From craniology to cultural sensitivity

An explorative research on the experience of people of colour with Dutch mental healthcare

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Abstract

How inclusive is mental healthcare? Studies have raised questions on the adequacy of treatments for Black people and people of colour. Researching this in the Dutch context, this paper argues that while participants overall had good experiences, these were mostly achieved in spite of the current mental health system, rather than because of it. First, the history of psychology is examined, showing its racial origins. Then, conversations with ten clients of colour, using a narrative method, are analysed using concepts from Critical Race Theory. This research reveals several important factors in experiences with mental health in general, thresholds to mental healthcare and the care itself. Thresholds can be: being perceived as different, a high pressure to perform, being expected to do emotional labour and cultural values. Part of these experiences might be caused by therapy being (perceived as) a Western phenomenon. To lower these thresholds and provide people of colour with adequate mental healthcare, cultural sensitivity is needed. However, participants report a lack of cultural sensitivity in Dutch mental healthcare. To close the gap between White people and people of colour in Dutch mental healthcare, this paper recommends further research in the context of the Netherlands. Specifically, this can be achieved by examining current policies of mental healthcare institutions, and testing certain forms of cultural sensitivity in order to improve policies and trainings for therapists.

Keywords: cultural sensitivity, institutional racism, mental healthcare, psychology, White supremacy

Introduction

“I thought my eating disorder was a luxury problem,” she told me, “that you could only get in the West. I felt very guilty for being apparently prosperous enough to have an illness like that, instead of family members or other people in Iran who had to deal with much bigger problems than I had.”

Like many other people of colour (Smits, De Vries & Beekman, 2005 among others), this woman I talked to experienced (internalised) stigma on mental health issues. She fled from Iran at a young age, and developing her eating disorder in the Netherlands, she felt guilty towards the family she left behind. Feeling guilty or ashamed is one of the many thresholds to seeking mental healthcare that Black people and people of colour can experience. Other thresholds can be a relatively important family culture, resulting in a taboo on seeking care outside the family, or the idea of being ungrateful if you do not make the most of the opportunities your parents gave you when coming here. These all result in stigmas – a blend of a lack of knowledge, negative attitudes and excluding or avoiding behaviours (Thornicroft, 2008) – on mental health issues.

It is these experiences with mental health issues among Black people and people of colour that I will focus on in this paper. However, it is more than the (internalised) stigmas that might keep Black people and people of colour from receiving adequate mental healthcare. The problem is also in the healthcare (system) itself. As Mensah, Ogbu-Nwobodo and Shim write, “race, as a form of caste system, empowers White patients and mental health professionals at the expense of patients and mental health professionals of colour” (2021: 4), resulting in negative experiences among clients of colour. For example, some people of colour say that they ‘just do not click’ with their therapists. Others drop out early, resulting in less contact moments in mental healthcare among Black people and people of colour on average (Hilderink, Van ‘t Land & Smits, 2009).

The shortcomings regarding adequate care for people of colour, thus seem to be a structural problem. Therefore, in this paper, I aim to link clients’ personal experiences with the broader concepts of structural racism and White supremacy, “a comprehensive condition whereby the interests and perceptions of white subjects are continually placed centre stage and assumed as normal” (Gillborn, 2006: 318). Perceiving White as normal, implies perceiving Black as not normal – a belief which I will show is also visible in mental healthcare.

A lot of research has been conducted on the thresholds Black people and people of colour experience when needing mental healthcare, as well as experiences they have with the

care itself. However, this is mostly research situated in the United States, focusing for example on African American communities (Budhwani & De, 2019; Suite et al., 2007; Logan, Denby & Gibson, 2013; Kawaii-Bogue, Williams & MacNear, 2017; Krill Williston, Martinez & Abdullah, 2019 among others). The studies show, for example, that African American women receive mental healthcare only half as often as White people, despite having higher rates of certain mental illnesses (Thornicroft, 2008). Mensah et al. add that over 30% of Black people, 20% of Latinx people, and 23% of Indigenous people report avoiding medical care "because of experiences of personal discrimination due to their race or ethnicity in healthcare settings" (2021: 3).

In the Netherlands, numbers are not as specific and research not as extensive. The Dutch (e.g. Fassaert, 2009) and Belgium (e.g. Levecque, Lodewyckx & Vranken, 2007) research available, mainly focuses on Turkish and Moroccan immigrants, thereby not only contributing to the classification of people but also directing possible problems with mental healthcare to failed integration or low socio-economic status on the side of the immigrants. The researchers are not looking at the issue in terms of possible mistakes and blind spots on the side of healthcare itself, let alone White supremacy. Furthermore, the studies are mostly quantitative, not grasping the lived experiences that are needed to get an in-depth view of the situation.

In order to fill this research gap, I have conducted my own research on the experiences of Black people and people of colour with mental health in general and Dutch mental healthcare in particular. This paper is the result of both an elaborate study on the history of psychology and mental healthcare, as well as in-depth interviews with Black people and people of colour. I aimed to explore the situation by really listening to the stories rather than noting numbers. Thus, in this paper I will answer the question: How do Black people and people of colour experience mental health issues and their contact with Dutch mental healthcare specifically? Furthermore, I am investigating possible institutional racism that Dutch mental healthcare may not be aware of or is wilfully ignorant about (Wekker, 2016).

To do this, I will use concepts from Critical Race Theory (CRT), a research field primarily interested in "studying and transforming the relationship among race, racism and power" (Delgado and Stefancic , 2017: 3). White supremacy is a big part of CRT, together with concepts like microaggressions and structural racism. This last concept is important because, as Mensah et al. write, "by accounting for power differences among racial groups, structural racism explains racial group differences better than individual prejudice and discrimination alone" (2021: 2).

In this research, I am writing Black with a capitalised B to "affirm the significance of being Black", to speak with the words of Sarah Glover, former president of the National Association of Black Journalists in the United States. She writes that "capitalizing the "B" in Black should become standard use to describe people, culture, art and communities" (Glover, 2020). The capital B is an act of contestation against any person/research/institution claiming that negative experiences are coincidental or can be attributed to shortcomings on part of people of colour themselves. White is also capitalised in my research, precisely because Whiteness is such a powerful construct.

The structure of this paper will be as follows. First, I give an overview of the context in which my research takes place, by reviewing other scientific studies on both the history of psychology, as well as the current situation regarding mental health stigmas and perception of contact with mental healthcare. This shows a gap regarding research in the Netherlands, leading to my own research, which I firstly explain the methodology of. After that, I analyse the conversations I had with people of colour. This analysis will be separated into multiple sections, which represent the most notable themes resulting from the in-depth conversations. In the conclusion, I look back on the most important findings and look forward by giving recommendations for further research.

