnic-religious background as well as their problems. Here it is important to take an intersectional approach that takes the entanglement of power relations and identities into account. The stigma will not only differ in degree but also in quality with different effects on the individual. So there is a strong sense of shame among families with a Turkish background. This shame can be so strong that the persons with mental health problems remain in the house and avoid the public sphere. Often fathers would blame mothers for giving birth to such a child. Even when diasporic Muslims hold positive opinions towards mental healing, social stig-

ma is strong, because of the concern for the family's social standing. The disclosure of mental health problems is still considered shameful (Ciftci et al., 2013).

People with no severe mental health problems typically distance themselves more from their diagnosis than people with a more severe diagnosis. One can explain this by the fact that their symptoms do not look like the social stereotypes of mental health problems. Also people with no previous history of treatment are more likely to distance themselves from their diagnosis because they often believe that their problems are limited in time, recoverable, and manageable with medication or therapy. Stigma also influences the way people will deflect their identity as a person with mental health problems. The greater the perceived stigma, the greater the chance people will reject the characteristics linked to mental health problems. Finally, the number of conventional role identities one holds, influences the likelihood of deflecting an identity as a person with mental health problems: the more conventional role identities one holds, the less important the identity as a person with mental health problems is (Thoits, 2016).

Conclusion

In an attempt to gain insight into the dynamics at stake in the underrepresentation of diasporic Muslims in mental health care services in Ghent, we explored and analysed the perspectives of mental health care practitioners. We asked: "How do mental health care workers in Ghent, a middle-sized city in Belgium, approach and construct diasporic Muslims, as subjects and service users of mental health care?" We relied upon the work of Nikolas Rose (1998; 1999) to do so and turned more specifically to his method of studying subjectivity in relation to therapeutic practices and logics.

This analysis challenged us not only to illustrate and discuss different aspects of the subjectivity dimension, as laid out by Rose, but also to enlarge our analytical approach. First, our data required more attention to the neoliberal context. At the heart of the neoliberal approach to a psy-logic lies the responsibility to be a free and healthy subject, with a self that objectifies itself and constructs a hermeneutic of the self, whereby one learns to interpret oneself and to construct a narrative about the real self in psychological and medical terms (Rose, 1999). Rose's work has drawn attention to the political economy of neoliberalism that began its rise to hegemony in the 1980s and involves the application of liberal market principles to other, non-economic spheres of life (Rose, 1998; 1999). Yet the ways in which neoliberalism has prompted new modes of subjectification, revolving around the individual, its interests, freedom, and regulation of the self, have been particularly intense, and require more (specific) analytical attention.

Second, we discerned another potent logic running through the narratives of our respondents, which proved to be a crucial one in accounting for the views the mental health care workers we spoke to held about diasporic Muslims, i.e. a logic of

"cultural difference".[8] In order to further operationalize the logic of cultural difference, we turn to Edward Said's seminal work *Orientalism* (2005 [1978]). Relying on a Foucaultian understanding of discourse, Said (2005) defines Orientalism as a historical and systematic discipline by which Europe produced the Orient, thus unpacking the intricacies of power/knowledge through laying bare the intimate relationships between colonialism and the scholarly study of the Orient. At the heart of Orientalism as a style of thought, Said argues, lies the production of an ontological and epistemological distinction between the Orient and the West, a distinction that is essentialised. More recently, and notably in the context of the post-1989 reshuffling of the geopolitical landscape, the notion of the Orient has increasingly come to coincide with Islam resulting in the well-known oppositional framing of the West and Islam in which superior values are attributed to the West and inferior ones to Islam. The epistemological structures of Orientalism obscure the profoundly dialectical ways in which identities of, and knowledges about, Self and Other are constructed (Rondelez et al., 2016).

However, as we are teasing out the relevance of the work of Rose (1998; 1999) and Said (2005) to make sense of our empirical data, we also come to the conclusion that their work not only allows us to *select* and gain insights, but also to *deflect* crucial insights concerning underlying rationales and views of professionals in mental health care services. Their theoretical contributions enable us to challenge binary and categorical thinking, which is reflected in oppositional dichotomies between the Self and Other that often function as underlying and implicit assumptions in the field of mental health care. Their views enabled us to analyse how Muslims with a migration background are perceived as unknowing subjects, and how mental health professionals exercise authority over and use their expert knowledge on these subjects (Prior, 2003), developing an idea that the "culture" of Muslims with a migration background is homogeneous although they claim that they use a culturally sensitive approach. The work of Rose and Said, nonetheless, also created blind spots in our analytical grid, and only allowed for a critical deconstruction of this binary dialectic between ontologically different categories of Self and Other (see Foucault, 1978; Butler, 2004). The analytical grid did not enable us to go beyond a negative appreciation of professionals in mental health care and to imagine a non-deterministic and non-dualistic framing of the human subject formation of diasporic Muslims with whom they try to work (see Braidotti, 2013; Vandekinderen & Roets, 2016). Our analysis mainly uncovers individual approaches to recovery but does not illuminate a truly social approach to recovery, in which people with mental health issues and professionals have an alliance and share responsibility in shaping care and support practices in a continuous dialogue (Beresford & Croft, 2004; Vandekinderen et al., 2012). This will be of vital importance in future research.

8 We are not referring to the whole debate about norms and values in the sector of mental health. We only refer to ethnic culture here, but are aware that there are also other norms.

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