Literature review

Thus, I am focusing on two main points of interest, being mental health stigma in general and specifically among Black people and people of colour, and how people of colour perceive their contact with Dutch mental healthcare. I will structure this literature review in the same way, but I will start with an historical overview of the relationship between race and psychology.

An historical overview

To explore the perception of stigma and discrimination of Black people and people of colour in mental healthcare, it is important to look at historical context first. Just like racism in medicine, racism in psychology research goes way back (Suite et al., 2007). A lot of these racial practices were based on doctrinal racism, a belief that arose in the 18th century and encompassed the idea that people could be classified into distinct biological groups on the basis of phenotypic features, which were linked to inner characteristics such as inner mental or moral characteristics and (therefore) to value (Jackson Jr, 2017). The most telling example of this may be craniometry in the 19th and part of the 20th century, meaning the measurement of skull volume/brain size and its relation to race and intelligence, resulting in a Caucasoid > Mongoloid > Negroid hierarchy of intelligence (Lieberman, 2001).

Practices like these existed to scientifically justify the exploitation and enslavement of both natives of the New World and imported Black slaves (Weizmann, 2004). As Gould (1981) notices, this research was often not based on scientific objectivity – as far as that exists – but rather on racial prejudices of researchers. Not surprisingly, results were always the same. For example, an U.S. Census Report from 1840 'proved' the insanity of African Americans by stating that 'the further north blacks lived, the higher their rates of mental illness'. In the same era, a mental disorder called 'drapetomania' was invented to describe African slaves' urge to be disobedient and escape slavery (Poussaint & Alexander, 2001).

These roots in White hegemony are still visible in contemporary psychology. Taking into the account that we live in a world "whereby the interests and perceptions of White subjects are continually placed centre stage and assumed as normal" (Gillborn, 2006: 318), Black people are automatically 'not normal' and are thus sometimes misdiagnosed. There is proof of an overdiagnosis of heavy disorders, like schizophrenia, and underdiagnosis of less heavy mental disorders, like affective disorders, among African Americans, Afro Caribbeans and Latinos/as/x. (Suite et al., 2007). For example, Day (2002) found that Black children are diagnosed with Oppositional Defiant Disorder (which indicates disobedience and aggression)

more often than White children. According to Bhugra and Bhui (1999), both underdiagnosis and overdiagnosis are often a result of ignorance and a lack of effort in attempting to understand the cultural norms and experiences of clients.

This intertwined nature of psychology and social life is also visible in more recent developments that shaped mental healthcare: the shift from psychoanalysis to symptom based treatment. Until the 1970s, (American) psychiatry was dominated by a psychoanalytic view, viewing mental disorders "as conflicts of personality and intrapsychic conflict" of which symptoms were just a reflection (Mayes & Horwitz, 2005: 249). This dynamic psychiatry asked for treatment in which the personal history of an individual was analysed, rather than the symptoms treated (Mayes & Horwitz, 2005). Critique on this eventually led to an official classification in which mental illnesses were not broad entities, but symptom-based, categorical diseases of which symptoms should be alleviated with the optimal treatment for each disease (Mayes and Horwitz, 2005). This paradigm shift was not caused by new knowledge, as Mayes and Horwitz (2005) argue, but was rather political and economic, again showing the presence of social structures in psychology. Furthermore, it led to a system in which the causes of a mental illness are less important than the symptoms, thereby not really taking into account differences in clients' backgrounds.

Thresholds to mental healthcare

With this history of psychiatry in mind, I am now turning to the current situation. While mental health issues occur in all demographic groups, some people are more vulnerable to mental illness than others. Budhwani and De (2019) show that women on average report more days with bad mental health than men. Meanwhile, married people, young people, people with a higher income, people with college degrees and employed people reported significantly fewer poor mental health days.

Not all people suffering from mental illness receive treatment. Wittchen and Jacobi (2005) show that in Europe, mental illnesses affect 27 percent of the population every year, 74 percent of them receiving no treatment. People who do seek help, often wait a long time to do so; it takes for example six to eight years for mood disorders. People who identify as male, are poorly educated or are a member of an ethnic minority, wait even longer than average (Wang et al., 2005). Also, certain social groups have lower rates of treatment for mental disorders, for example African Americans in the U.S. and Black Caribbean groups in the U.K. (Hines-Martin et al, 2003). African Americans are said to seek and receive mental healthcare only half as often

as White people, despite having on average higher rates of some mental illnesses (Thornicroft, 2008).

Not seeking mental healthcare can have different reasons, the most prevalent being a lack of accurate and useful knowledge about mental illnesses and treatability; ignorance about how to access treatment; negative beliefs concerning other people with mental illnesses; expectations of discrimination against people with mental illness (Thornicroft, 2008); and 'the preference to solve the problem on one's own', also called self-reliance (Fassaert et al., 2009).

Self-reliance, and therefore thresholds to mental healthcare, exist in every ethnic group. An interesting finding of the study by Fassaert et al. (2009) was however that not only percentages of perceived barriers were in general higher among migrant groups, but also, 'pessimism' (thinking nothing would help) was not present in the group of Dutch participants at all, while 36 percent of participants with a migration background reported feeling it. Thornicroft (2008) summarises barriers to mental healthcare specifically for Black communities in Britain and the U.S. Those are "socio-cultural (health beliefs and mistrust of services), systemic (lack of culturally competent practices in mental health services), economic (lack of health insurance), or individual barriers (denial of mental health problems)" (Thornicroft, 2008: 16).

The shame and fear of being rejected can also play a role. Corrigan (2004) states that people often minimise their contact with mental healthcare to avoid being labelled as mentally ill. Stigma is thus another barrier to mental healthcare. While stigma can be influenced by cultural factors and beliefs (Smits, De Vries and Beekman, 2005 among others), the perceived need for treatment seems to not be lower for people of colour than among Whites, or as Fassaert et al. (2009) problematically say, ethnic Dutch people. The researchers even found that perceived need among mental healthcare was significantly higher among Turkish participants compared to Dutch and Moroccan people. In my research, I aim to focus on the reasons behind the discrepancy between needing help more, but receiving it less.

Structural racism in mental healthcare

If perceived need for mental healthcare is not lower among ethnic minorities compared to ethnic majorities, then what is the cause of migrants' underutilisation of mental services and dropout from treatment (Fassaert et al., 2009)? Here, I want to turn to people of colour's experiences with mental healthcare.

As Cénat (2020) writes, racial discrimination, racial profiling and microaggressions do (still) exist within mental healthcare institutions, impacting or preventing adequate treatment of clients of colour. This is partly maintained by psychological research, where for example racial comparisons of intelligence test scores are still presented as meaningful scientific questions (Winston, 2004). Even psychiatrists and other mental health professionals wanting to make a change "often struggle to square racial injustice with the mission and values of the profession" (Mensah et al., 2021: 1), also because "the risk of being labeled racist after one verbal misstep outweighs the considered benefits of dialogue" (Mensah et al., 2021: 2-3).

These racial prejudices and/or ignorance of structural racism impact people of colour's view on and experiences with treatment. The main reason for people of colour's access to care is not (internalised) stigma, but negative perceptions of mental health services and poor experiences with care services, "including attitudes described as discriminatory and racist" (Cénat, 2020: 929). People of colour are more likely to feel treated with disrespect by healthcare professionals and report more problems about communication with their physician than White people. 5% of African Americans and 13% of Latinos/as/x believe they would receive better healthcare if they belonged to another ethnic group, compared to 1% of White people (Geiger, 2001).

This perceived stigma in healthcare has also been proven to worsen mental illnesses. In the study by Budhwani and De (2019), perceived stigma in healthcare settings was associated with 61 percent higher odds of reporting a depressive disorder. Mensah et al. (2021) also state that perceived racial discrimination is associated with increased depression, anxiety, posttraumatic stress disorder and psychological stress. This causes a vicious circle: while people go to mental healthcare for their issues to be treated, racial discrimination in mental healthcare might cause other, new issues.

The findings mentioned in this section imply that in mental healthcare, too, White supremacy is present, making people with non-White ethnic identities feel like outsiders because healthcare is not adjusted to them. This seems at least the case in the U.S. With my own research, I examine the situation in the Netherlands. This is important especially because research from the U.S. is not directly applicable on the Dutch context. For example, the very notion of 'race' is not a taboo in the U.S., but it is in the Netherlands, where 'colourblindness' is pretended, meaning that people claim not to see colour and conversations on race therefore are shunned (Essed & Trienekens, 2008). While Dutch people are proud of this colourblindness, I aim to investigate if in mental healthcare, this is deserved.

Method

To examine racial inequalities in mental healthcare in the Netherlands, I have carried out an explorative qualitative research. Conducting qualitative research is important, because quantitative data fail to grasp the lived experience. I have talked with ten persons of colour that had experience with Dutch mental healthcare. These were all young people (between 21 and 33 years old) and mostly women (seven participants identified as woman, one as man and two as non-binary). However, there was a big variety in both ethnic and cultural background, and psychiatric diagnosis, from depression to eating disorders, psychosis and autism. I ensured this by using purposive sampling, a form of non-probability sampling that is characterised by choosing participants in a strategic way, so that "those sampled are relevant to the research questions" (Bryman, 2016: 418). This way of sampling was useful for my research, because it led to a diverse set of experiences and therefore an in-depth view of the situation regarding mental healthcare for people of colour. I have primarily sought participants through social media.

Although I did make sure that each conversation covered both of my main themes, i.e. mental health experiences and contact with Dutch mental healthcare, I did not have any specific questions prepared. This way, I could listen to participants' stories and let them lead me in their experiences, which is very important in an explorative research, i.e. when there is not much other research available in a specific context. The purpose was to create both an in-depth view of participants' mental health experiences and a feeling of what experiences or themes were most important to them. This 'storytelling', using narratives as a form of data collection, is often used in CRT. Narratives are a useful tool to not only study personal (racialised) experiences, but also link them to bigger power structures in society, e.g. the dominant beliefs of White supremacy (Treviño, Harris & Wallace, 2008). This focus on power dynamics is important, because it explicitly names Whiteness and centres its role in the construction of (structural) racism itself (Beliso- De Jesús & Pierre, 2020). As such, my analysis adopts CRT's focus on notions on Whiteness and White supremacy.

The conversations resulted in audio recordings between 1 hour and 15 minutes and 2.5 hours. After transcribing these, I analysed them using Atlas.ti, initially using open coding (Holton, 2007) because the themes were not yet clear. Analysis of these codes and the corresponding quotations, enabled me to view the most important, interesting and recurring themes in the conversations.

Lastly, I spoke to an employee working in the field of innovation and quality of care, at one of the many mental healthcare institutions in the Netherlands. This enabled me to take into account the current status of mental healthcare policies, and whether or not care for people of colour is already specifically incorporated therein.

Limitations

While the analysis of my conversations resulted in thought provoking findings, I do want to stress that one should be careful with interpreting them. Firstly, purposive sampling is a form of non-probability sampling, meaning that the findings are not generalisable to all clients of colour in Dutch mental healthcare. My qualitative research is rather meant to provide context for the small amount of quantitative numbers that are available on diversity in the Dutch mental healthcare system. After all, reading that Black people and people of colour have less contact moments with mental healthcare does not mean anything if you do not understand the reason, let alone where to start to fix it.

Aside from the relatively small probability sample, that is also not very diverse in terms of age, intersectionality is another reason to be careful with (drawing) conclusions. Because there are so many factors contributing to one's perceivement of mental health and thresholds to seeking care, it is very hard to distinguish which experiences are related to being a person of colour and which to, for example, family dynamics. Living as a person of colour in the Netherlands is a different experience for everyone, and so is living with a mental illness. Furthermore, contact with mental healthcare is for a big part dependent on the therapist and their beliefs and experiences.

Analysis

In this chapter, I will summarise and analyse the conversations I had with my participants. I will group specific experiences in order to highlight some of the most important factors influencing their experience with mental health problems and/or Dutch mental healthcare. With that, I aim to map the current situation of being a Black person or person of colour with mental health struggles in the Netherlands.

While I have tried to make a distinction between factors influencing mental health and factors influencing perceivement of mental healthcare, it turned out that this was not doable, because the lived experiences inside and outside therapy settings largely overlap. For example, when someone experiences stress as a result of being perceived as different in the 'real world', it is very likely that they also experience that feeling in group therapy settings where (almost) everyone else is White, including the therapist. This illustrates the point that structures within mental healthcare are being influenced by, and are part of, bigger structures in society. As I have shown in my literature review, White supremacy is not only the basis of Western society as a whole, but also the basis of mental health research in particular, making the experiences with mental healthcare similar to lived experiences in society as a whole. As a result, most topics I will point out in this chapter influence one's mental health as well as experiences within therapy.

I want to start with a disclaimer. While this chapter emphasises pain points more than positive experiences, the majority of my participants has had a good experience with Dutch mental healthcare, meaning that the therapy helped them. However, that does not mean that the racist origins of mental health research – which still impact mental healthcare nowadays – do not cause problems. For example, some people reported being helped by mental healthcare, while still experiencing not being understood or not fitting into the boxes of the system. Therefore, I argue that most of participants' good experiences were achieved *in spite of* the current mental health system, rather than because of it. One participant even explicitly spoke about having to ignore the flaws in the system, in order to make therapy work for her. It is this underlying system that I want to touch in my analysis.

There is another disclaimer I want to make, being that of intersectionality. Intersectionality is the assumption that "inequities are never the result of single, distinct factors. Rather, they are the outcome of intersections of different social locations, power relations and experiences" (Hankivsky, 2014: 2). While in this analysis, I mostly talk about the influence of race, skin colour and/or ethnic background, these aspects are only one aspect of one's lived

experiences. As Cyrus writes, "members of multiple-minority groups, such as […] queer people of colour (LGBTQ-POC), are more likely to be exposed to experiences of stigmatization, discrimination, and fear of rejection" (2017: 194). Furthermore, navigating this multiple marginalised identity can cause a lot of stress. Therefore, we cannot only incorporate race as a variable, but also have to take into account other structures of oppression along the lines of e.g. age, gender, sexuality, socioeconomic class and body size. These factors all influence ones experiences with mental health and do intersect with one another, which also came to the fore during my conversations. However, the aim and scope of this paper are on the axis of race. This means that the other axes will serve as a backdrop to my analysis, in which racialised experiences are brought to the fore.

These nuances, however, need to be kept in mind while reading the six following sections. In each section, I will highlight an overarching theme of notable findings from my conversations, concerning perceived mental health, barriers to seeking care and experiences with Dutch mental healthcare. Each section will be opened with a quote from one of my participants.

Therapy as a Western phenomenon

> It is a privilege to be able to go to therapy. If you live in a country where 'normal' healthcare is very bad and people are dying and all that, you are not going to invest any money in mental health. That is not a priority, you know. And also… Countries like Surinam and the Antilles are already 1-0 behind because of slavery and how the economy has been left behind. If you are still recovering from that, where do you get the privilege to invest in mental healthcare?

There is no doubt about therapy being a privilege in the Netherlands. While most mental healthcare is being paid by health insurances, you still have to pay 385 euros 'eigen risico' (own risk) a year, for example. You also have to be able to make time for therapy, which might be impossible e.g. as a single parent. However, as many of my participants stated, therapy is not only a privilege, it is also a Western privilege.

There are multiple reasons for that, according to my participants. One reason can be the bigger taboo that mental health issues are in some non-Western societies, another the possibility that therapy is just not a priority. As one participant noticed: "Rethinking situations, as you do a lot in therapy, is a very privileged way of thinking, because it shows you have mental and practical space for that." As I will show in a further section, having this privilege can cause a

feeling of guilt among people whose ancestors did not or whose family does not have this privilege.

The quote I started this section with, is also notable. "If you are still recovering from slavery, where do you get the privilege for investing in mental healthcare?" the participant asked me – maybe also herself. With recovering from slavery, she meant not only economic recovery, but also psychological recovery. Important in this is the intergenerational transmission of trauma, the phenomenon that children of survivors of trauma "can 'inherit' the physic markers of those who lived through and survived a horrific past" (Jacobs, 2016: 1). As Jacobs (2016) shows, this generational trauma does not only live through physic markers, but also through family narratives, cultural narratives, belief structures and social relations of attachment and connection. Some participants note that this is not really seen by therapists, limiting the depth of therapy. Furthermore, this generational trauma might negatively impact the trust that descendants of slaves or other abused populations can have in White therapists, since White psychologists used to be precisely the people misusing them for their own racist assumptions.

Therapy being a Western phenomenon, or at least perceived as one, is thus a key finding, as it might be the basis for some of the struggles non-White people might have with therapy. This is going both ways. On the one hand, people from non-Western cultures might face more incomprehension regarding their mental health struggles than people from Western societies do, resulting in a higher threshold for seeking help. On the other hand, Western mental health institutions are not originally 'designed' with any non-Western cultures in mind. This causes people of colour to feel different within the system, a finding which I turn to in the next section.

Being (perceived as) different

> It is better to sort of lock yourself out, than to try to fit in while you know it is not true. Because if it comes down to it, you are different anyway.

Because of structural racism, being Black is very likely to coexist with being valued different, being seen as 'the Other'. As Snell writes, "if you are an Other, you are an addition, not the same, or different from the rest" (2018: 272). And you are not only different – you are less than other people, not enough. As CRT brings to the fore, Otherism is inherent to White supremacy, since for one race to be superior, there has to be another group that is inferior. Specifically, when being White is the norm, you have no choice but to feel like an outsider as a Black person

or person of colour. This has many implications for one's mental health, both inside and outside therapy settings.

As participants imply, being perceived as different is in a lot of cases directly related with not feeling safe and being very aware of yourself and your surroundings. A lot of Black people mention feeling very unsafe when walking into a room with only White people. Feeling different and/or unsafe heavily impacted participants' mental health. The constant feeling of having to adjust yourself to fit in, costs a lot of energy and makes people feel insecure, thereby impacting their mental health. The same applies to always being alert. As one participant told me: "I am constantly waiting for people to say anything bad, because you are just so used to people saying racist things."

Apart from explicit remarks from people, there are also the subtle, constant reminders that you are different and society is not fully adjusted to you. As Essed and Trienekens (2008) write, "[…] allochtonen are informally considered and treated as second-class citizens, never quite Dutch, never quite the norm, always considered as aspiring, as a problem, lagging behind" (2008: 58). Thus, non-White people are not 'real Dutch' and are constantly reminded thereof. Participants mention for example not finding their shade of foundation in the drugstore and being adressed in English on the street. These microagressions, causing feelings of being different, impact people of colour mentally. As Molina, Alegría and Mahalingam notice, "the stress that results from being treated rudely, ignored, or thought of as less smart, for example, is thought to accumulate over time, triggering psychological and physiological responses that may adversely affect the health of those discriminated against" (2012: 2), of which mental health is a significant part.

One reaction on being the odd one out, can be to make oneself smaller, not stand out any more than you already do. Participants mention not wearing their afro when going to work and never speaking up. This insecurity, never really fitting in and always having to adapt, can cause a lot of stress and eventually depression (Lilly et al., 2018). Here, a paradox is forming. While on the one hand, the stress caused by not fitting in can increase the need for seeking help, the not fitting in itself can be a threshold to the primarily White system of mental healthcare, because of the assumptation that one's situation is probably hard to understand for White therapists who do not have any insecurities of (not) belonging in a certain society.

Furthermore, not being White can be a barrier to acknowledging that one might have a mental illness, since a lot of media attention on people with mental issues only incorporates White people. One participant, for example, talked about not realizing she had an eating disorder because she did not have the 'typical' skin colour and size. "The idea is: an eating

disorder is for blonde, extremely thin girls. So I always thought: we do not get that. That does not happen to us." This is also a striking example of an intersection of ethnic origins and body size in the perception of mental health issues. It also bolsters the argument that CRT, although focused on race, should and does encompass other marginalised positions.

Being (perceived as) different and therefore feeling unsafe, does not only impact mental health and thresholds to mental healthcare, but also the effectiveness of care itself. It is this impact of feeling unsafe on mental healthcare experiences I am now turning to. Senses of safety are especially important in therapy settings, because you need them in order to open up and make the therapy work. As one participant said, "you really expose yourself in a whole different way […] those are all very scary things you do not do daily." Therapy settings are thus already environments people are not used to and probably do not like being in, but when they are also predominantly White environments – "again", as one participant added – this might make people of colour feel even more uncomfortable.

During some conversations, I noticed a strong search for safety on other levels to compensate that. One (religious) participant told me that she could feel safer when a fellow client liked the same music as her, or when her room had a view on a little chapel. Most persons who did have a therapist of colour, said that also gave them a safer feeling. Even the prospective of getting to talk with someone who probably will understand the feeling of being different, can make people feel more safe.

Lastly, feeling like you do not belong can also have another effect in therapy. Some people of colour speak about being very aware of how their therapist sees them, because they do not want to fit into negative stereotypes and therefore be misdiagnosted. One person spoke: "What if they will see me as an angy Black woman, that sort of stuff – yes, that also plays a role. […] The moment you sit in that room and start to tell those stories, you do not want to take into account how the other sees you. […] That is also not ideal for therapists, because they will never get to the core of someone." As the participant said herself, this being aware of how you and your experiences might come across, might be a barrier to fully being open to therapy.

Concluding, being perceived as different has impact in many ways. On the one hand, not belonging in a society can cause stress and other mental health issues, partly by trying to make oneself smaller, partly because a lot of people do not feel safe and are always alert of their surroundings. On the other hand, there is the impact on therapy. If a Black client does not feel safe in a White therapy setting, this might impede being open and vulnerable to a therapist. The same goes for being very aware of how a therapist sees them. Being different can also cause (extra) pressure to perform, highlighted in the next section.

Pressure to perform… twice

> I feel like my parents and grandparents always thought: if you go to school and have a nice job, then your life will not be as bad a ours has been. That makes you feel like: I have to. Sort of like living their missed opportunities through us. […] That is why I always heard: you cannot have a boyfriend, because school is important. Stuff like that. […] It sometimes makes you feel like you cannot do what makes you happy.

Being expected to have a nice job, a loving partner, a busy social life, a 'perfect' body, proud parents and much more, can cause much stress. However, some of my participants also mentioned a whole other pressure to perform. For example, some people reported a feeling of having to work twice as hard as a person of colour, having to prove that they are not what all stereotypes say about them. Apart from causing stress, this can also cause a feeling of not being able to 'afford' a mental illness. As one participant explained: "As a Black person in the Netherlands, you are already 2-0 behind – best case scenario. […] So you do not have the privilege to say, well, I do not feel well today. Or tomorrow, or next week. Because you are already seen as lazy without that." The fear of going to therapy ruining the effort you have made to disprove stereotypes, can be a threshold for seeking mental healthcare.

In other cases, the pressure to perform meant having to live up to expectations of participants' families, who moved to the Netherlands so their children could have a better future. This is something family members did not always say, but more of a feeling participants had, either consciously or unconsciously. This also sets expectations for how they should feel if they 'ticked those boxes' of a 'perfect' life. One participant told me: "If you have a good job and a nice house, and all goes well, then you should feel well. Right? Because that was all you had to do. […] And then if you are not happy, then it is egoistic to say that, or… You just think, [my mother] probably also did not feel like working so hard, taking night shifts and all that jazz, you know. So you think you are just spoiled, suffering while you do not even have to work as hard as her." Another participant added: "My ancestors survived slavery, and I am crying about going to a supermarket."

A woman who fled to the Netherlands at the age of six, also mentioned feeling guilty about developing an eating disorder. "I thought it was a luxury problem, that you could only get in the West. I felt very guilty for being apparently prosperous enough to have an illness like that, instead of family members or other people in Iran who had to deal with much bigger problems than I had." This feeling of guilt can also heighten the barrier to seeking mental

healthcare, because feeling spoiled or as if you are overreacting could limit taking your mental illness seriously. Furthermore, the guilt can be something clients feel is not understood by their therapists. The policy advisor from the mental healthcare institution I talked to, admitted that "it is hard, that feeling of guilt. The guilt for living on this place on the Earth, we [as White counsellors] do not have that." When clients have to explain the feeling of guilt, they are performing emotional labour, highlighted in the next section.

Emotional labour

> I should not have to sit there, while working on my therapy and all the shit I have been through, from rapings to I do not even know what, and also worry about how I can feel safe as a Black woman. That should not have to be that way. In the end, nobody said anything to the girl that touched my hair. It was me who had to say it. But it just should have been in the rules. We do not do this. We do not touch each others hair, we do not discriminate.

Nearly all participants reported themselves being the responsible party to end discrimination and racism in mental healthcare. The woman I quoted above, for example, found it really hard to speak up about not liking people in her therapy group to touch her hair – but nobody else did it for her: "You always have to say it. Every single time. And even then, they do not want to hear it. It makes them feel awkward. So I am also responsible for them not feeling awkward. That is very tiring." Later on in our conversation, she stated that it should not be her responsibility to point out racism and microaggressions; it should be a responsibility of the healthcare institutions themselves.

Pointing out and explaining racism to others is a form of emotional labour, meaning work that requires "conjuring emotional states in others and managing one's own emotions" (Hochschild, 1983: 7). In explaining racism, people of colour have to manage their own emotions regarding the topic, requiring a level of effort. This can be linked to both mental health itself and effectiveness of therapy. For example, it can be very draining to talk about something that hurts you. Both inside and outside of therapy, this negatively impacts the energy people have left for other things – for example, recovering from your illness. Emotional labour is therefore associated with the negative consequences of burnout, fatigue and emotional inauthenticity (Steinberg & Figart: 12).

Furthermore, therapy can become less effective when emotional labour is involved. Firstly because it stands in the way of people being fully open to their therapist and showing their feelings, but also because there is a risk of people spending most therapy time on

explaining racism instead of talking about the effects of it. Knowing that participants had to explain issues concerning inequality to therapists, was in some cases even a reason not to talk about them. One woman told me about wanting to speak about Black Lives Matter with her White therapists, but not doing it, because she did not want to "play the role of explaining". She said: "You want to go beneath it, to the feelings that are touched. To the therapy part, really. But you cannot get there as long as your therapists is missing certain parts of information." She also explicitly stated that she had to actively try to handpick the that tools worked for her, "sort of cutting, pasting and puzzling within a White system, instead of therapy directly matching my circumstances."

The emotional labour expected from Black people and people of colour in this situation, was confirmed by the policy advisor I talked to. She told me: "In our organisation we do not have anything put in writing on the topic of how to deal with discrimination or racism. There is a lot, but nothing in this area." According to her, this was mainly because it was no public issue yet. "We often make policy for something that is a societal problem. For example, if there are less clinical beds available and therefore more people [with mental illness] on the streets, of course something is done with that. If people with mental issues are getting more aggressive, of course more research is done on that. […] [But if it is no societal problem and] if clients do not lay it on therapists' plates very often, it does not develop fast."

She did see an opportunity in Black Lives Matter: "If there is more of a public debate, it is more visible in society, and therefore in consulting rooms and the sector." This explanation implicated that is indeed expected from Black people and people of colour to make it an issue themselves, even if this takes them a lot of energy. The policy advisor added that "[the lack of guidelines] is not intentional, I think it just has to do with the size of the issue" – thereby confirming that in the Netherlands indeed, inequality in mental healthcare is not really perceived as a significant problem.

Cultural values

> If I go to my family and I would say you know, I had therapy last week, they would look at me like: are you seeing ghosts or something? Why? But if I speak about it with friends, they are like: how did it go? I went to therapy too! That is an entirely different conversation, one without taboo, or that is not a weird story if you tell it.

My participants had a lot of different backgrounds: from Surinamese to Iranian and Algerian to Aruban. In what ways cultural background influences the way one sees and experiences mental

health (issues), is an interesting question. However, I firstly want to point out the pitfall of blaming any problems in healthcare on someone's 'different culture', instead of the problematic system. This focus on culture is a visible tendency especially in the Netherlands. As Essed and Trienekens write, in this country, "references to race or race-like characteristics are shunned. The dominant discourse on racial-ethnic groups is almost exclusively about 'cultural' problems" (2008: 56) instead of race. Focusing on the problems of other cultures or intercultural communication, can thus be a form of ignorance about one's own share of the problem. Following CRT methods, in order to discuss the problems of the system, the focus should be on power structures, specifically White supremacy.

Furthermore, there is a big difference between the values of a culture as a whole and the values that are teached within a family (partly) identifying with that culture. Scorzelli and Reinke-Scorzelli for example write that the reasons provided for evaluation of certain approaches to counselling seem to be based "more on the students' interpretation of religious or cultural values than any group norm" (2001: 86). I want to stress, therefore, that anything my participants told me relating to cultural values is coming from their experiences and interpretations. While I do not take these experiences as the truth about entire cultures, it is beyond the scope of my research to take any position in this. This being said, participants did mention a big influence from their culture and/or family when talking about perceiving mental health (issues). While this has a lot of facets, I will try to highlight the most important ones.

First of all, a lot of participants reported that in their circle of family and friends, you 'just do not talk about it'. If you are feeling down, just think positive, count your blessings, work hard and you will be fine. One participant talked about her family getting 'super awkward' when she was expressing her emotions during her depression, because "we normally do not do that here". If you do not talk about something, it is very hard to acknowledge that it even is there, making this a threshold to seeking help.

This acknowledging of something being wrong is also not common in a lot of families and/or cultures. The participant I just quoted, told me that her family often said "someone is hyperactive, someone is very quiet – you know, that is just how he is. But then I think: that is not just how he is, that is his trauma. But no one talks about that." Of course, it is difficult for a lot of people to say if something is just personality or rather part of mental health issues. However, immediately writing off a depression or anxiety disorder as 'that is just how you are' stands in the way of acknowledging that you do not have to suffer like that for your entire life.

People can also feel misunderstood because their problems are just not really known by their family. "My mother does not understand it, because back in the days in Surinam, there

was no ADHD", a participant told me. Not having information about something often leads to incomprehension or even stigma (Furlotte & Schwartz, 2017). If you do not know anything about psychosis or eating disorders, you are more likely to believe stereotypes that tell you someone is 'crazy' for having them, than when you do have more knowledge. Stereotypes therefore cause stigmas on talking about mental health and seeking help for it.

In many cases, respondents also mentioned the big role of the family when it comes to navigating mental health issues. As one participant told me: "In Surinamese culture, everything is being fixed by family. Is something wrong? Your family will take care of it. You do not have to make it more public than that." This idea of handling it yourself, without needing a psychologist, can be a huge barrier for seeking help, because that is not a common solution for having issues (Villatoro, Morales & Mays, 2014). Besides, if you do seek help, that can be seen as a shame or even betrayal. After all, you were not only uncapable of fixing it yourself, but you also are not making use of the help of your family, instead telling all your 'secrets' to an outsider. A family culture can also keep people from being open about their mental health, as multiple participants explained, because they do not want the entirely family or community to know they are going to therapy if they only tell their parents.

Another aspect mentioned by participants is religion. If faith is important in a family or culture, it can have a huge impact on the way people experience mental health struggles and their ability to being open to help. As one participant explained: "In my church, psychosis and being trans are seen as demonic. So they are very heavy subjects, especially psychosis. So it also must have been very scary for my parents, who did not understand how that could happen. Me being posessed by demons." They continued: "I have been raised with the idea of everything mental being demonic and bad. If you are a good Christian, you do not get mental health problems, so to say. So that made it hard for me to accept being admitted to a mental healthcare institution." When mental health is seen as something only for 'bad religious people', this can cause huge stigmas, both in social settings and internalised. This shame can be a barrier for people to seek help. And when they do, a non-religious therapists may not really connect with them. "If I would still have been religious, then I would have taken absolutely nothing from a psychiatrist or psychologist not being Christian", the same participant said. People might also not even consider seeking help; if praying is seen as the best way to deal with emotions, therapy might not even be in the picture, another participant thought.

In short, my participants talked about several aspects of their culture or family impacting their mental health (perceivement): not talking about mental health; not acknowledging mental illnesses; fixing things within the family; and religion. These can all be thresholds to mental

healthcare, either because of stigma or simply a lack of knowledge about mental illnesses. Ideally, these are things that should be considered in their contact with a therapists, but that is not always the case. In the last section, I will analyse this (lack of) cultural sensitivity.

A lack of cultural sensitivity

> I had to fill in one of these schemes, using the situation: imagine you are walking outside, you say hi to your neighbour and he does not say hi back. The thought behind it is: the neighbour does not like me. But you could also fill in a scheme with, that I come home after that, there is no food in the fridge, I tell my mom that and she starts yelling at me like: I cannot help it and you just have to deal with it. That is an entirely different level of not feeling good enough than when your neighbour does not say hi back. And these situations make me feel like: you [as a therapist] just cannot fully relate to the situations we have been through.

In the previous sections, I have highlighted five findings that influenced both perceivement of mental health, barriers to therapy and experience with mental healthcare. I have showed that the mental health of the Black people and people of colour I spoke with, was impacted by being perceived as different, both inside and outside therapy settings; that they felt a higher pressure to perform than White people and they sometimes felt guilty for being privileged enough to focus on mental health; that they felt like they had to do a lot of emotional labour explaining racism to people; and that in their families, it is often unusual to talk about mental health issues, let alone seek help for them. All of these aspects can cause problems leading up to therapy, but during therapy more thresholds to receiving adequate care can form. In this last section, it is solely this relationship with mental healthcare and caregivers that is at stake.

Ideally, in order to make a therapy traject as useful as possible, therapists should be able to take into account all these bigger and smaller cultural and religious aspects I have talked about. This is a form of cultural sensitivity, meaning "an ongoing awareness of cultural differences and similarities among populations" (Majumdar, Browne, Roberts and Carpio, 2004: 162). Attributes to this are knowledge (a therapist must have knowledge about different cultures and values in order to have cultural sensitivity), consideration (the background and beliefs of a client must be considered for cultural sensitivity to follow), understanding (the impact of a client's beliefs must be understood), respect and tailoring (cultural sensitivity means altering care for a group or individual) (Foronda, 2008). To achieve these attributes, there must also be self-awareness and the ability and willingness to examine one's own ethnoculture, attitudes, beliefs and behaviour (Majumdar et al., 2004: 162).

According to my participants, cultural sensitivity is not always present. One example is the way some White psychologists handle the fact that racism is impacting the mental health of their client. For therapists, it is common to look at how a client reacts on a situation. How do they experience it and how can they change that? While with racism, changing your thoughts does probably not lessen the suffering, because the system stays the same and continues to hurt you. As one participant said: "[I did not talk with my therapy about racism] because I was like yeah, but if she really goes into: how can you make yourself suffer less from it, then that is not… It does not work like that." As stated before, thinking the impact of racism can be erased by changing your mindset, is a very privileged way of thinking. Not considering the view of the patient reveals not only a lack of knowledge, consideration and tailoring, but mostly of understanding.

As already said, the feeling of being treated with cultural sensitivity is much more present when having a person of colour as a therapist – regardless of the therapist's cultural background. This is mostly because people do not have to explain everything; there is a shared basic understanding of how it feels to be different, to always work twice as hard, to have certain traumas and that family dynamics and cultural values might differ. This shared understanding, a feeling of not having to explain everything, might make people feel more relaxed, and therefore more open to talk about deeper feelings.

People of colour who do not have a therapist of colour, can feel misunderstood because of seemingly small, maladjusted things, like the examples therapists use. For example, if you are used to always listening to your parents and being punished when speaking up, it is not easy when a therapist suggest you shuld 'just' have a direct conversation with your parents – because that is just not what you do. And if you are used to being very humble, it feels contraintuitive when a therapists says you have to take up space and express yourself. In the quote I started this section with, it is very clear that the therapist is using an example that the participant thought was very different than her own youth experiences. This shows a gap between the understandings and beliefs growing up in one family/culture or another. These situations, arising from very different life experiences, can have a negative impact on the effectiveness of therapy, because the therapy is not well adapted to the issues and circumstances of people of colour. Therapists knowing for example what is taboo in one culture and very common in another, could definitely benefit treatment.

The examples therapists use are not the only thing often unadjusted to a certain background or culture. Another aspect is the form of therapy itself. Research by Scorzelli and Reinke-Scorzelli indicates that while students in India felt that a cognitive approach to

counselling conflicted with their values and beliefs (Scorzelli & Reinke-Scorzelli, 1994), counsellors in Thailand did actually feel the cognitive approach was consistent with their beliefs, mostly because of their belief in Buddhism (Scorzelli & Reinke-Scorzelli, 2001: 90). Thus, because of different values, certain treatments are likely to be received differently by certain people, families and cultures. In the current system, however, every diagnosis is treated with a specific therapy – even if this form of therapy is not necessarily fitting for their situation. Again, this is all based on a basic knowledge of different cultures with different characteristics or values.

While having a therapists of colour can certainly make things easier, it is not impossible for White therapists to have or develop cultural sensitivity. One participant for example talked about her being nervous for the first conversation with her therapist, until another (White) employee walked in and said one Surinamese word to her. "That really made me give therapy a chance", she said, "because before that I was just like, nevermind, the system is too White, they probably do not get me." Of course, it is not always that easy, but at that moment, it helped her feel seen and feel a little more relaxed. Especially because safety is so important in therapy settings, it would definitely be useful to pay more attention to that. This can also be achieved by small things, like recognizing that a Black person might feel unsafe and talking about that.

Therapists could learn this by following a training in cultural sensitivity. As a study by Majumdar et al. (2004) shows, these trainings can have multiple positive effects. They specifically name improved understanding of multiculturalism, increased open-mindedness and cultural awareness, and ability to communicate with minority people. Also, there is an improvement in considering social circumstances, considering culture to be important, seeking information on cultural beliefs and likelihood to adopt healthcare literature (Majumdar et al., 2004). This can have positive health outcomes for clients.

To put the current lack of cultural sensitivity on the agenda, it is important to centre the existence of power structures and their impact on marginalised groups, as CRT does. However, in the Netherlands, racism is not really a topic. As Essed and Trienekens (2008) state, the Netherlands pretends colourblindness, meaning that people claim not to see colour in order to uphold the belief in their innocence. If race is not acknowledged, it is believed there is no reason to talk about racism (Delgado & Stefancic, 2011). Pretended colourblindness and perceiving oneself as very tolerant, thus limit the space to talk about racism, let alone actively trying to find ways to handle superdiversity adequately. This taboo on race and acknowledging differences between groups of people is also keeping public debate away from cultural sensitivity in healthcare, something that I argue needs to change.

Conclusion

In this paper, I have attempted to answer the question: How do Black people and people of colour experience mental health issues and their contact with Dutch mental healthcare specifically? While most participants have had good treatments ultimately, I argue that these were mostly achieved in spite of the current mental health system, rather than because of it. Furthermore, adopting CRT's view that we should primarily study relationships among race, racism and power, I argue that the lack of care specifically adapted to people of colour is a result of White supremacy, taking Whites as the standard.

A few notable findings emerged from the analysis of my conversations. First of all, therapy is (seen as) a Western privilege. Being able to go to therapy shows you have the mental and practical space for that, forming a threshold for people who do not have that space. Because of White supremacy, historically it has been mostly White people having these privilege. Therefore, therapy being a 'luxury' Western phenomenon may cause people of colour to feel guilty towards their ancestors who have survived slavery or people in their home country. As my research shows, some people feel ashamed for suffering when they have a relatively prosperous life, which might limit taking their mental illness seriously and therefore can be a threshold to mental health care. This guilt is something therapists do not always understand, so clients of colour have to perform tiring emotional labour in explaining this, which they also do when explaining (structural) racism.

Another big factor is the feeling of being different, which is caused primarily by microaggressions emphasising that participants are not 'real Dutch'. Feeling different costs a lot of mental energy, which can lead to mental health issues. Furthermore, it is related to feeling unsafe in White environments, which is very problematic especially in therapy settings, where a sense of safety is needed to open up. While on the one hand, the stress caused by not fitting in can increase the need for seeking help, the not fitting in itself can be a threshold to the primarily White system of mental healthcare, because of the assumptation that one's situation is probably hard to understand for White therapists. Another threshold can be cultural or family values, like not talking about mental issues or even not acknowledging anything is wrong. A lot of participants also mentioned a family culture, in which it is taboo to seek help outside your family. Such an (internalised) taboo can lastly be seen in religious environments, where mental health issues are seen as, for example, something only bad Christians can get.

Many participants who did have a White therapist, mention a lack of the cultural sensitivity that is needed to take all these factors into account. My conversations with

participants thus have confirmed that the lack of cultural sensitivity is a structural problem, making it something the mental healthcare system should put high on the agenda. To be sure I am not suggesting that therapy only has to be adapted to a certain culture, however, here again I want to make a difference between culture, one's interpretation of it and other important aspects of specific backgrounds. Even though knowledge of norms and values within a group are important, therapists should never lose sight of individual differences among members of that group. Only tailoring therapy to presumed group differences is not enough. I want to add, in line with wat Mensah et al. (2021) write, that we need to be careful not to put the focus solely on the responsibility of caregivers themselves. While they definitely have a responsibility in being aware of their own beliefs and cultural differences, I think the focus should primarily be on the system itself. Reasoning from a CRT perspective, the mental healthcare sector needs to look critically at not only its (White) history, but also its current policies and the possible structural racism therein, centring the role Whiteness plays in the construction of this.

Thus, while institutions seem to be relying on people of colour themselves to achieve this, I argue that the system needs a change from within, starting by examining both national policies and the (perceived) lack of diversity in employees, as well as urging individual therapists to examine their own beliefs and cultural awareness. Only by doing this, people of colour can receive care that takes into account their background, experiences and beliefs.

Recommendations for further research

The findings of this study do indicate a systemic problem in mental healthcare, resulting in less effective care for people of colour. While my research was mainly explorative, I argue that these circumstances deserve and *need* more attention in sociology. More quantitative and qualitative research needs to be done in the context of the Netherlands, examining not only the exact issues but also the causes and what people of colour feel needs to change.

Specifically, this can be achieved by examining current policies of mental healthcare institutions and findings the gaps in terms of cultural sensitivity. After that, certain forms of cultural sensitivity, like adapted therapy techniques and adapted examples in current techniques, should be tested in order to improve not only policies, but also cultural sensitivity training for mental healthcare employees.

Furthermore, it might be useful to examine ways in which thresholds to mental healthcare can be lowered. Options that my participants suggested were not only a diversification of mental healthcare employees, but also for example making use of role models

of colour normalising mental health issues. Only by focusing on both research and practical steps, can we improve mental healthcare for Black people and people of colour in the Netherlands.

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Appendix

Consent form for participants

Hoi!

Superfijn dat je mee wilt doen aan mijn onderzoek naar de ervaring met psychische klachten en de Geestelijke Gezondheidszorg van mensen van kleur. Ik doe dit onderzoek omdat er nog weinig bekend is over mogelijk (institutioneel) racisme binnen de GGZ, terwijl kennis daarover heel belangrijk is, bijvoorbeeld als aanleiding om het beleid te verbeteren.

In ons gesprek wil ik je dan ook vragen naar jouw ervaringen in de GGZ en met psychische klachten in het algemeen. Natuurlijk hoef je alleen te vertellen wat je wil vertellen. Mocht je achteraf bedenken dat een bepaalde uitspraak of ervaring absoluut niet meegenomen mag worden in het onderzoek, dan kun je dit altijd aangeven.

Als je dit formulier ondertekent, ga je ermee akkoord dat ons gesprek wordt opgeslagen en geanalyseerd. Dit geldt ook voor gevoelige data, bijvoorbeeld over je psychische klachten en over je etnische achtergrond. Jouw toestemming is nodig om je antwoorden voor mijn onderzoek te kunnen gebruiken. Dit gebeurt alleen voor wetenschappelijke doeleinden: alleen mijn scriptiebegeleider en ik kunnen de data inzien. In mijn uiteindelijke scriptie is de informatie niet terug te leiden tot jou. Na het afronden van mijn scriptie zal de opname van ons gesprek worden verwijderd.

Je hebt op elk moment recht om je eigen data in te zien, om persoonlijke data te verwijderen of om je toestemming voor het gebruik van je antwoorden in te trekken.

Voor vragen of opmerkingen kun je me altijd bereiken via 584001mk@eur.nl of 06 27 42 38 27. Mijn onderzoek wordt uitgevoerd in opdracht van de Erasmus Universiteit Rotterdam. De EUR heeft ook een data protection officer, die bereikbaar is via privacy@eur.nl.

Ga je hiermee akkoord? Vul dan onderstaande gegevens in:

Volledige naam:
Handtekening:
Datum:

Alvast bedankt!
Maaike Kooijman